

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

APPEAL FROM HORRY COUNTY  
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case Nos. 2008-CP-26-9047 and 2008-CP-26-9368

Sean D. Fay, as Personal Representative for the  
Estate of Kelly L. Fay, Deceased, ..... Respondent/Appellant,

v.

Grand Strand Regional Medical Center, LLC, d/b/a  
South Strand Ambulatory Care Center, and Stephen  
W. Law, D.O., Dr. Richard Young, M.D., and  
Grand Strand Urology, LLP, ..... Defendants,

Of whom Grand Strand Regional Medical Center,  
LLC d/b/a South Strand Ambulatory Care Center is, ... Appellant/Respondent.

And Of Whom Stephen W. Law, D.O. is, ..... Respondent/Appellant,

And Of Whom Dr. Richard Young, M.D., and  
Grand Strand Urology, LLP, are, ..... Respondents.

RECORD ON APPEAL – VOLUME II

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**SC Court of Appeals**

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1 JURY.)

2 THE COURT: All right. Mr. Alston, I'm going to let you  
3 switch seats again, sir. If you will just move on down to the  
4 regular seat there, if you don't mind.

5 And as you all know because you, of course, were back in  
6 the jury room with Ms. Jones, she began to have some  
7 discomfort this morning. In fact I had noticed her. She was  
8 sort of moving and fidgeting, maybe a good way to describe it,  
9 but I appreciate the fact that she was -- even in spite of her  
10 discomfort she was willing to stay with us, but felt upon the  
11 advice of her physician that she should not, and thus she  
12 left, and I have discharged her as a juror with the Court's  
13 thanks for her willingness to serve as long as she did, and as  
14 long as she could, so we now have twelve jurors.

15 You will recall at the end of the morning hour we were  
16 in the plaintiff's case, and please call your next witness,  
17 Counsel.

18 MR. FOSTER: Thank you, Your Honor.

19 We would call Dr. Mike Benjamin Siroky.

20 THE COURT: Please come forward to take the oath of a  
21 witness.

22 MIKE B. SIROKY, being first duly  
23 sworn, testifies as follows:

24 DIRECT-EXAMINATION BY MR. FOSTER:

25 MR. FOSTER: I apologize for mispronouncing your name,

1 Dr. Siroky.

2 How you doing this afternoon?

3 A. I'm doing fine.

4 Q. All right, Dr. Siroky, I think you've been in here this  
5 morning, have you not?

6 A. Yes, I have.

7 Q. So you've been an expert witness before, have you not?

8 A. Yes.

9 Q. You sort of know the drill. I'd like for you to sort  
10 of introduce yourself to the jury. Tell us where you're from,  
11 and then I'd like to go through your education and training  
12 with you, if you would?

13 A. All right. I'm Mike Siroky, I was raised in Ohio, and  
14 went to college at Boston University, and I went to medical  
15 school at Boston University. I did some training in New York,  
16 for one year at Albert Einstein in -- in medicine and surgery,  
17 and then came back to Boston, and I was at Harvard for two  
18 years for general surgery, and then I went back to Boston  
19 University for Urology training, and I finished in 1976.

20 I've been a urologist for thirty-four years, I guess  
21 that is, and I'm currently working full time, seeing patients  
22 as a urologist. I am the Chief of Urology at the VA hospital  
23 in Boston, and I'm on the faculty at Boston University as a  
24 professor.

25 Q. Dr. Siroky, are you board certified in any areas of

1 medicine?

2 A. Urology.

3 Q. All right, sir, and how long have you been board  
4 certified in urology?

5 A. Thirty-two years. No -- excuse me -- since 1978.

6 Q. Okay, you grandfathered in, so to speak?

7 A. Yes, I am, yeah.

8 Q. Okay, Dr. Siroky, did you ever teach at Boston  
9 University?

10 A. Yes. I am teaching now at Boston university.

11 Q. All right, and were you ever chief of urology at Public  
12 Health Service Hospital in Boston?

13 A. I was.

14 Q. Chief of Urology at the VA hospital?

15 A. I still am.

16 Q. Chief of Urology at -- well the VA Health Care System  
17 is the same thing?

18 A. Same thing.

19 Q. All right, I'm not going to go through your whole CV  
20 here, okay, but I would like to ask you just a couple of  
21 questions off of it. You've been a consultant for the  
22 National Institute of Health Urology panel?

23 A. Yes.

24 Q. You peer-review urology journals ---

25 A. Yes, I do.

1 Q. ---Articles that go into the medical literature, that  
2 sort of thing?

3 A. That's right.

4 Q. Have you been a consultant for the World Health  
5 Organization?

6 A. Yes.

7 Q. American Urological Association?

8 A. I'm a member of the American Urological Association.

9 Q. Were you ever on the admissions committee to Boston  
10 University School of Medicine?

11 A. Yes, for ten years.

12 Q. Okay, and I believe you've had numerous awards and  
13 prizes, have you not?

14 A. Yes sir.

15 Q. The Best Doctors in the World, I believe?

16 A. I don't know about the world.

17 Q. In America -- excuse me?

18 A. In Boston.

19 Q. How about in America?

20 A. Well, I can't recall.

21 Q. Okay. You've done research?

22 A. Yes sir.

23 Q. You've published books?

24 A. Yes sir.

25 Q. You've edited books ---

1 A. Yes.

2 Q. ---And articles in journals?

3 A. Yes.

4 Q. On Urology?

5 A. Yes.

6 Q. And you say you've been practicing Urology for thirty-  
7 four years; is that correct?

8 A. Since 1976.

9 Q. Is that a copy of your CV?

10 A. Yes sir.

11 Q. All right. Thank you, Dr. Siroky..

12 Dr. Siroky, tell the jury how often you see kidney stone  
13 patients. I'm sorry, I didn't know you were getting some  
14 water at the time.

15 A. Very frequently. I don't know how to estimate how  
16 often but it's -- it's a major problem. We, or I should say  
17 I, deal with them almost daily.

18 Q. All right ---

19 MR. FOSTER: Before I go any further, Your Honor, we  
20 would -- we would offer Dr. Siroky as an expert in Urology,  
21 and the treatment of kidney stones.

22 THE COURT: Are there questions as to expertise?

23 MS. SCALISE: No questions, Your Honor.

24 MR. TODD: No questions, Your Honor.

25 MR. AIKEN: No sir.

1           **THE COURT:**   Any objection?

2           **MS. SCALISE:**   No objection.

3           **MR. AIKEN:**    None.

4           **THE COURT:**   Hearing none, then the witness is so  
5 qualified.

6           You may proceed.

7           **MR. FOSTER:**   Thank you, Your Honor.

8   Q.       Dr. Siroky, so I don't have to repeat this every time I  
9 ask you a question about you opinion --opinion or opinions in  
10 this case, will you agree with me that any opinion that you  
11 render in this case will, to a reasonable degree of medical  
12 certainty, being more likely than not, to have occurred ---

13   A.       Yes.

14   Q.       ---Or not have occurred?

15   A.       Yes.

16   Q.       All right, sir. Now, do you recall way back when, Dr.  
17 Siroky, when this case first started, or when you were first  
18 contacted?

19   A.       I believe it was about five years ago.

20   Q.       I just -- just generally, do you remember when -- did  
21 you receive a package of materials to review?

22   A.       Yes.

23   Q.       Well, before you received the package of materials to  
24 review, did you receive -- somebody contacted you from my  
25 office and ask you if you'd be wiling to review it for us.



1 A. I don't specifically recall, but I imagine that's what  
2 happened.

3 Q. Okay, and you subsequently received a package of  
4 information, medical records, that sort of things to review?

5 A. Yes.

6 Q. And as the case progressed did you receive further  
7 information by way of depositions, and other medical records  
8 we -- we were being able to come up with, that sort of thing?

9 A. Yes.

10 Q. All right. And as far as the films go, did you feel --  
11 did you receive copies of the radiological reports in this  
12 case, that were taken on January 26th, 2002 ---

13 A. Yes.

14 Q. ---Of Kelly Fay.

15 A. Yes.

16 Q. And did you also -- did you also receive medical  
17 records from Grand Strand when she went on -- on January 28th,  
18 on Monday, 2002, to review, as well as all reports that were  
19 provided with those records?

20 A. Yes.

21 Q. Okay, and have you considered all those records?

22 A. Yes, I have.

23 Q. All right, did you find it necessary to see the actual  
24 films before rendering an opinion in this case as to the  
25 urological stan -- the urological standard of care?

1 A. No, I did not feel I needed to do that.

2 Q. Okay. Have you since looked at those films?

3 A. Yes, I have.

4 Q. Okay. Can you read them, interpret them?

5 A. Yes, I can.

6 Q. CT and -- CT and/or x-ray?

7 A. Yes.

8 Q. All right, and just to repeat myself, thirty-four years  
9 in Urology?

10 A. That's correct.

11 Q. All right, and have you -- how much time -- have you  
12 spend -- have you -- how much time do you spend around E.R.  
13 physicians in dealing with kidney stones?

14 A. A lot. I mean, I can't estimate it. but, you know,  
15 obviously stone patients -- did you specifically refer to  
16 stone patients in your question?

17 Q. Yes.

18 A. Stone patients come in frequently, and the emergency  
19 room is calling for consultation, and we go see them in the  
20 emergency room, and we take it from there.

21 Q. Okay, Dr. Siroky, based on your education, your  
22 training, and your experience in the emergency room, treating  
23 kidney stone patients side by side with emergency room  
24 doctors, do you feel as though you are qualified to give  
25 opinions about the standard of care, not only of a urologist,

1 but of an E.R. physician, in treating a kidney stone patient?

2 A. Yes, as far as an E.R. physician is concerned, in so far  
3 as their dealing with urological conditions, I feel that I am  
4 qualified.

5 Q. And ---

6 MR. AIKEN: May we examine the witness on that basis,  
7 if he's been offered as an expert in emergency medical?

8 THE COURT: Right.

9 Counsel, your first questions dealt with urology. If  
10 Mr. Aiken wants to voir dire on the issue of Urology as it  
11 relates to E.R. medicine then the court will permit it.

12 MR. FOSTER: Yes sir. Absolutely.

13 THE COURT: All right, go ahead. Mr. Aiken.

14 EXAMINATION BY MR. AIKEN:

15 Q. Dr. Siroky, is there one sentence in your CV about you  
16 having any expertise in Emergency Medicine?

17 A. No.

18 Q. This CV is thirty-three pages.

19 A. That's right.

20 Q. Now I asked you those questions when you were giving  
21 the deposition, didn't I?

22 Well, let me see if I can get you a copy, Doctor?

23 THE COURT: And you may open the original, Counsel, if  
24 you wish, please do.

25 Let me just, while you're doing that, say to the jury,

1 when a deposition is taken the original is sealed by the court  
2 reporter so that it cannot be opened or tampered, otherwise it  
3 would be obvious that it had been opened, and the seal would  
4 have been broken. This is why the Court gives permission to  
5 open an original deposition in these proceedings.

6 Go ahead, Counsel.

7 Q. Doctor, I think I've got three sections. Page eighty-  
8 seven. If you can find that for me. When you're at eighty-  
9 seven just me know, please.

10 A. I have it.

11 Q. On line two my question was, "Have you ever qualified,  
12 sir, to offer expert opinions on the standards of care for  
13 emergency physicians", and what was your answer?

14 A. No.

15 Q. Second question, "Do you hold yourself out today as  
16 having the expertise and experience to offer expert opinions  
17 on the standard of care for emergency physicians", and what  
18 was your response?

19 A. No.

20 Q. And my last question on page one oh one, line seventeen  
21 when you get there. The question was, "In your previous  
22 experience as an expert have you ever offered opinions that  
23 you held with a reasonable degree of medical certainty  
24 regarding standards of care of emergency physicians and  
25 deviations therefrom", and was not your answer, sir, "No, I'm

1 not qualified to offer such opinions." Is that what you said?

2 A. That's right.

3 MR. AIKEN: I object to this gentleman being qualified  
4 as an expert witness on Emergency Medicine. I have no problem  
5 with his urological expertise.

6 THE COURT: Very good.

7 MR. FOSTER: Can I just finish out his deposition  
8 testimony, Your Honor?

9 THE COURT: You want to publish further from the  
10 deposition?

11 MR. FOSTER: Yes sir.

12 THE COURT: And you may. Go ahead.

13 MR. FOSTER: I'm just going to ask ---

14 DIRECT-EXAMINATION BY MR. FOSTER CONTINUED:

15 Q. Do recall when I was asking you questions -- let me ask  
16 you this question first ---

17 MR. FOSTER: Can I ask one voir dire question on my  
18 own, Your Honor?

19 THE COURT: Go ahead.

20 Q. Dr. Siroky, has it been your experience, in being an  
21 expert witness, that different states have different laws as  
22 to what you're allowed to testify to?

23 A. Yes.

24 Q. All right, let me -- let me read -- let me read from  
25 the deposition, on page one twenty-one, that Mr. Aiken was

1 reading from, starting with line eight. "Okay for the purpose  
2 of my questions assume that to be true -- skip that. I'm in  
3 the wrong place.

4 Page one twenty, on line twenty, I asked you the  
5 question, "Were you aware that under South Carolina law, that  
6 as a physician with a medical degree, you are competent to  
7 testify in any area of medicine that you have sufficient  
8 education, training, and experience that you believe yourself  
9 to know the standard of care in; did you realize that", and  
10 your answer was, "I did not", wasn't it?

11 A. That's right.

12 Q. All right, and then on page one twenty-two, line three,  
13 I asked you, "All right, however I want to know is -- do you  
14 feel as though through, your training, education, and  
15 experience, interaction with E.D. physicians treating kidney  
16 stones. that you know the standard of care of an emergency  
17 room physician treating a kidney stone", and your answer was,  
18 "Yes, I'm very familiar with that", was it not?

19 A. That's right.

20 Q. "Now assuming for the purposes of my question that  
21 under South Carolina law you are, in fact, competent to  
22 testify as to the standard of care of an E.R. physician  
23 treating kidney stones, versus say an appendectomy -- okay, to  
24 solely restricting it to kidney stones, are the opinions that  
25 you rendered in this deposition against Dr. Law, Law's

1 deviation from the standard of care, are they to a reasonable  
2 degree of medical certainty."

3 THE COURT: All right.

4 MR. AIKEN: He's testified under oath, himself, he  
5 doesn't have the experience or qualifications to render such  
6 opinion. I stand on his testimony.

7 THE COURT: All right, Counsel, let me ask you, how was  
8 the witness notified, or what was stated in interrogatories  
9 with regard to the witness's expertise? If you'll publish  
10 that to me, please.

11 MR. AIKEN: I can certainly find those, Your Honor. I  
12 have not looked at them in some time. Could you give me just  
13 a minute.

14 THE COURT: Well let's -- let's take a moment and see.

15 All right, ladies and gentlemen, during the course of  
16 discovery the parties notify the other side about who their  
17 witness will be, and in the area of an expert witness, what  
18 area of expertise they intend to testify upon, so we're going  
19 to wait and see what the Plaintiff notified the Defendants  
20 this witness would be testifying about originally.

21 MR. AIKEN: Whatever it says I'm -- that's why we asked  
22 him those questions. I don't know what he said. I wanted to  
23 hear it from him.

24 THE COURT: I -- I -- very good.

25 (COUNSEL IS LOOKING FOR INFORMATION.)

1 STATE OF SOUTH CAROLINA ) COURT OF COMMON PLEAS  
2 )  
3 COUNTY OF HORRY ) (08-CP-26-9047)  
4 ) (08-CP-26-9368)  
5 SEAN D. FAY, as Personal )  
6 Representative of the )  
7 Estate of Kelly L. Fay, )  
8 deceased. ) TRANSCRIPT OF RECORD  
9 )  
10 )  
11 GRAND STRAND REGIONAL ) May 17, 18, 19, 20, 21, 2010  
12 MEDICAL CENTER, LLC, dba ) May 24, 25, 26, 27, 28, 2010  
13 SOUTH STRAND AMBULATORY ) Conway, South Carolina  
14 CARE CENTER, et al )  
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B E F O R E:

HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.

A P P E A R A N C E S:

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CIRCUIT COURT REPORTER  
FIFTEENTH JUDICIAL CIRCUIT

VOLUME 4 OF 8  
(SEE VOLUME 1 FOR INDEX)



1           **MR. FOSTER:**   I'm sorry, Your Honor. That's research we  
2 did. I better take that back. I don't have one to give  
3 opposing Counsel.

4           **THE COURT:**   Say again?

5           **MR. FOSTER:**   Thank you. I'm sorry.

6           **THE COURT:**   That's all right. Thank you.

7           **MR. FOSTER:**   Your Honor, might I help? Our response is  
8 dated October 2006. Our response is -- our original response  
9 is here in my hand, dated 2006, lists -- Dr. Siroky is  
10 expected -- (A) -- lists his name and address -- and then (A),  
11 is expected to testify as to his opinions of the care and  
12 treatment rendered to Plaintiff by Defendants, plural. Dr.  
13 Siroky is expected to testify, to a reasonable degree of  
14 medical certainty, that the Defendants deviated from the  
15 standard of care. Dr. Siroky is expected to testify that, at  
16 a minimum, the failure to rule out infection, and consider for  
17 admission on the parts of Defendant Young and Defendant Law,  
18 as well as the failure of the hospital staff to take a  
19 discharge temperature and properly advise Plaintiff when the  
20 Plaintiff called for medical advice led to subsequent sepsis  
21 and Plaintiff's ultimate death.

22           **THE COURT:**   I'm going to stop you there. That's  
23 sufficient. All right, that's -- I don't need to see it.  
24 You're published it.

25           Mr. Aiken, I'm going to overrule your objection. The

1 issues you raise go to credibility and believability. You may  
2 take that up with the witness, but the court will allow him to  
3 testify because I believe interrogatories properly notified  
4 the Defendants at this witness may testify with regard to the  
5 standard of care of Dr. Law.

6 You may proceed.

7 **MR. FOSTER:** Thank you, Your Honor.

8 Q. Where were we, Dr. Siroky? Can you remember?

9 A. No, I can't.

10 Q. It's getting late, isn't it.

11 Okay, let me get back to that.

12 **MR. FOSTER:** Your Honor, has he been qualified already?

13 **THE COURT:** Over objection ---

14 **MR. FOSTER:** Over objection, all right.

15 **THE COURT:** ---Of Mr. Aiken. Yes.

16 Q. Dr. Siroky, I think we were back to the point where we  
17 were sending you materials. Did you receive materials -- did  
18 you receive materials all along the way throughout this  
19 litigation?

20 A. Yes.

21 Q. Okay ---

22 **THE COURT:** Actually where you were was, you had asked  
23 whether or not he was capable to make a -- render an opinion  
24 with regard to E.R. physician with urological issues. Then  
25 there was an objection, so that's where you stopped.

1           **MR. FOSTER:**   Thank you, Your Honor, very much.

2           **THE COURT:**   Yes sir.   Go ahead.

3           Q.       My next question to you, Dr. Siroky, is, in that same  
4           vein. when you're working with E.R. physicians concerning  
5           urological patients, were you, or were you not necessarily  
6           involved with the E.R. nurses involved in taking care of  
7           urological patients?

8           A.       Yes, I am.

9           Q.       All right, and in the E.R. when you -- where you were  
10          called down to attend, as a urologist, to a urological patient  
11          by the emergency physician, did you also have the opportunity  
12          and duty to direct the nurses in their care and treatment of  
13          those urological patients?

14          A.       Absolutely.

15          Q.       And do you believe that your thirty-four years of doing  
16          that gives you sufficient knowledge, based on your training  
17          and education, to render an opinion as to whether or not the  
18          nurses, in fact, in this case, in fact, deviated from the  
19          standard of care or not?

20          A.       Yes.

21          Q.       All right, Dr. Siroky, why don't we start off here and  
22          just let me ask you this question right up front. I believe  
23          you have already told me that every opinion you give me is  
24          going to be to a reasonable degree of medical certainty, more  
25          likely than not, correct?

1 A. Yes sir.

2 Q. Do you, sir, have opinions as to whether or not --  
3 let's start with the -- with Dr. Young -- deviated from the  
4 standard of care in his care and treatment of Ms. Fay?

5 A. Yes, I do.

6 Q. Okay, could you, please -- and I know we're going to  
7 get into some detail here, but is there -- do you believe that  
8 you could outline these opinions, and then we could may --  
9 perhaps explore in more detail?

10 A. Well, I'll try to summarize them. My opinion is that  
11 Dr. Young failed to properly account for the possibility of a  
12 infected renal system in this patient, failed to take account  
13 of the size of the stone, failed to take account of the  
14 location of the stone, failed to take account of the  
15 obstruction caused by this stone, and the risk that it caused,  
16 rather, the risk that it posed to this patient's well being  
17 and -- and life, and due to that failure, deviated from the  
18 standard of care.

19 Q. All right, sir, did -- did you mention the degree of  
20 obstruction?

21 A. I did.

22 Q. Let me ask you this. Does the extravasation of urine  
23 have anything to do with your opinions?

24 A. It enters into it, but it's not -- you know, not  
25 everything by itself.

1 Q. Okay, let's do this -- and let's see if we can  
2 summarize what your opinions are about the emergency physician  
3 as well. Can you -- you think you could do that, and then  
4 we'll kind of explore everything in a little more detail.

5 A. Well, as far the care in the emergency room it was --  
6 it deviated from the standard of care in, again, not  
7 documenting the temperature of the patient on discharge, or  
8 near the time of discharge, as we've already heard, not  
9 obtaining a white cell count to rule out an infection, and  
10 discharging the patient without any antibiotics, and failing  
11 to take adequate precautions for an infected renal system.

12 Q. All right, sir, and could we do the same, perhaps, for  
13 the nurses? Let's start with Nurse New, the treating nurse,  
14 while she was in the hospital right before -- until right  
15 before discharge.

16 A. Nurse New, as well as the discharging nurse, Mary  
17 Beth -- I can't remember her last name.

18 Q. Doolittle.

19 A. Doolittle. Yes, Mary Beth Doolittle -- both deviated  
20 from the standard of care in not documenting the temperature  
21 of the patient on anything more than the triage occasion, and  
22 failing to assess the status of the patient during her course,  
23 adequately assess the status of the patient during her time in  
24 the emergency room, which was over four hours.

25 Q. Okay. Now, how about the unknown nurse and/or doctor,

1 and/or female voice on Sunday. Do you have an opinions about  
2 that phone call based on -- you've been sitting in here today,  
3 haven't you, instead of me putting up all the medical records  
4 again.

5 A. Right.

6 Q. Do you feel like you're familiar -- are you familiar  
7 enough with the records to talk about them without having to  
8 put up every record?

9 A. I believe so. Again, when a patient who has been in  
10 the emergency room the previous day, and has a record  
11 available for review, calls back as they were told to call  
12 back, then that patient should be offered some medical advice,  
13 and my opinion what they were told, according to what I read  
14 in the depositions, did not constitute medical advice.

15 Q. Thank you, sir. Now let me ask you this, Dr. Siroky,  
16 those opinions that you just listed, before we dissect those,  
17 okay, do you have any opinions as to whether or not each and  
18 every one of those deviations from the standard of care that  
19 you just mentioned contributed to Kelly Fay's death?

20 A. In my opinion, it did.

21 Q. All of them, or some of them?

22 A. Well, all of them as a sum, yes.

23 Q. All right, sir. Let me ask you this, Dr. Siroky. Do  
24 you have an opinion as to whether or not Ms. Fay should -- all  
25 right, you recall the presentation to the E.R. on January

1 26th, 2002, at eight o'clock in the morning, do you not?

2 A. Yes.

3 Q. Okay, and you recall those records, do you not?

4 A. Yes. Well, I don't recall her presentation, but I  
5 recall the records.

6 Q. Okay, do you recall how she presented ---

7 A. Yes.

8 Q. ---Temperature, and that sort of thing. Would you like  
9 for me to put that up?

10 A. Well, go ahead, but -- yes.

11 Q. Let me hand you Defendant's Exhibit Number 1, which is  
12 already in evidence, and is the first -- the first E.R. visit,  
13 on the 26th, with a stone.

14 Well, here was my ultimate question, and I really don't  
15 think you need to get deep into those records for this  
16 question. As far as -- but here's the question. Do you have  
17 an opinion as to whether or not Kelly Fay should have been  
18 admitted, should have -- or sent home from the hospital on  
19 Saturday, January 26th, 2002?

20 A. This is, I think, the crux of the case. Because of the  
21 size of this stone, because of it's location, because it had  
22 extremely low chance of passing on its own, and because it was  
23 completely obstructing, this patient should have been  
24 admitted. After admission she could have either been observed  
25 for a while, or she could have been taken to the operating

1 room for a stint placement, or even lithotripsy, although  
2 that's usually not done on weekends. But if -- had that been  
3 done her outcome would have been different.

4 Q. All right, do you have an -- all right, what do you  
5 base your opinion that she should have been admitted on  
6 Saturday on?

7 A. I base it on the fact that she had a large stone that  
8 was wedged into the ureter, just below the ureteropelvic  
9 junction, as was drawn earlier today for the jury, which had,  
10 as I said -- I characterized it as very low chance -- I would  
11 say almost no chance of passing on its own, and was causing a  
12 complete obstruction as evidenced by certain changes on the  
13 KUB film, and certain changes on the CAT scan film.

14 Having established that fact something has to be done in  
15 an emergent fashion to relieve that obstruction, because with  
16 a total obstruction not only do you run two major risk -- one  
17 risk is the risk of an infection in this closed space, which  
18 then becomes like an abscess, the second risk is damage to  
19 that kidney, because complete obstruction -- and we don't know  
20 exactly how long that complete obstruction can -- can be  
21 present before irreversible damage takes place, but there is a  
22 risk of permanently damaging that kidney because the urine has  
23 no place to go. So you have an obstructed system that can  
24 either become infected and/or can cause damage to the kidney  
25 because of the obstruction. For those two reasons, that



1 obstruction has to be relieved in a, let's say, timely manner.  
2 I'm not going to say it has to be within four hours or twenty-  
3 four hours, but it has to be done in a timely manner to  
4 relieve that obstruction ---

5 Q. Okay.

6 A. ---And that's the standard of care.

7 Q. Okay, when a patient presents, as Kelly Fay presented  
8 on Saturday, does the E.R. physician and/or urologist, or both  
9 have -- if one is consulted, have a duty -- do you know -- do  
10 you have an opinion as to whether or not they have a duty to  
11 rule out infection before that patient is sent home?

12 A. Absolutely.

13 Q. Absolutely -- what is the opinion?

14 A. Yes, absolutely, they do.

15 Q. All right, and the various ways to rule out infection  
16 would be what?

17 A. Well, starting with vital signs, including temperature,  
18 the white cell count, and the urinalysis, and/or dip-stick,  
19 whatever is the practice in that hospital.

20 Q. All right, let's talk about that dip-stick for a  
21 minute. Does this appear to you to be a blow up of the report  
22 on the dip-stick?

23 A. Yes. I have it here.

24 Q. All right, sir. Does anything -- all right, how --  
25 what sort of -- what sort of stone did Kelly Fay present with?

1 A. You mean ---

2 Q. From the records, that they knew at the time?

3 A. The sort of stone, meaning its composition?

4 Q. No, sir. I mean, was it obstructing, was it ---

5 A. Yes, it was obstructing.

6 Q. Okay ---

7 A. It was obstructing the passage between the kidney and  
8 the bladder. It was, in the way, blocking the flow of urine.

9 Q. Okay, Dr. Siroky, do you treat a patient that presents  
10 with a completely, or almost completely obstructing kidney  
11 stone, the same way you treat an every day kidney stone that  
12 you see in the -- lets say it's in the distal ureter, down  
13 here instead of up here, with -- with clear drainage of urine  
14 and that sort of things, do you treat them the same way or is  
15 this a different animal?

16 A. It's considerably different. As I said before, the  
17 three major factors are the size of the stone, the location of  
18 the stone, and the degree of obstruction. Those are not  
19 necessarily separate factors, because one sort of relates to  
20 the other. In other words a larger stone has a higher chance  
21 of obstructing than a smaller stone, so this was ---

22 Q. How big was this stone?

23 A. This stone was, according to the report, five by eight  
24 millimeters, according to the radiology report. So the stone  
25 is certainly good ---

1 Q. Was it five by eight, or four by eight, according to  
2 the KUB?

3 A. According to the KUB it was four by eight, I think.  
4 Yes.

5 Q. Continue. What was it according to the CT?

6 A. Well according to the CT it's quite a long stone. It's  
7 on at least four cuts of the CT.

8 Q. What did the radio -- what does the radiology report  
9 say it was, before you looked at the films?

10 A. Oh, the CT?

11 Q. Yes sir.

12 A. I think he only gave it one dimension, on one -- in one  
13 axial cut.

14 Q. What was that dimension?

15 A. Eight millimeters.

16 Q. Was it eight or five?

17 A. Five, yeah, five. Yeah. Yeah.

18 MS. SCALISE: Your Honor, objection. Leading.

19 THE COURT: Counsel, now that was -- that was leading.  
20 Actually I'm going to ---

21 MR. FOSTER: I just thought we had been through this so  
22 much, Your Honor. I won't -- I won't lead him. I thought  
23 that was just ---

24 THE COURT: Well, you -- that was clearly testifying  
25 for the -- for the witness.

1           MR. FOSTER: I'll be more than happy to show it to him,  
2 Your Honor.

3           Q.       Okay, according to this radio -- according to this CT  
4 report, Doctor, what was the size of the stone on CT,  
5 according to Dr. Chomyn, in his radiology report?

6           A.       Five millimeters.

7           Q.       Millimeters?

8           A.       Well, point five centimeters is five millimeters.

9           Q.       Okay. All right, continue if you would, please.

10          A.       Well, I think we were talking about the characteristics  
11 of this stone, in terms of its size and location. So the size  
12 is considerable. It's of a size that makes it difficult for  
13 the stone to pass. The location also makes it difficult for  
14 the stone to pass because it was wedged in the upper ureter,  
15 indicating that it had not made very much progress down the  
16 ureter. The final factor is the degree of obstruction, and  
17 that you can judge from the size of the kidney, from the  
18 amount of distention of the renal pelvis, which is the  
19 collecting system of the kidney, and if there's any ureter  
20 that's involved, from the distention of the ureter. You can  
21 also assess that from the degree of extravasation, which  
22 happens when you have acute obstruction that then leads to a  
23 back pressure that needs to be relieved in some way, and  
24 usually results in a leak of urine from various portions of  
25 the kidney. It may leak from the sinus, it may leak from the

1     fornix, it may leak into the lymphatics -- and you can see  
2     things on x-ray -- but it indicates that the pressure is high,  
3     and which indicates that the obstruction is fairly complete.

4     Q.     Okay. All right now, and when you say the fornix, and  
5     the sinus and all that, perhaps you might want to -- can you  
6     put that in more ---

7     A.     Well those are weak areas where a blow out can occur,  
8     so when you have high pressure those are the areas that tend  
9     to give, and that's where the leak happens.

10    Q.     All right now, we've heard a lot about this dip-stick  
11    test. Can you tell us if anything -- if you have any opinions  
12    about the results of this dip-stick and -- I'll stop right  
13    there.

14    A.     Well, the first thing you would look for on a dip-stick  
15    -- and maybe we should talk a little bit because I don't think  
16    it's been described as to what these dip-sticks are.

17    Q.     Okay, could you explain that to the jury, please?

18    A.     Yeah, they're just chemical reagent sticks. They're  
19    about this long, and on them you've got anywhere from four to  
20    six small reagent areas, and those areas, when you dip it into  
21    the urine, are going to change colors. So, for example, you  
22    can measure the sugar in the urine according to the color  
23    change of the block that's related to glucose, and there's a  
24    code right on the bottle that tells you which block is for  
25    which item. One of the important items relates to the

1 presence of blood. You almost always have blood in the urine  
2 with a stone. And this dip-stick indicates that the blood is  
3 negative. That's highly unusual. It also indicates that  
4 there's no nitrite, which indicates that there's no detected  
5 bacteria, and no leukocyte esterase, which indicates that  
6 there's no white cells.

7 Q. Well now can you actually see white cells on a dip-  
8 stick?

9 A. No, this is a product of the white cells. That's  
10 what's being measured.

11 Q. Can you actually see bacteria on a dip-stick?

12 A. No, this is a byproduct of the bacteria that's being  
13 measured.

14 Q. Is a microscopic ---

15 A. So clearly the dip-stick is measuring only chemical  
16 components of the urine, whether it's sugar or whether it's  
17 hemoglobin. By the way, it doesn't really measure blood  
18 either, because it doesn't look for red cells. It looks for  
19 hemoglobin.

20 Q. Okay ---

21 A. So if it detects hemoglobin it will give you a positive  
22 reading for blood.

23 Q. All right. Do you know whether or not a microscopic  
24 analysis, and a dip-stick combined, is more accurate than a  
25 dipstick alone ---

1 A. Yes. It's more accurate in that ---

2 Q. ---In detecting infection?

3 A. At detecting infection specifically ---

4 Q. Yes sir.

5 A. ---Only. Yes. It's more accurate because the dip-  
6 stick has false positives and false negatives. One of the  
7 well known false negatives relates to this nitrite test for  
8 infection, which depends on the bacteria producing certain  
9 chemicals that react in this nitrite reaction, but not all  
10 bacteria produce that, and so you could look at this urine  
11 under the microscope and you could see bacteria, and yet the  
12 nitrite test could be negative on the dip-stick because that  
13 species of bacteria doesn't produce that chemical, therefore,  
14 won't be detected, so if you want to call it a false negative  
15 you could call it a false negative for the dip-stick in  
16 detecting that bacteria. So, of course, if you did a dip-  
17 stick and a microscôpic examination it would cover those areas  
18 where the dip-stick is deficient. So, yes, it would be more  
19 accurate.

20 Q. All right. Continue what you were saying about the --  
21 about the -- what jumps -- what sticks out to you.

22 A. Well, what sticks out is that there was no blood, and  
23 as I said, that is extremely unusual in the presence of a  
24 stone, because a stone has a rough edge and will rough up the  
25 inside of the urinary tract and there will be bleeding, and

1 that even small amount of blood will be detected. What this  
2 unusual -- this normal result, which is unusual, tells me, is  
3 that there is a complete obstruction from the stone, and none  
4 of the abnormal urine can get by it, therefore, it can't be  
5 detected because this test was done on urine that was taken  
6 from Kelly Fay's bladder, and how did it get to her bladder.  
7 If the stone is totally obstructing the right side it must  
8 have come from the left side, which is normal and, therefore,  
9 no abnormal urine mixed in with the bladder urine and,  
10 therefore, this dip-stick result is normal, and that tells me  
11 that there's a complete obstruction with -- to, you know, a  
12 probable degree of medical certainty, of that right side.

13 Q. All right, and do you know whether it is perfectly  
14 normal or not?

15 A. Well, it's yellow, clear, there's no glucose in it.  
16 there's no bilirubin, there's no ketones, specific gravity is  
17 one point oh two oh, which is a little on the high side but  
18 she probably wasn't drinking a lot at the time, there are no  
19 red cells -- no blood I should say -- pH is five, which is the  
20 lower end of the normal scale for -- for pH, but it's -- it's  
21 certainly not abnormal. there's no protein, there's no  
22 nitrite, and there's no leukocyte esterase, so it's as normal  
23 as -- I shouldn't say normal -- it's as negative as you can  
24 get.

25 Q. Okay. Should -- do you have an opinion as to whether



1 or not that should send up any red flags to the physician?

2 A. It does to me, as I just explained ---

3 Q. Not whether it does to you. Under the standard of  
4 care, do you have an opinion as to whether or not that should  
5 up any red flags to the E.R. doctor and/or to the urologist to  
6 whom he relays that information?

7 A. I don't think there's a standard of care that applies  
8 to this, but I think this is clearly so unusual that someone  
9 would wonder how did this urine become so normal in the face  
10 of a stone.

11 Q. All right, do you recall -- did you ever read Sean  
12 Fay's deposition?

13 A. Yes.

14 Q. Do you recall whether or not in there was any  
15 conversation between Dr. Law and Sean about Dr. Law's reaction  
16 to the -- his initial reaction to this dip-stick, the dip-  
17 stick results?

18 A. No, I don't remember that specifically, no.

19 Q. If you would, Dr. Siroky, can you read -- do you still  
20 have that open to the -- to the dip-stick result?

21 A. Yes.

22 Q. All right, can you read the date at the top where it  
23 says run date?

24 A. Says 1/27, looks like, '02. It's kind of hard to read.

25 Q. 1/27/02?

1 A. That's what it looks like.

2 Q. That was the next day, wasn't it. Was that the next  
3 day?

4 A. Yes, it was. Yes.

5 Q. Do you have an opinion as to whether there's anything  
6 unusual about that?

7 A. That might have been the date they printed it out, and  
8 that one date might refer to the date that they printed it.  
9 It might not refer to the time that it was done, I don't know.

10 Q. Okay, let me ask you this. Assuming, based on your  
11 testimony just now, that this kid -- that this stone was  
12 completely obstructing, and she's only getting urine out of  
13 her left kidney instead of her right kidney, then do you have  
14 an opinion as to whether or not a microscopic urinalysis, or  
15 even a urine culture would have done any good?

16 A. Well, the urine culture would not have been available  
17 for some time, probably not till Monday, so it would have been  
18 of interest, and probably should have been done, but would not  
19 have changed anything as far as the decision-making that went  
20 on on the Saturday and Sunday. A microscopic examination to,  
21 reasonable degree of medical probability, would have also been  
22 negative.

23 Q. So then what do you attribu -- how does the physician  
24 then rule out infection if you've got -- if you have a  
25 complete obstruction, and a urinalysis isn't going to show it,

1 a urine culture wouldn't -- you get preliminary results back -

2 --

3 A. Uh-huh, from the culture?

4 Q. Yes.

5 A. Twenty-four to forty-eight hours.

6 Q. Okay, then -- then what do they do to try to rule out  
7 infection under the -- to comply with the standard of care?

8 A. Again, physical exam, which includes the vital signs,  
9 extremely important to look for any signs of infection at that  
10 moment and time, when the patient is in the emergency room,  
11 but also you have to have a high level of suspicion. You have  
12 to put things together, and come to the realization that  
13 you've got an obstructing stone, which is causing high  
14 pressure on the kidney, which is not going to pass on its own,  
15 and is high risk of becoming infected, so since you know that  
16 infection would be potentially life threatening, you've got to  
17 use all your resources to try to rule it out, and failing that  
18 you've got to protect the patient by admitting the patient for  
19 observation.

20 Q. All right, let's say that the -- let's move on here. I  
21 want to cover this, too. Let's move on here and let me ask  
22 you if you've seen the -- what Dr. Law dictated, and had typed  
23 up, with regard to what happened in the emergency room.

24 A. Yes.

25 Q. Have you seen that?

1 A. Yes.

2 Q. All right, and under consult, what does it say, as far  
3 as Dr. Young is concerned?

4 A. "Case was discussed with Dr. Richard Young, on-call  
5 urologist, who ..." ---

6 Q. Can I stop you right there?

7 A. Yes.

8 Q. All right, "Case was discussed with Dr. Richard Young,  
9 on-call urologist...". In your opinion, for Dr. Young and Dr.  
10 Law to have complied with the standard of care, what should  
11 have transpired in that conversation?

12 A. Well, to start with there should have been a  
13 description of the patient, the description of her situation,  
14 transmittal of all relevant facts, so that the consultant  
15 urologist, Dr. Young, could make a decision about her -- about  
16 her disposition, and a decision-making process to decide  
17 whether it's safe, or not safe, to send the patient home.

18 Q. All right, you read Dr. Young and Dr. Law's  
19 depositions?

20 A. Yes.

21 Q. Do you have an opinion as to whether or not Dr. Law,  
22 first of all, had a duty to relay all pertinent information to  
23 Dr. Young on the phone when he called him?

24 A. Yes, he did.

25 Q. All right, if Dr. Law did not relay all pertinent

1 information to Dr. Young on the phone, what should Dr. Young  
2 have done, if anything?

3 A. Well Dr. Young should have his own standards for what  
4 is safe for the patient, so if he does not obtain the  
5 information that he wants he should ask for it, or arrange to  
6 have it done. So, for example, if he's interested in a  
7 temperature and they tell him that they haven't taken the  
8 temperature he should ask that a temperature be taken. If he  
9 thinks that the white cell count is going to be important in  
10 his decision-making and there isn't one, he should say, let's  
11 get a white count before we send this patient home.

12 Q. What would you -- what is your opinion as far as what  
13 the pertinent information would be in total, just what you --  
14 is that just what you testified a minute ago?

15 A. Yeah, just what I've been testifying to.

16 Q. Size, location --

17 A. Obstruction. Size, location, obstruction.

18 Q. All right. Let me ask you this question. Again, you  
19 read both their depositions, correct?

20 A. Yes.

21 Q. Do you happen to recall in there what -- whether Dr.  
22 Young said he was aware of the CT results or not, when Dr. Law  
23 called him?

24 A. I can't recall. I have to see the page, please.

25 Q. Okay. Assume for the purposes of my question that the

1 urologist, Dr. Young, testified that he was aware of the CT  
2 results from Dr. Law, the E.R. physician, called him.

3 A. Uh huh (indicating positive)

4 Q. All right, can you tell from the record when she went  
5 to CT?

6 A. Nine o'clock or so.

7 Q. Let's see, let's look on the nurses notes here. Does  
8 that help?

9 Do you see on here, Dr. Siroky, at 10:20 on the nurses  
10 notes?

11 A. Uh-huh, returned from CT, right.

12 Q. All right, so is it fair to say that she was back --  
13 according to the nurse's note she was back from CT at 10:20,  
14 to the E.R.; is that correct?

15 A. That's right.

16 Q. All right, so if, when Dr. -- if Dr. Young, the  
17 urologist, was aware of the CT results, it was sometime after  
18 10:20; would that be fair?

19 A. Yes.

20 Q. All right now, here's what I don't understand. If a  
21 kidney stone -- do you have an opinion as to whether or not a  
22 kidney stone and a fever is a true urologic emergency?

23 A. Yes, I do. It is an emergency.

24 Q. Okay. So one of the pieces of significant information,  
25 I would gather, in your opinion. is the temperature of the

1 patient.

2 MS. SCALISE: Object to the form, Your Honor. Leading.

3 MR. FOSTER: I'll rephrase, Your Honor.

4 THE COURT: Sustained.

5 MR. FOSTER: I'll rephrase it.

6 Q. Is one of the pertinent - is one of the more -- do you  
7 have an opinion as to whether or not the temperature of the  
8 patient, or whether she had a fever, was one of the more  
9 pertinent pieces of information that should have been relayed?

10 MS. SCALISE: Your Honor, objection.

11 THE COURT: And again, Counsel, your answer is within  
12 the question.

13 MR. FOSTER: All right, Your Honor.

14 Q. What was one of the most pertinent pieces of  
15 information -- two pieces of information, that should have  
16 been relayed between the two?

17 A. Well, the temperature is obviously one of the most  
18 important, because it determines whether a patient has a fever  
19 or doesn't have a fever, and as we've already heard this  
20 morning, fever can be due to infection, it can be due to other  
21 things as well. It can be due to the stone itself. But fever  
22 certainly is an extremely important alarm that infection may  
23 be present, so I don't know what the two most important things  
24 are, but certainly the temperature is one of the things that I  
25 would want to know.

1 Q. Okay. If you were consulted by an E.R. physician would  
2 you want to know -- would you want to know if there was a  
3 kidney stone?

4 A. Well, I'm presuming that's already been discussed.

5 Q. Would you want to know the size?

6 A. Yes.

7 MS. SCALISE: Your Honor, objection to leading.

8 THE COURT: She's right, Counsel. You cannot -- what  
9 you need to ask him is, what would he wish to know, what would  
10 he want to know, without you telling him what it is.

11 Sustained.

12 Q. Tell me everything you would want to know from the E.R.  
13 physician if they called you and said we've got a patient with  
14 a kidney stone.

15 A. I would want to know, first, the size of the stone, and  
16 all of it's three dimensions, if possible. I want to know the  
17 location of the stone in the urinary tract. I want to know if  
18 there's any indication of obstruction as manifesting on the x-  
19 ray films, and I would want to know if the patient has any  
20 manifestations of infection at that time, as shown by  
21 temperature, and also by white cell count.

22 Q. All right, sir. Now -- now, would that information be  
23 necessary for the urologist and the E.R. physician to have  
24 complied with the standard of care? Do you have an opinion on  
25 that?



1 A. I believe that is the standard of care.

2 Q. All right. Answer this question for me. If whether or  
3 not the patient had a fever during that conversation is  
4 important then can you look at the records and tell this jury  
5 how Dr. Law could tell Dr. Young whether or not Ms. Fay, Kelly  
6 Fay, was febrile at the time they talked.

7 A. He couldn't tell by means of temperature measurement  
8 because there was no temperature measurement at the time he  
9 was discussing it with Dr. Young.

10 Q. All right. Do you have an opinion as to whether or not  
11 if Dr. Law didn't tell Dr. Young, Dr. Young should have asked?

12 A. Yes. That is the standard of care.

13 Q. You've read radiology reports before?

14 A. Yes sir.

15 Q. Have you ever read a radiology report that reads,  
16 emergency room is aware before?

17 A. Or something to that effect, yes.

18 Q. To state -- to ask the obvious, could you tell the jury  
19 what that means?

20 A. Well, it means that the staff of the emergency room has  
21 been notified of the results of this film.

22 Q. Dr. Siroky, in a patient with a kidney stone, do you  
23 know, or do you have an opinion as to whether or not you, or  
24 anyone as a physician, can determine whether or not a patient  
25 is stable if you don't know their temperature?

1 A. I'm not sure I can answer that, because I don't know  
2 how you mean stable.

3 Q. Stable for discharge.

4 A. Good enough to go home.

5 Q. Yes sir.

6 A. I know in my opinion temperature is critical to  
7 determining whether the patient can be discharged.

8 Q. All right, sir. Now, on the -- again, you read Sean  
9 Fay's deposition, did you not?

10 A. Yes.

11 Q. Do you recall whether it indicated anything in there  
12 about a telephone call on Sunday?

13 A. Yes.

14 Q. Do you recall what the response was?

15 A. To him?

16 Q. Yes sir.

17 A. To his telephone call?

18 Q. Yes sir.

19 A. I'm paraphrasing, but the response was, if Ms. Fay  
20 feels like she needs to come in then she should come in,  
21 otherwise she should continue with the instructions she  
22 received.

23 Q. Let me ask you this, Dr. Siroky, do you have an opinion  
24 as to what was suppose to happen to that kidney over the next  
25 forty -- approximately forty-eight hours, from Saturday until

1 an appointment on Monday?

2 A. Yes, I do. This, again, is one of the important  
3 aspects, I think, of this case, is that you have radiologic  
4 evidence that the kidney is nearly completely obstructed, and  
5 you are going to leave it in that state for at least forty-  
6 eight hours, because from Saturday morning till Monday morning  
7 is forty-eight hours. That's a fairly long time for a kidney  
8 to be completely obstructed, during which time bad things can  
9 happen, one of which would be infection, and the other which,  
10 as I mentioned before, would be an impact on the kidney  
11 itself, it's health.

12 What happens with prolonged obstructed -- I shouldn't  
13 say prolonged, but what happens with unrelieved obstruction is  
14 that the pressure eventually interferes with the blood supply  
15 to the kidney, and over time, not forty-eight hours, but over  
16 time, the kidney suffers. So leaving this kidney obstructed  
17 for forty-eight hours is the crux of this issue.

18 Q. Okay. Now, if Dr. Young had gone into the hospital --  
19 assume for the purposes of my question they -- that in the  
20 E.R. that the nurses took her temperature and it was a hundred  
21 degrees, and that Dr. Young went into the E.R. to see her,  
22 what could he do to help her?

23 A. Well, I think he would have two choices at that point.  
24 He could admit her to the hospital for antibiotic treatment,  
25 IV fluids, pain control, and observation, to see whether she

1 developed further signs of infection, because may he would  
2 think at that point the temperature of a hundred is not that  
3 impressive, let's see what happens over the next six hours or  
4 so and we'll decide what we're going to do. In the meantime  
5 he would keep her without food in case she had to go to the  
6 operating room emergently, and be prepared to intervene if the  
7 clinical situation deteriorated.

8 Or, choice number two, he could decide, well, rather  
9 than waiting, this stone looks like it's not going to pass, it  
10 looks like I'm going to have to do something about it so I  
11 might as well do it now rather than later, it's one o'clock in  
12 the afternoon on Saturday, I'm not doing a whole lot, let's  
13 schedule her in the operating room and put up a stint. A  
14 stint involves looking in the bladder with a scope -- the  
15 patient has to be in the operating room under anesthesia --  
16 and putting up a wire and passing a stint over that wire.  
17 It's a very straightforward, simple procedure, takes less than  
18 fifteen minutes. It bypasses the stone, and the problem is  
19 alleviated until the stone can be dealt with definitively, but  
20 at least the obstruction is bypassed, and that protects the  
21 kidney from further damage, and protects the patient from the  
22 possibility of a serious infection.

23 So I would say that he had those two choices. He could  
24 have come in and examined the patient and said, you know, in  
25 my opinion, after carefully examining her, and looking at this

1 piece of information, that piece of information, I'm going to  
2 send her home. That also is a clinical decision, but he would  
3 have made it with an adequate amount of information.

4 Q. Okay. And did I already ask you what a fever is,  
5 what -- what degree a fever is?

6 A. I don't think you did.

7 Q. Could you tell us your opinion, please sir?

8 A. It's any temperature over a hundred point four, so that  
9 would be a hundred point five or higher.

10 THE COURT: Anything further?

11 MR. FOSTER: I think I'm just about through, Your  
12 Honor.

13 THE COURT: Very good.

14 MR. FOSTER: Beg your indulgence one moment.

15 Just a few more, Your Honor.

16 Q. Dr. Siroky, in regard to -- have you understand from  
17 reading the depositions and listening to this case when you've  
18 in the courtroom, that there is an issue concerning the  
19 physician/patient relationship, that Dr. Young denies that he  
20 had a physician/patient relationship with Kelly?

21 A. Yes, I understand that.

22 Q. Do you have any opinions on that issue?

23 A. Yes. I think that if you look here on this note and  
24 you see that Dr. Young is identified as the on-call urologist,  
25 presumably for the emergency room, that means that he has to

1 make himself available with urological services for any  
2 patient that walks into the emergency room and is deemed to be  
3 in need of urological care.

4 As the on-call urologist he was contacted by the  
5 emergency room and he made a medical decision. Medical  
6 decision-making is the first part of a doctor/patient  
7 relationship. He also suggested that she see him on Monday  
8 morning which, again, is a part of the doctor/patient  
9 relationship, so my opinion is that there was a doctor/patient  
10 relationship in view of his being a member of this medical  
11 staff, being the on-call urologist for that weekend,  
12 discussing the case with the emergency room physician, and  
13 making a medical decision.

14 Q. All right. And what was that medical decision?

15 A. Medical decision was to send her home, and to see her  
16 on Monday morning.

17 Q. Okay. Now, do you understand, Dr. Siroky, whether or  
18 not the law requires that the patient also accept him as a  
19 doctor, as well as the doctor accepting the patient as -- her  
20 as a patient?

21 A. Yes.

22 Q. Do you have any opinions as to whether or not the forms  
23 that the -- that the hospital had Kelly sign in regard to  
24 forwarding her records to Dr. Richard Young on Monday had  
25 anything to do with her acceptance of him as a doctor?

1 A. Well, I believe it does indicate that at that point in  
2 time.

3 Q. All right. Let me ask you this, do you know anything  
4 about -- as a physician, about HIPAA?

5 A. Yes sir.

6 Q. Do you know what HIPAA is? What is HIPAA?

7 A. HIPAA is the Federal Law which prohibits the  
8 unwarranted sharing of patient confidential information.

9 Q. All right. If Dr. Young had not accepted her as a  
10 patient do you have -- do you understand or have an opinion as  
11 to whether or not he should have been in possession of her  
12 medical records?

13 A. He should not have been.

14 Q. As you look at the typewritten E.R. report that Dr. Law  
15 wrote -- do you see that?

16 A. Yes.

17 Q. Who was copied on that?

18 A. Dr. Richard Young.

19 Q. Did you read both of the depositions?

20 A. Dr. Young and Dr. Law.

21 Q. Yes sir.

22 A. Yes.

23 Q. Did you see any language in those depositions that  
24 indicated whether or not there was any joint decision-making?

25 A. I can't recall, you know, specific language.

1 Q. All right. Can you recall your impression ---

2 A. My impression was that there was joint decision-making.

3 Q. Dr. Siroky, one last question. Did you come down here  
4 for free, or are you charging for your time?

5 A. I am expecting to be compensated.

6 Q. And -- and how much do you charge?

7 A. Six Thousand Dollars for a day of testimony.

8 Q. And that's plus expenses; is that correct?

9 A. That's correct.

10 MR. FOSTER: All right, Dr. Siroky, thank you very  
11 much.

12 THE COURT: All right, ladies and gentlemen, let's take  
13 our afternoon break at this time.

14 Dr. Siroky, I'm going to ask you not to speak to the  
15 lawyers on either side, although you are welcome to stand down  
16 and take a break, but because you are a witness under  
17 testimony please don't talk with Counsel.

18 Let's all remain where we are while our jury returns to  
19 the jury room.

20 Have a nice break, ladies and gentlemen. If you want to  
21 go outside we'll certainly make that available to you.

22 (THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE  
23 JURY.)

24 THE COURT: All right. We'll be in recess now  
25 approximately fifteen minutes, but that's subject to the



1 return of the jury from their break.

2 (THE FOLLOWING TAKES PLACE AFTER A BREAK AND OUTSIDE THE  
3 PRESENCE OF THE JURY.)

4 MR. FOSTER: May I approach?

5 THE COURT: You may.

6 Please be seated, ladies and gentlemen.

7 Well, Counsel, you -- well, no. If you want to approach  
8 let's let the other lawyers come with you, will be fine.

9 (BENCH CONFERENCE TAKES PLACE OFF THE RECORD.)

10 THE COURT: All right. We're going to let Mr. Foster  
11 ask one more question.

12 Please bring in the jury.

13 And Ms. Scalise, are you going to be the first  
14 questioning attorney?

15 MS. SCALISE: (NODS HEAD AFFIRMATIVE)

16 THE COURT: All right. Very good.

17 (THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE  
18 JURY.)

19 THE COURT: All right, ladies and gentlemen, Mr. Foster  
20 advised, without objection from the other side, he has one  
21 final question for the witness.

22 MR. FOSTER: Thank you, Your Honor.

23 THE COURT: You may ask it.

24 BY MR. FOSTER CONTINUED:

25 Q. Dr. Siroky, I forgot to ask you one question, sir.

1 Based on your reading of the medical records and Sean Fay's  
2 testimony in regard to Kelly's condition when they arrived  
3 home, do you have an opinion, sir, to a reasonable doubt of  
4 medical certainty, more likely than not, whether or not Kelly  
5 was febrile when she left that hospital?

6 A. Yes. According to his testimony she had an elevated  
7 temperature in the early afternoon of January 26th, and I  
8 would say it's more likely than not that she had a temperature  
9 on leaving the emergency room.

10 MR. FOSTER: Thank you, Dr. Siroky.

11 THE COURT: And now cross-examination.

12 And Ms. Scalise, you may proceed.

13 MS. SCALISE: Thank you, Your Honor.

14 CROSS-EXAMINATION BY MS. SCALISE:

15 MS. SCALISE: Dr. Siroky, we met years ago. Good to  
16 see you again.

17 A. It was a cold day in January.

18 MS. SCALISE: It was very cold.

19 Q. As part of your training you did a residency in  
20 urology; is that correct?

21 A. Yes. And tell the jury, what is a Fellowship?

22 A. A Fellowship is training after the residency, of  
23 variable amount of time, in a sub-subspecialty. Urology is a  
24 specialty, but there are areas within urology that some people  
25 elect to obtain further training.

1 Q. All right. And you didn't elect to obtain further  
2 training in a Fellowship, did you?

3 A. No.

4 Q. So you are not a Fellowship-trained urologist in  
5 stones, are you?

6 A. No.

7 Q. And in fact, your area of interest is not kidney  
8 stones; is that correct?

9 A. It's not an are of my research interests, no.

10 Q. And in fact, you've never even written on the topic of  
11 kidney stones, have you?

12 A. That's correct.

13 Q. Never written on the topic of kidney infections, have  
14 you?

15 A. Not that I can recall.

16 Q. All right. And in fact, your actual area of expertise,  
17 or are of special interest, is in erectile dysfunction, ---

18 A. That's one.

19 Q. ---Incontinence ---

20 A. That's another.

21 Q. ---And bladder disorder.

22 A. Neurogenic bladder, in particular.

23 Q. Okay. And that's when people who are, unfortunately,  
24 paralyzed, and they have problems with their urinary system;  
25 is that right?

1 A. That's correct.

2 Q. Let's talk a little bit about your work as an expert.  
3 Isn't it true that you spend five to six hours a week -- or is  
4 it more -- doing this expert witness work?

5 A. That's fair.

6 Q. All right. And in fact, you average forty to fifty  
7 cases a year in reviewing as an expert.

8 A. I think that's an over-estimate. I actually think it's  
9 more like thirty to thirty-five.

10 Q. Do you recall giving testimony in 2004 and 2005 in a  
11 Greenville County case when you told those attorneys that you  
12 were averaging forty to fifty cases a year?

13 A. That was then.

14 Q. Okay. So back then you were, but maybe not now.

15 A. Not now.

16 Q. Not this year. Okay. And in fact, you've actually  
17 testified in South Carolina, have you not?

18 A. Once.

19 Q. Okay. And in that case -- that was a case in  
20 Greenville, South Carolina.

21 A. Yes.

22 Q. And in that case my expert, Dr. David Albala, was the  
23 expert opposing you; is that correct?

24 A. I believe so.

25 MR. FOSTER: Objection, Your Honor. May we approach?

1 I know where this is going.

2 THE COURT: No sir. If you have an objection state it  
3 from your seat, Counsel. Go ahead.

4 MR. FOSTER: The next question is going to be  
5 relevancy, because I know what the question is going to be.

6 THE COURT: Well, I can't -- I can't rule in advance.  
7 I have to hear the question, Counsel.

8 And before you answer it please let me respond to the  
9 objection.

10 MS. SCALISE: I'm not going further than that.

11 Q. I just want to make sure -- you have met Dr. Albala  
12 before, have you not?

13 A. But not in the circumstances that you are describing.

14 Q. Not as an expert witness?

15 A. No.

16 Q. Okay. So y'all actually weren't in the same courtroom  
17 at the same time; is that right?

18 A. That's correct.

19 Q. All right. Now, eighty percent of your work that you  
20 do is for plaintiffs, for patients or their families; is that  
21 right?

22 A. That's correct.

23 Q. And in fact, twenty percent of your income comes from  
24 doing what you are doing here today.

25 A. That's correct.

1 Q. And you actually have your own website,  
2 UrologyExpert.com, don't you?

3 A. Yes Ma'am.

4 Q. Okay. So kind of like Sean has his website,  
5 SeanFay.com, you've got UrologyExpert.com?

6 A. Correct.

7 Q. All right, and in the website -- this is where people,  
8 if they want to try to find a urology expert they can go  
9 online, find out about you; is that right?

10 A. Yes.

11 Q. And, in fact, don't you say in your website, that you  
12 establish a good rapport with the jurors ---

13 A. That's correct.

14 Q. ---And that you have the ability to explain complex  
15 technical issues to a non-professional audience?

16 A. That's what it says.

17 Q. All right. Now, if I understand my math correctly  
18 you -- or actually let me ask you this question first. How  
19 long have you been doing this expert witness work?

20 A. Six or seven years.

21 Q. You haven't been serving as an expert since 1983, for  
22 the past twenty-seven years?

23 A. I have been asked on occasion to look at cases, but  
24 I've only been doing it as a serious, you know, part of my  
25 time since 19 -- since 2003. I have, throughout my career,

1 consulted on medical legal cases, but the bulk of it has been  
2 since 2003.

3 Q. It's actually on your website -- you have a sentence.  
4 You say, "He has served as an expert witness and legal  
5 consultant since 1983."

6 A. That's correct.

7 Q. Make sure -- is that what it says?

8 A. That is correct.

9 Q. Now, you've been serving as an expert since 1983.  
10 Isn't it true that you have reviewed hundreds, if not even  
11 over a thousand cases in your career?

12 A. Could be close to a thousand, yes.

13 Q. All right. All right now, let's actually talk about  
14 the case. You have testified, I believe, today that when Dr.  
15 Law and Dr. Young talked on the telephone that -- you told  
16 this jury that what Dr. Young needed to know, what he had to  
17 find out, was what the size of the stone was, the location of  
18 the stone, whether there was an obstruction, and if there was  
19 infection; is that right?

20 A. Yes, signs of infection.

21 Q. Signs of infection, and which you further defined for  
22 us as being a temperature and a white blood cell count. Is  
23 that right?

24 A. Yes.

25 Q. Now you've read the testimony of Dr. Law, and have read

1 the testimony of Dr. Young. Do you recall where Dr. Law  
2 said -- and actually Dr. Young said that Dr. Law told him that  
3 this was a -- read it from her, because this is from Dr. Law's  
4 dictation -- that this patient was afebrile, did not have a  
5 fever. Do you remember him telling -- you remember that  
6 testimony?

7 A. Yes.

8 Q. Okay. And that he told -- that Dr. Law told Dr. Young  
9 that this was a stone in the right UPJ, it was moderately to  
10 severely obstructing, correct?

11 A. Yes.

12 Q. All right. And he also said that the labs were normal,  
13 correct?

14 A. The labs that they had.

15 Q. Okay. So, Dr. Law has told Dr. Young, and Dr. Young  
16 has found out everything that you say he needed to know,  
17 correct?

18 A. Not the temperature.

19 Q. But he said he (SIC) was afebrile.

20 A. But the patient wasn't afebrile at the time they were  
21 talking.

22 Q. All right. So your testimony is that, when Dr. Law  
23 called Dr. Young -- and this would be sometime right before  
24 11:38 in the morning, correct ---

25 A. Yes.



1 Q. ---That it was your testimony that Dr. Young should  
2 have asked Dr. Law, now what time was that temperature taken?  
3 Is that what your testimony is?

4 A. Yes.

5 Q. So Dr. Young cannot rely on a board-certified emergency  
6 room physician to know whether or not this patient is febrile,  
7 or not?

8 A. Dr. Young has to make his own determination.

9 Q. Is it -- your testimony is that Dr. Young is suppose to  
10 basically henpeck Dr. Law and ask him question after question.

11 MR. FOSTER: That's argument -- objection, Your Honor.

12 THE COURT: Sustained as to argumentative, Counsel.  
13 Please rephrase.

14 MR. FOSTER: Thank you.

15 MS. SCALISE: Yes sir, Your Honor. Sorry.

16 Q. Is it your testimony that Dr. Young then, is suppose to  
17 quiz Dr. Law?

18 A. That's what happens ---

19 Q. Okay.

20 A. ---In fact.

21 Q. And in fact, if Dr. Law said that this temperature was  
22 taken that morning, in your opinion that's not enough?

23 A. That's right, because they don't have a white count,  
24 and the urinalysis, or such as they did, the dip-stick, was  
25 remarkably negative.

1 Q. All right. Well, let's talk about that urinalysis --  
2 and I've kind of written out what it said because I have  
3 terrible, terrible vision. I think it's very difficult to  
4 read this. But what I've highlighted is what I've kind of  
5 written out, and one of the things is that the blood was  
6 negative, that the pH was five point oh, the nitrites were  
7 negative, and the leukocyte esterase was negative. And you  
8 said that this is a completely negative urinalysis.

9 A. Yes.

10 Q. And you are not critical of the fact that this was a  
11 dip-stick urinalysis, correct?

12 A. That's the standard of care now in emergency rooms.

13 Q. All right. And with this your testimony is, the only  
14 explanation for this result is because it was a completely  
15 obstructed stone, correct?

16 A. That is the most likely explanation.

17 Q. Isn't it also a likely explanation that there was no  
18 infection at this point in time?

19 A. Yes. It's possible that there was no infection at that  
20 time, but the thing that's striking is that there is no blood.

21 Q. All right. Well, let's talk about there's no blood.  
22 You are familiar -- and I believe you read the medical records  
23 from Cape Fear Medical Center, correct?

24 A. Yes.

25 Q. And you are aware that Kelly presented to Cape Fear

1 with a kidney stone, correct?

2 A. Yes.

3 Q. And at the bottom of that page, other than those  
4 medical records, she also had a urinalysis at Cape Fear, did  
5 she not?

6 A. Yes, she did.

7 Q. And at that urinalysis it was also negative for blood,  
8 wasn't it?

9 A. That's right.

10 Q. All right. So, here Kelly Fay, she's had two different  
11 urinalysis, with kidney stones, that both have negative for  
12 blood; is that correct?

13 Q. That's right.

14 Q. And in fact, isn't it true that ten to twenty percent  
15 of urinalysis can be negative for blood?

16 A. Right, which means that eighty to ninety percent are  
17 positive.

18 Q. Right. But there are ten to twenty that can be  
19 negative, and there still be a normal urinalysis, and can  
20 still have kidney stones.

21 A. It's -- yes. I mean, let's just, you know, describe  
22 this as it is. Ten to twenty percent of the urinalysis in  
23 patients with stones are negative for blood. That's the  
24 experience. But it's unusual, and that's what I'm saying.

25 Q. All right. And I think then you said, because it's

1 unusual that, if Dr. Law had ordered a complete blood count,  
2 which would have included a white blood cell count ---

3 A. Yes.

4 Q. ---It's your testimony that that still would have  
5 probably been normal.

6 A. Hard to say.

7 Q. Well, wasn't that your testimony ---

8 A. No.

9 A. ---Earlier. You said it would be normal.

10 A. Did I say that?

11 Q. That's what I wrote down.

12 A. Okay.

13 Q. But I'll let the jury -- it's whatever they heard.

14 A. Yes. As I say, it's hard to know whether it would have  
15 been normal or not, because the stone itself can cause an  
16 elevation of the white -- the blood cell count.

17 Q. Well -- and let's talk about that. What kind of stone  
18 did Kelly Fay have on January 26, 2002?

19 A. What kind of stone?

20 Q. Right. Was it a struvite stone?

21 A. Well, we don't know.

22 Q. Okay. Was it a stone that had proteus inside of it?

23 A. We don't know.

24 Q. So how do you know she had a proteus infection on  
25 January 26, 2002?

1 A. I didn't say she did.

2 Q. Do you know what kind of in -- are you saying -- was  
3 she infected in the E.R. on January 26, 2002?

4 A. I don't think there's any way to know for sure.

5 Q. So you can't say to this jury, most probably that Kelly  
6 Fay had an infection when she was in the E.R. on January 26,  
7 2002?

8 A. What I can say is that the infected urine was not going  
9 to show up in her bladder, infected urine was not going to  
10 affect this urinalysis or this dip-stick, therefore, we have  
11 to surmise that since she later presented with an infected  
12 system that there were bacteria behind that stone, but I  
13 wasn't there, I'm not inside her kidney, and I can't say for  
14 sure. I can say that that's likely the case.

15 Q. But you can't say to this jury, most probably, that she  
16 had an infection on January 26, 2002, while she was in the  
17 emergency room, can you?

18 A. No, I can't. No.

19 Q. Now, and let's talk about -- well, actually, let me ask  
20 you this for a question. If she had a proteus infection or  
21 proteus was in her stone, would that cause her pH to be  
22 elevated? You wouldn't have a pH of five point oh, would you?

23 A. Proteus generally raises the pH if the proteus is in  
24 contact with the urine.

25 Q. And before I get to the obstruction, let me also ask

1 you this about the white blood cell count. To obtain the  
2 blood for that white blood cell count that would have been  
3 run, would it not -- let's see, where is the IV -- when the IV  
4 was started at 8:30 in the morning; is that right?

5 A. Could have been, or they could have ordered it later.

6 Q. All right. And so you can't say that, at 8:30 in the  
7 morning her blood would have been infected to the point that  
8 she would have had an elevated white blood cell count.

9 A. I can say that her blood -- blood count would probably  
10 have been elevated, either from the stone or from an infection  
11 that was beginning, or both. I would say that it's more  
12 likely than not that she had an elevated white count at that  
13 moment in time, but it wasn't drawn so I'm just going by  
14 statistics.

15 Q. So you can't say that, most probably at 8:30 in the  
16 morning it would be elevated due to infection, can you?

17 A. No, I can't.

18 Q. Okay. Now let's talk about obstruction. I've got a  
19 diagram -- and this is not evidence, this is more just for  
20 demonstrative purposes, because I'm kind of visual, I like to  
21 see things. Is this a fair representation of how the kidneys  
22 are, and these are the ureters and the bladder? Is that fair  
23 to say?

24 A. Yes.

25 Q. Where is the UPJ junction?

1 A. Actually you can see it better on this side. In this  
2 particular case we are talking about the right side, but the  
3 drawing over there has a lot of vessels in front of it. Over  
4 here on the left side you see the interior of the kidney has  
5 been exposed and cut away. This part of the collecting system  
6 is called the renalpelvis, and it's been mentioned before, and  
7 then over here we have the ureter. Where they join, which  
8 again, is a little bit indeterminate, but there's a change in  
9 the caliber at this point where it goes from wide to narrow,  
10 and that's the uteropelvic junction, so approximately here on  
11 this side, and approximately here on this side.

12 Q. All right. And let me actually draw on the -- so that  
13 I'll -- make sure we are all on the same page. Is this where  
14 you said it was going to be, right -- right here?

15 A. Yes.

16 Q. Okay. So I'm going to draw a little line right there -  
17 - shouldn't have done in yellow -- UPJ. Okay. And is it your  
18 testimony, based on looking -- let me ask you this. Did you  
19 look at the KUB as well?

20 A. Yes.

21 Q. And you also looked at the CAT scan?

22 A. Yes.

23 Q. And did you see that the stone had actually moved from  
24 UPJ, from the time of the KUB until the CAT scan was  
25 performed?

1 A. Well, I would have to disagree with that conclusion.

2 Q. Okay. So it's your testimony that this stone was  
3 obstructing -- had not moved the entire time she was in the  
4 emergency room; is that your testimony?

5 A. Yes.

6 Q. And I think it's testimony also that it was a  
7 completely obstructing stone.

8 A. Yes.

9 Q. And aren't you -- do you agree that the only way you  
10 can truly say it was obstructing is if you had a contrast CAT  
11 scan?

12 A. Even then you can't be a hundred percent sure. But,  
13 what you can say is that, on the CAT scan that was done, the  
14 ureter below the stone was normal, the ureter above the stone  
15 was dilated, the renalpelvis, that white area above the stone,  
16 was significantly dilated, and the entire kidney was about  
17 fifty percent bigger on the right than on the left. So I  
18 think that's enough evidence to say that that was obstructed.

19 Q. All right. But doesn't the radiologist say that the  
20 ureter has a normal caliber? I mean, is that what that says?  
21 Ureter has a normal caliber.

22 A. Yes, and I agree with that, the ureter below the stone  
23 has a normal caliber.

24 Q. And as far as -- so what you are relying on -- I  
25 guess -- let me go back and ask my question though. Isn't it



1 true that a contrast CAT scan is the only way you can truly  
2 tell if a stone is obstructing the ureter?

3 A. No. There are even better ways than a CAT scan, and  
4 usually patients who come into the emergency room for stones  
5 have a CT scan without the contrast. There's no ---

6 Q. Which is what she had.

7 A. Which is what she had. There's no need to use contrast  
8 in order to identify the stone, it's location, and it's  
9 potential obstruction.

10 Q. All right. And are you aware that at autopsy they  
11 couldn't find the stone?

12 A. They didn't look for it.

13 Q. Your testimony is, Dr. Edward Proctor, our Pathologist  
14 here in Horry County, that he did not look for the stone?

15 A. That's right. He doesn't mention it as being there or  
16 not being there.

17 Q. Okay. Isn't it true that the reason he doesn't mention  
18 it is because it wasn't there, Kelly had already passed it?

19 A. How do you know?

20 Q. Was that not testimony from her husband that she said,  
21 I feel like I've passed the stone?

22 A. That doesn't mean ---

23 MR. FOSTER: Objection, Your Honor. That's --  
24 competence.

25 A. ---That she did.

1           **THE COURT:** Counsel, just a moment. No speaking  
2 objection. One word. What was your objection?

3           **MR. FOSTER:** Competence, of what Kelly Fay said.

4           **THE COURT:** I understand. No speaking objections,  
5 please.

6           **MS. SCALISE:** I've got a question that might can  
7 clarify it.

8           **THE COURT:** All right. Please ask your next question.

9           Q. Okay. You are aware that Kelly had the first kidney  
10 stone in 2001, correct?

11          A. Yes.

12          Q. And that stone passed, did it not?a

13          A. Yes.

14          Q. And if someone has a kidney stone that passes do they --  
15 - they know what it feels like to pass a stone?

16          A. They know what the pain feels like.

17          Q. Okay. And they know what the pain feels like when it's  
18 gone, or the stone is passed?

19          A. But pain can improve even if the stone remains.

20          Q. So if Kelly told her husband, or told her mom that she  
21 thought -- as a lay person -- she thought her stone had  
22 passed, do you have any reason to disbelieve that?

23          A. Yes. I have plenty of reason to disbelieve that.

24          Q. Okay.

25          A. The only way you can tell is if you catch the stone.

1 Q. Is it your testimony that when Kelly died, and at the  
2 autopsy, her stone was still obstructing at this UPJ junction?

3 A. To a reasonable degree of medical probability.

4 Q. All right. And so that obstruction should have been  
5 evident to Dr. Proctor at autopsy, correct?

6 A. Yes.

7 Q. And he would have seen evidence of obstruction; is that  
8 correct?

9 A. Well, he did see evidence of obstruction. He saw  
10 microabscess in the kidney, he saw pyelonephritis in the  
11 kidney, he saw all kinds of changes that were related to this  
12 episode.

13 Q. But he did not -- or at least in his testimony, as well  
14 as in the actual Autopsy Report, there's no evidence that  
15 there was a stone at the UPJ; is that correct?

16 A. There's no evidence either way, either positive or  
17 negative.

18 Q. Okay. And your testimony is, because that Kelly Fay  
19 had an obstruction -- she had an obstructive stone -- that Dr.  
20 Law and/or Dr. Young, that they should have made sure that  
21 Kelly was admitted; is that right?

22 A. That's my opinion.

23 Q. And if she was admitted, I think your testimony was,  
24 she was going to receive pain control, she was going to have  
25 her temperature taken; is that correct?

1 A. Yes, so far.

2 Q. And you thought maybe she could also have some  
3 antibiotic?

4 A. Yes.

5 Q. Okay. If that stone is obstructing, wouldn't you agree  
6 that the antibiotics aren't going to reach whatever the urine  
7 is behind the stone?

8 A. Yes, that's true, but the antibiotics would prevent her  
9 from having generalized sepsis throughout her body. As shown  
10 by the autopsy she had septic emboli in her lungs, in other  
11 parts of her body, in her liver, and of course in that kidney,  
12 so that indicates that the infection spread through the blood  
13 to other organs, and what the antibiotics do is, they make  
14 that less likely to happen. Even if -- you are correct --  
15 they can't clear the primary infection, but they certainly can  
16 change the course of the patient.

17 Q. But now, do you have patients who don't want to been  
18 admitted, who don't want to be sitting in a hospital bed,  
19 receiving oral antibiotics?

20 A. Yes, but then we make them sign out and against medical  
21 advice.

22 Q. Isn't that all the more important why a physician would  
23 tell the patient, if your pain becomes out of control, or if  
24 you have increased nausea, vomiting, any fevers or chills,  
25 return to the emergency department immediately?

1 A. Yes. That's good advice.

2 Q. Yes. Because that way, when the patient develops  
3 fevers, develops chills, she can be treated, correct?

4 A. Yes.

5 Q. All right. And wouldn't you agree that patients would  
6 rather be at home than they would rather be in a hospital bed?

7 A. Not -- not necessarily.

8 MR. FOSTER: Objection, Your Honor. Speculation.

9 THE COURT: It's been asked and answered, so you may  
10 proceed.

11 Counsel, it's overruled.

12 MS. SCALISE: Thank you, sir.

13 Q. Is there any medical literature that you can point to  
14 that supports that an antibiotic for an obstruction, in the  
15 absence of any sign -- I'm sorry, let me straight -- go back.  
16 Is there any medical literature that supports giving an  
17 antibiotic to someone who does not show any signs or symptoms  
18 of infection?

19 A. Yes. Prophylactic antibiotics are given all the time.

20 Q. And I think when I asked you that question in your  
21 deposition you said you couldn't point to any specific medical  
22 literature; isn't that correct?

23 A. Right. I'm just pointing to practice, and practice is  
24 to give prophylactic antibiotics. For example, we give  
25 prophylactic antibiotics twenty-four hours before surgery.

1 Q. But for prophylactic antibiotics for a patient with a  
2 kidney stone, you are testifying that's standard of care?

3 A. Yes. It's the standard of care if you have a  
4 completely obstructing stone.

5 Q. All right. Now doesn't antibiotic -- doesn't that give  
6 a patient a false sense of security, that if I'm going home  
7 with an antibiotics then -- okay, these antibiotics are going  
8 to treat me if I get more fevers or I get chills?

9 MR. FOSTER: Your Honor, objection, speculation again.

10 THE COURT: Overruled. The witness is an expert and  
11 may answer.

12 A. Well, whether it does or doesn't give them any sense of  
13 security, the course of the disease is going to be what it is,  
14 and they are going to manifest further signs if they have an  
15 infection, or not manifest them if they -- if they don't. If  
16 the antibiotics are successful, and doing what they are  
17 suppose to do, then it will suppress the infection for a  
18 period of time.

19 But you are absolutely correct. This is a potentially  
20 dangerous situation that even antibiotics may not clear, and  
21 probably won't clear, that needs physical intervention. It  
22 needs that stone to be bypassed.

23 Q. All right. And with that stone being bypassed your  
24 testimony was, it didn't have to be done that day.

25 A. That's my testimony. I did not have to be done that

1 day, but the patient had to be in a controlled situation  
2 where, if she became acutely ill -- and these things can  
3 happen so quickly -- so that if you send the patient home and  
4 you tell them to come in if you have fever and chills, they  
5 may not be able to even make a phone call unless they have  
6 family members or other people around to help them.

7 So, for example, this is a twenty-five year old person,  
8 but if it's an eighty year old frail individual who lives  
9 alone, you have to take that into consideration because if  
10 they become acutely ill they are not even going to be able to  
11 call the ambulance. So that's why it's the -- it's the  
12 standard of care to, you know, take precautions.

13 Q. But Kelly had somebody there with her, didn't she?

14 A. Yes, she did.

15 Q. And in fact, Dr. Law's testimony was, he gave those  
16 oral instructions to both Kelly and Sean Fay, did he not?

17 Q. Yes.

18 Q. You also testified, I believe earlier, that there was a  
19 concern that a patient can have kidney damage because of  
20 obstruction, correct?

21 A. Yes.

22 Q. So wouldn't you agree that the literature is, you don't  
23 have kidney damage until six weeks after there's been a  
24 complete obstruction?

25 A. The literature is that you don't have irreversible

1 kidney damage, but you have kidney damage right from the  
2 beginning, however, if it's relieved within a certain period  
3 of time -- and you indicate six weeks -- the kidney can  
4 recover.

5 Q. So in this case this -- Kelly could have waited till  
6 Monday? She could have waited even sometime later that week  
7 to have had that obstruc -- I mean, to have had the urine  
8 drained?

9 A. No, I don't believe she had a week.

10 Q. Well, I'm just saying, let's say she didn't have the  
11 infection, I mean is that something ---

12 A. Uh huh (indicating positive)

13 Q. ---Just having an obstruction, that's not something  
14 that's going to cause immediate damage, you've got to do  
15 something before Monday?

16 A. Yes. Without the infection you've got more time.

17 Q. Let's see -- you also -- you mentioned something about  
18 extravasation, but then I believe you testified that really  
19 didn't matter in this case; is that right, because I mean, you  
20 didn't really see any evidence of any significant  
21 extravasation, did you?

22 A. There is some evidence of it on the CT scan.

23 Q. Well, there's evidence of some minimal.

24 A. Minimal ---

25 Q. It's not ---



1 A. Yes.

2 Q. Do you agree it's not severe ---

3 A. No.

4 Q. ---Extravasation.

5 A. No.

6 Q. And I think with that -- let's see -- so you are  
7 referencing the CAT scan that says there's minimal  
8 extravasation, right?

9 A. Yes.

10 Q. And so that wasn't anything that required admission, in  
11 and of itself?

12 A. Not by itself.

13 Q. If you testified -- and I just want to make sure I'm  
14 sure on this -- that she had almost no chance of passing this  
15 point -- or actually this five millimeter stone.

16 A. The stone is not five millimeters. The stone on the  
17 KUB is like a small ice cream cone in shape, with the tip of  
18 the ice cream cone pointing downward, and the widest part  
19 being at least as wide as the ureter, so that stone is wedged,  
20 in -- and in my opinion she's got a less than twenty percent  
21 chance of being able to pass that.

22 Q. All right. And isn't it true that in your career as a  
23 urologist you've seen kidney stones as big as my fist, haven't  
24 you?

25 A. Some patients can pass big stones, yes.

1 Q. All right. And in fact, the kidney stone can encompass  
2 this entire area within the kidney, can it not?

3 A. Yes.

4 Q. And yet some of those can still pass, can't they?

5 A. Chunks of it.

6 Q. All right. Let's see, if Dr. Law contacted Dr. Young  
7 at 11:38, you would agree that she hadn't actually been  
8 discharged from the hospital at that point in time.

9 A. That's correct.

10 Q. Now you also talked about conversations that you have  
11 with the E.R. physicians, correct?

12 A. Yes.

13 Q. And in fact, where you are at your hospital, that's a  
14 teaching hospital, isn't it?

15 A. Yes.

16 Q. And isn't it true -- I believe you testified when I  
17 took your deposition, that every time a patient comes into the  
18 E.R. with a kidney stone they always call a urologic resident?

19 A. They call someone on our service, yes.

20 Q. Okay. And the reason for that is because these E.R.  
21 doctors aren't board certified E.R. doctors, are they?

22 A. Well, they are board certified E.R. doctors.

23 Q. No, but they are calling -- now your urologic resident,  
24 they are not board certified, are they?

25 A. No. They are in training.

1 Q. They are in training, and that's why the E.R. doctors  
2 call them, isn't it, because they are helping to train and  
3 educate those urologic physicians.

4 A. No. They are calling them to get input from the  
5 urology service. If the resident can't handle it they will  
6 kick it up to an attending to make a decision about that  
7 particular patient, so they are calling to get consultation,  
8 just like on this sheet here there's consultation between the  
9 emergency room and urology. It's exactly the same thing,  
10 consultation has to take place.

11 Q. All right. And I believe that was your testimony, that  
12 the people who call you are actually seeking your advice.

13 A. Yes.

14 Q. Okay. And you read Dr. Law's deposition, and Dr.  
15 Young's deposition, and you are aware that Dr. Law testified  
16 he already made the decision to discharge the patient before  
17 he called Dr. Law -- I mean Dr. Young, correct?

18 A. Yes. He may have already made that decision, but I  
19 think he made the right decision to consult with Dr. Young.

20 Q. All right. And wasn't it also the right decision to  
21 call Dr. Young about following up with this patient?

22 A. Well yes. Once you make the decision to discharge the  
23 patient the patient needs follow-up.

24 Q. Okay. And so if this patient had been appropriate for  
25 discharge then you would agree that that would be appropriate

1 for Dr. Young to have seen her on that Monday?

2 A. Yes.

3 Q. Now you talked about HIPAA, and how HIPAA was one of  
4 the reasons why Kelly Fay had to sign that authorization. Are  
5 you aware that HIPAA did not come into effect until after  
6 2002?

7 MR. FOSTER: Objection, Your Honor. May we approach?  
8 That's mischaracterization ---

9 THE COURT: Counsel, you -- you go ahead, if you want  
10 to state your objection.

11 MR. FOSTER: Mischaracterization of the Law.

12 THE COURT: We'll give you redirect on that point,  
13 Counsel.

14 MR. FOSTER: All right.

15 THE COURT: Go ahead.

16 Q. I'm looking at a document about HIPAA compliance, and  
17 what is the date that it has on there, when the HIPAA is  
18 suppose to come into effect? Is it October of 2002?

19 A. Yes.

20 Q. Okay. And that's after January, 2002, correct?

21 A. Yes.

22 MS. SCALISE: Okay. Thank you, Doctor.

23 A. Let me just say that, even prior to HIPAA patients had  
24 to sign a consent to have their medical records sent to  
25 anybody, including to themselves.

1 Q. Do you remember reading Dr. Young's deposition where he  
2 said he never even got any records on Kelly Fay?

3 A. Yes.

4 MS. SCALISE: Beg the Court's indulgence.

5 Q. Doctor, isn't it true that a hospital cannot accept a  
6 patient for you?

7 A. I'm not sure I understand what you mean by that.

8 Q. You know, for you to have a physician/patient  
9 relationship with a patient isn't it true that you would have  
10 to be the one who accepted that patient; it can't be the  
11 hospital accepting a patient for you, or the E.R. doctor  
12 accepting a patient for you?

13 A. Well, that's a mischaracterization of what happens.  
14 When you join the staff of a hospital you sign their bylaws.  
15 The bylaws state that you are going to be responsible for  
16 covering the emergency room, in your specialty, on a regular  
17 schedule. If you are the only urologist on that staff you are  
18 going to be on-call twelve months a year, because they need  
19 twenty-four seven coverage, and in doing that, in covering the  
20 emergency room, you are taking on the patients that need  
21 urological consultation and care that come into that hospital,  
22 so I wouldn't characterize it as the hospital accepting a  
23 patient for you, you've accepted the patient by signing the  
24 bylaws and by being on the staff of that hospital. If you  
25 don't want to do that, then don't join that hospital.

1 Q. And that's your opinion, correct?

2 A. But that's -- but that's pretty much the way most  
3 hospitals work now.

4 Q. And in fact, you are not aware of any medical  
5 literature that talks about physician/patient relationship,  
6 are you?

7 A. Not specifically, no.

8 Q. Okay.

9 MS. SCALISE: That's all I have. Thank you, Doctor.

10 THE COURT: Is there further cross-examination?

11 MR. AIKEN: Is it my turn?

12 THE COURT: All right. Go ahead.

13 MR. FOSTER: Forgot about you, Mr. Aiken.

14 MR. AIKEN: Thank you. I don't have many.

15 CROSS-EXAMINATION BY MR. AIKEN:

16 Q. Doctor, just a few more questions about your expert  
17 witness experience. I think you've offered medical testimony  
18 in the states of Massachusetts, Rhode Island, New Hampshire,  
19 New York, Pennsylvania, Ohio, Illinois, North Dakota, Montana,  
20 Utah, Florida, Texas, Mississippi, Georgia, and South  
21 Carolina.

22 A. That's pretty accurate.

23 Q. Okay. And when your deposition was taken in 2007, we  
24 asked you about 2006, and your income from testimony in 2006  
25 was very substantial, wasn't it, for expert testimony?

1 A. I don't know. What was the figure?

2 Q. It was Sixty-Four Thousand Dollars. That's a lot of  
3 money. Would you agree?

4 A. It's relative.

5 Q. It's relative. Okay. And when did you look at these  
6 films, Doctor, the CT, the KUB -- the two CTs?

7 A. I looked at them last night.

8 Q. Last night?

9 A. Uh huh (*indicating positive*)

10 Q. Okay. Okay. Now, Doctor, with all of this testimony  
11 about being an expert, I suppose today that because you are  
12 offering testimony against an emergency physician that you are  
13 deviating from your accepted practice of not offering  
14 testimony against emergency physicians; is that true? You've  
15 never done it?

16 A. I am not an emergency room physician, and I do not  
17 comment on what their standard of care is, however ---

18 Q. You have commented today, Doctor ---

19 MR. FOSTER: Let -- Your Honor ---

20 A. Exactly. And this is South Carolina.

21 Q. Well, in 2007 you -- the question was, in your previous  
22 experience as an expert, have you ever offered opinions that  
23 you held, with a reasonable degree of medical certainty,  
24 regarding standards of care of emergency physicians and  
25 deviations therefrom, and you said no, I'm not qualified ----

1 A. That's correct.

2 Q. ---To offer such opinion. Well, so you have ---

3 MR. FOSTER: Your Honor -- I'm sorry -- objection.  
4 He's not giving him a chance to answer the question.

5 THE COURT: All right. Just a moment.

6 Q. Is that correct?

7 A. What was your question?

8 THE COURT: And Mr. Aiken, when you pose it, let the  
9 witness explain if he wishes.

10 MR. AIKEN: All right. Okay. I'm sorry.

11 Q. The question. In your previous experience as an  
12 expert, have you ever offered opinions that you held, with a  
13 reasonable degree of medical certainty, regarding standards of  
14 care of emergency physicians and deviations therefrom? And  
15 your answer, on page one oh one, if you wish to look was, no,  
16 I'm not qualified to offer such opinions. Is that what you  
17 said?

18 A. Yes. And that answer I stand by, because I am not an  
19 emergency room physician, nor am I an obstetrician, nor am I  
20 an anesthesiologist, or any other specialty. I am only  
21 qualified to give opinions in my expert field of Urology,  
22 however, if a patient presents to an emergency room with a  
23 urological problem I am qualified to comment on the care that  
24 they received, and the reason is that there is only one  
25 standard for the care of that patient, whether it's given by



1 an emergency room physician, or by a urologist. A particular  
2 urological problem has a standard of care, and I can comment  
3 on that.

4 Q. Since the early 1970s have you kept up with the  
5 protocols and practices of emergency physicians?

6 A. With regard to urological issues, yes.

7 Q. Well, let's look at page one thirty-five, Doctor. I  
8 was hoping I could be short.

9 The first line, question. "Since the early 1970s -- or  
10 it says '70s, have you kept up with the standard -- correction  
11 -- have you kept up with the changes in protocol and practices  
12 for emergency physicians?" You said, "Not specifically".  
13 Didn't qualify. That's what you said, right?

14 A. Yes. And I stand by that answer. Again, I am not an  
15 emergency room physician, I don't read their literature,  
16 however, as a member of the practicing community I know what  
17 they do with regards to urology patients.

18 Q. Doctor, I'm not going through it again. We've heard it  
19 plenty of times. This is Dr. Law's dictated note, and it  
20 talks about the discharge instructions here -- Ms. Scalise  
21 read them. There's nothing ambiguous, unclear, about that, is  
22 there?

23 A. No.

24 Q. And it says, "D" down here, 1/26/02 at 11:38:20, that  
25 is standard usage of the word dictated, doesn't it -- isn't

1 it?

2 A. Yes.

3 Q. So that means Dr. Law dictated this note even before  
4 Kelly Fay left the E.D..

5 A. Apparently so.

6 Q. Okay. And you have no reason to question the  
7 truthfulness of that statement, do you?

8 A. None.

9 Q. None. Doctor, there's been some discussion about the  
10 dip-stick. Now, do you know if the dip-stick process at Grand  
11 -- of South Strand, in 2002, was done with an automated  
12 machine?

13 A. My guess is it was, because of the report that -- that  
14 they have here, yes.

15 Q. So that means you don't just dip a dip-stick in a urine  
16 and come up and look at it. You put it in a machine and it  
17 reads the results, right?

18 A. Right. But the principals are the same as what I  
19 outlined.

20 Q. Doctor, Kelly Fay became ill, really ill on Sunday  
21 morning, didn't she, the fever, violent fever -- violent  
22 chills, rather, and fever?

23 A. I don't know about the violent, but she had chills.

24 Q. Well, Mr. Fay said violent.

25 A. Uh huh (indicating positive)

1 Q. If she was ill, Doctor ---

2 A. Uh huh (**indicating positive**)

3 Q. ---And she was even more ill Monday morning, would you  
4 agree?

5 A. Yes.

6 Q. If Sean Fay had taken his wife to the emergency  
7 department on Sunday, is it more likely than not she would be  
8 alive?

9 A. If she had been admitted, and if she had had that stone  
10 bypassed, yes, she would be alive.

11 Q. The question was, is it more likely than not, if Sean  
12 Fay had taken his wife to the E.D. on Sunday morning ---

13 A. Uh huh (**indicating positive**)

14 Q. ---That Kelly Fay would be alive?

15 A. No. I can't answer that, because he took her to the  
16 emergency room on Saturday, and she was sent home. She could  
17 have been sent home on Sunday. We don't know what the outcome  
18 would have been, but as I say, my answer is that, if she had  
19 had intervention, yes, she would be alive.

20 Q. Look at page fifty-six, Doctor.

21 A. Of the deposition?

22 Q. Yes sir. Line twenty. Question: If she had come to  
23 the emergency room on that Sunday do you have an opinion as to  
24 whether or not she would be alive today, and your response  
25 was, quote, I believe she would be alive.

1 A. If she had been admitted.

2 MR. AIKEN: That's all.

3 THE COURT: Further ---

4 MR. TODD: No questions, Your Honor.

5 THE COURT: All right. Is ---

6 MR. FOSTER: Briefly, Your Honor.

7 THE COURT: Redirect. You may proceed.

8 REDIRECT-EXAMINATION BY MR. FOSTER:

9 Q. Dr. Siroky, Ms. Scalise asked you if you were a  
10 Fellowship-trained stone -- a Fellowship-trained Urologist.  
11 Do you recall that question?

12 A. Yes, I do.

13 Q. Do you have to be a Fellowship-trained Urologist to  
14 take care of a kidney stone?

15 A. Of course not.

16 Q. Is an emergency room physician perfectly competent to  
17 take care of a kidney stone?

18 A. Take care?

19 Q. Well, diagnose, and at least manage by consultation?

20 A. Yes.

21 Q. Okay. I mean, do you have to have any subspecialty  
22 training in stones to be able to treat stones?

23 A. No. It's part of the specialty.

24 Q. Okay. As far as routine stones go, Dr. Siroky, do  
25 emergency room -- do or do not emergency room physicians treat

1 those routinely?

2 A. Yes, they do.

3 Q. Now -- now Ms. Scalise also asked you if you ever  
4 published anything on kidney stones. My question to you is,  
5 have you ever edited books that had chapters containing the  
6 treatment of kidney stones in them?

7 A. Yes, I have.

8 Q. Now, Ms. Scalise also asked you about what you saw on  
9 the CT, and the migration of the x-ray. Do you recall those  
10 questions?

11 A. Yes.

12 MR. FOSTER: Your Honor, briefly, we are going to show  
13 four cuts in the KUB, just so the jury -- they haven't seen  
14 any of these yet, so they have an idea of what they look like,  
15 and what he did see. She asked him.

16 THE COURT: How are you going to show that?

17 MR. FOSTER: On this view box right here. I'm going to  
18 pull this table over here and put it on there.

19 THE COURT: All right. Are they in evidence?

20 MR. FOSTER: Yes sir.

21 Would you step down, please, Dr. Siroky.

22 THE COURT: Please make sure that the witness speaks up  
23 so we can all hear, Counsel.

24 MR. FOSTER: We are going to try not to get all up in  
25 jury -- but close enough where they can see these things.

1           We may not be. Okay.

2           Dr. Siroky, would you please put up the copy of the KUB  
3 that we had -- -

4           **MR. FOSTER:** Do we have the original here?

5           **MS. SCALISE:** That's it.

6           **MR. FOSTER:** Okay.

7           Q. All right. Dr. Siroky, can you tell the jury -- I'm  
8 sorry. Some how you are going to have to face the Court  
9 Reporter. We are going to have to switch sides, and you've  
10 got to be able to show all the jury.

11           I'll try to hold the box.

12           A. So, this is the film that we talked about before, which  
13 is a plain film that we had. These are the vertebrae, the  
14 spine, these are the bones of the pelvis, and so on. These  
15 are the ribs. These are the ribs here.

16           So, you can also see the outline of both kidneys. Here  
17 is the left kidney. You can see it's shadow. And here is the  
18 right kidney, going like that, and if you take a measurement  
19 on these kidneys, like that, you can see that this kidney  
20 measures to about where the pen ends, is much bigger than the  
21 left kidney. This is the kidney that has the stone, and here  
22 you see someone has very conveniently put some marks around  
23 it. You can see there is a white area. A stone will show up  
24 as white on an x-ray. So this is the stone, and you can see  
25 the size of this stone, and you can also see, comparing this

1 to that diagram that was shown before with the ureters and the  
2 collecting system, how it's at the junction of the ureter and  
3 the renalpelvis, so the right side has a stone, the stone is  
4 fairly large, and it's at, or just below, the ureteropelvic  
5 junction, or UPJ, so that's what was seen on the KUB done in  
6 the emergency room. This is the film from that -- from that  
7 visit.

8 Q. Can you tell anything about the kidneys on there?

9 A. The right kidney is considerably enlarged compared to  
10 the left.

11 Q. Can you show the jury the outline, Doctor, so they can  
12 tell what you are talking about?

13 A. This is the outline of the right kidney, this is the  
14 outline of the left kidney.

15 Q. Okay.

16 Did you have copies of the CT?

17 That's an Exhibit. I'll use that.

18 Does anybody have any objection to showing copies so we  
19 don't have to go through all the original exhibits to find the  
20 cuts that we are specifically talking about?

21 MS. SCALISE: Do you know what -- do you know which  
22 image you want? I could tell you which one it is.

23 MR. FOSTER: Huh.

24 MS. SCALISE: I can tell you which one it is.

25 MR. FOSTER: Okay. Well, I tell you, you can just --

1 if you don't ---

2 MS. SCALISE: Which image number?

3 MR. FOSTER: Wait just a second.

4 A. So this is what's called a CT scan or computerized  
5 thermography, and as opposed to the other film where you saw  
6 the whole patient, and the whole abdomen. These are little  
7 cross sections that are taken through the body. This is the  
8 front of the body, the abdomen. This is the back. The  
9 patient is lying on a table. This is the right, and this is  
10 the left. So, in effect, we have like a slice going through  
11 the body, from front to back, and you can see what organs are  
12 on that slice.

13 Then what happens is, the slices progressively increase  
14 downward. They usually start about here, and they go in tiny  
15 little increments right down the body to the pelvis, which is  
16 down here. And then there are some films as well.

17 So on these slices what you begin to see is the left  
18 kidney, which is -- the right kidney -- excuse me -- which is  
19 here, and then on the other films, the earlier films, you are  
20 going to see the left kidney.

21 Q. Let's put those up. We'll read what cuts they are.

22 A. This is cut forty-one, so it's going to be cut forty-  
23 one and down.

24 Q. Okay.

25 MS. SCALISE: More like thirty-two and ---



1 A. This is the same. This is forty-one. This is a copy  
2 of the ---

3 Again, this is the -- so, here we are, a little bit  
4 higher -- a little bit higher, and again you see here the  
5 right kidney, left kidney, right kidney, left kidney, right  
6 kidney, left kidney, and we are going down further and further  
7 down in the body. Finally you can see here the pelvis that  
8 we've been talking about, how dilated it is compared to the  
9 other side.

10 Q. What do you mean by dilated?

11 A. Wide, wide compared to the other side.

12 As we follow it down there's going to be other panels  
13 you have here.

14 Q. Is that all right?

15 A. Yes.

16 Okay. I don't know if people can see this, but right  
17 here you see a small bright spot, right there, which is the  
18 stone, right there, right there, and as you follow this down  
19 you continue to see it on several cuts, which means it's, you  
20 know, fairly long because it shows up on several cuts, and  
21 this is the right ureter, just below the ureteropelvic  
22 junction, so the same stone that was seen on another film is  
23 showing here, in cross section.

24 This is a CAT scan that was done at 9:30 or ten o'clock  
25 Saturday morning, that was discussed, and this is the CAT scan

1 that was read in that report, and this is the CAT scan that's  
2 been talked about all along.

3 Q. Okay. Can you tell any difference -- can you tell any  
4 difference between the kidneys on this?

5 A. Yes. You know, again, on the other panel that we saw  
6 that the right kidney was bigger than the left, we saw that  
7 the right kidney had evidence of a dilated renalpelvis  
8 compared to the left, and we saw that the right ureter was  
9 dilated above the stone, but not below the stone.

10 Q. Can you tell about any leaking of urine?

11 A. You can see a little bit of minor extravasation above  
12 the stone.

13 MR. FOSTER: All right. Thank you, Doctor.

14 Marian, are these all -- Ms. Scalise, are these all  
15 original right here?

16 MS. SCALISE: If they have the stickers on them those  
17 are exhibits.

18 THE COURT: Anything further now on redirect?

19 MR. FOSTER: Your Honor, I've got just a few more to  
20 follow up on, Your Honor, briefly.

21 Q. Do you remember Ms. Scalise questioned you, Dr. Siroky,  
22 about patients not wanting to be -- go in the hospital ---

23 A. Yes.

24 Q. ---And what patients thought, and that sort of thing.  
25 Do you -- do you -- do you have an opinion as to whether a

1 A. No sir.

2 Q. Okay. He's just your assistant?

3 A. He is a trained assistant. Yes sir.

4 Q. Now, Dr. Proctor, please tell the jury what Kelly died  
5 from, in your opinion?

6 A. This woman died as a result of clinical sepsis, which  
7 is overwhelming blood-borne infection within the body. It was  
8 cultured positive for a bug called proteus, which is a gram  
9 negative rod, and it can cause severe illness, and that was  
10 cause of death.

11 Q. All right.

12 A. Clinical sepsis, as a result of proteus.

13 Q. And clinical sepsis in the kidney, correct?

14 A. Clinical sepsis ---

15 Q. All over the body?

16 A. All over the body.

17 Q. Which came, you believe, originally from the kidney --  
18 from a kidney?

19 A. I think that that may have been the nidus or the  
20 origination point, yes sir.

21 Q. And you have no idea about a stone because you did not  
22 -- you did not mention a stone in your report, correct?

23 A. I could tell you totally about a stone. There was no  
24 stone there. Both ureters were examined. You will see the  
25 report that the ureters appear normal. I ran the ureters.

1 -- that's a different ---

2 THE COURT: All right. We'll take it up today before  
3 we leave.

4 Please bring in the jury.

5 (THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE  
6 JURY.)

7 THE COURT: Welcome back, ladies and gentlemen.  
8 Please call your next witness.

9 MR. FOSTER: Your Honor, Plaintiff would call Dr.  
10 Oliver Wood.

11 THE COURT: Please come forward and take the oath of a  
12 witness.

13 OLIVER G. WOOD, JR., being first  
14 duly sworn, testifies as follows:

15 DIRECT-EXAMINATION BY MR. FOSTER:

16 MR. FOSTER: Good morning, Dr. Wood.

17 A. Good morning.

18 Q. Dr. Wood, please introduce yourself to the jury. Tell  
19 them where you are originally from, how long you've lived  
20 there, your educational background, etcetera.

21 A. I grew up in Greer, South Carolina. After graduating  
22 from high school I go to U.S.C and I earned a Bachelor of  
23 Science Degree in Business Administration. I then went in the  
24 United States Navy for two years. Came back and earned a  
25 Master's Degree in Economics at the University of South

1 in this case to the jury.

2 A. In the case of Kelly Fay I have evaluated her loss in  
3 earning capacity. Earning capacity means what a person is  
4 capable of earning in their highest and best use, and I've  
5 evaluated that from the time of her death till her normal  
6 Social Security retirement age.

7 MR. FOSTER: All right. Your Honor, we now submit Dr.  
8 Oliver Wood as an economic expert in the evaluation of  
9 economic loss in personal injury and wrongful death cases.

10 THE COURT: All right. Are there questions for the  
11 witness on expertise?

12 MR. TODD: None, Your Honor.

13 MS. SCALISE: No questions.

14 MR. AIKEN: No sir.

15 THE COURT: Hearing none. Is there objection? Hearing  
16 none, then the witness is admitted as an expert in those  
17 areas.

18 You may proceed.

19 MR. FOSTER: Thank you, Your Honor.

20 THE COURT: Thank you.

21 Q. Dr. Wood, were you hired by my firm to make a study of  
22 the economic loss in this case?

23 A. Yes.

24 Q. All right. And the methodology that you used to  
25 evaluate the economic loss, is that accepted among economists?

1 Five Fifteen. The after trial, One Million Three Seventy-  
2 Seven Four Sixty-Seven, making a total of One Million Seven  
3 Seventy-One Nine Eighty-Two. That's the estimated economic  
4 loss in the case of Kelly Fay.

5 Q. All right. Thank you, Dr. Wood.

6 Dr. Wood, I'm going to hand you a piece of paper and ask  
7 you if you recognize that.

8 A. This is eight and a half by eleven charts equal to what  
9 I just went over.

10 Q. Okay. The exact same charts that you went over with  
11 the jury just now.

12 A. Yes.

13 MR. FOSTER: All right. Your Honor ---

14 Let me ask you this, Dr. Wood. Do you have any opinion  
15 as to whether or not this might be helpful to the jury since  
16 there are so many years involved in this and numbers, to be  
17 able to -- do you think it would be helpful to them to have  
18 that in the jury room?

19 A. We know from learning people are better off in a visual  
20 mode than an auditory mode. Yes.

21 MR. FOSTER: Your Honor, at this time we would like to  
22 have this marked as an exhibit.

23 THE COURT: All right, Counsel, you need to review it  
24 before you respond?

25 MR. FOSTER: I was going to let ---

1 there over an hour are they also suppose to have vitals taken  
2 according to South Strand's Policy and Procedure upon  
3 discharge, before discharge?

4 ANSWER: I would say yes.

5 QUESTION: Okay. And is that required under the nursing  
6 standard of care? Is it required under the nursing standard  
7 of care to take discharge vitals on a patient so you know what  
8 their status is when they leave the hospital?

9 ANSWER: Would you explain the standard of care?

10 QUESTION: Well, the standard of care in South Carolina  
11 is to find as what the average of the reasonably prudent nurse  
12 would do under the same or similar circumstances.

13 ANSWER: You should, every hour, check temperature,  
14 check vital signs.

15 QUESTION: Okay, and upon discharge?

16 ANSWER: Yes. If it's more than one hour, yes.

17 QUESTION: Okay. And is that because that then gives  
18 you a record of what their status -- their vitals were when  
19 they left the hospital?

20 ANSWER: Yes.

21 QUESTION: Ma'am?

22 ANSWER: Yes.

23 QUESTION: All right. And I believe you said it -- not  
24 only standard of -- all right, and I believe you said that it  
25 is not only standard of care, but it was also policy and

1           QUESTION: Okay. And then it says, a patient with a  
2 complaint of chest pain or abdominal pain will have a minimum  
3 of two vital signs recorded, correct?

4           ANSWER: Yes.

5           QUESTION: And that included temperature?

6           ANSWER: Yes.

7           QUESTION: Can you tell me why Ms. Fay only had one  
8 temperature taken?

9           ANSWER: Number one, when she came in -- that was eight  
10 o'clock -- was ninety-eight point one, and then I repeat the  
11 vital sign on 9:10, and blood pressure is stable, and the  
12 heart rate is seventy-two, respiration is sixteen.

13           And after that I did another one at 10:20. Blood  
14 pressure, almost to the nickel, one twenty over eighty. Pulse  
15 is the same, seventy-two, respiration is seventeen.

16           QUESTION: Okay.

17           ANSWER: I didn't repeat the temperature check. Number  
18 one, vital signs stable, and heart rate is only seventy  
19 something, seventy-two, and respiration is not fast. Usually  
20 when we go to the room, not just to check vital signs, we  
21 assess patient. We look at the general appearance, look at  
22 the skin, touch patient, and you have to touch patient arm in  
23 order to get a pulse rate, so if I don't think this patient --  
24 anything indicate have a fever I don't usually check it.

25           QUESTION: Okay. Do you know of any policy and



1 STATE OF SOUTH CAROLINA ) COURT OF COMMON PLEAS

2 COUNTY OF HORRY ) (08-CP-26-9047)

) (08-CP-26-9368)

3 SEAN D. FAY, as Personal )  
4 Representative of the )  
Estate of Kelly L. Fay, )  
5 deceased. )

TRANSCRIPT OF RECORD

6 )  
7 GRAND STRAND REGIONAL ) May 17, 18, 19, 20, 21, 2010  
MEDICAL CENTER, LLC, dba ) May 24, 25, 26, 27, 28, 2010  
8 SOUTH STRAND AMBULATORY ) Conway, South Carolina  
CARE CENTER, et al )

9  
10 B E F O R E:

11 HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.

12 A P P E A R A N C E S:

13 RUSKIN C. FOSTER, ESQ.  
14 BRADLEY HEWITT, ESQ.  
15 ATTORNEYS FOR PLAINTIFF

16 MONTEITH P. TODD, ESQ.  
17 RANDOLPH L. LEE, ESQ.  
18 ATTORNEYS FOR DEFENDANTS, GRAND STRAND

19 J. BOONE AIKEN, III, ESQ.  
20 ATTORNEY FOR DEFENDANTS, LAW AND CAROLINA HEALTH

21 MARIAN SCALISE, ESQ.  
22 LYDIA L. MAGEE, ESQ.  
23 ATTORNEYS FOR DEFENDANT, YOUNG

24 DIXIE COX EUBANK  
25 CIRCUIT COURT REPORTER  
FIFTEENTH JUDICIAL CIRCUIT

VOLUME 5 OF 8  
(SEE VOLUME 1 FOR INDEX)

1 gentlemen.

2 And Mr. Waldowski -- did I say that correctly?

3 A. Yes sir.

4 **THE COURT:** All right. Well, let me say to you,  
5 congratulations. I'm advised that the jury has chosen you as  
6 foreperson, and so I would say to you, congratulations for the  
7 confidence that they have expressed in you, and later on in my  
8 charge to the jury I'll talk with you a little bit about your  
9 responsibilities as foreperson, but here in advance just let  
10 me say thank you for agreeing to serve in that important  
11 capacity. I look forward to working with you.

12 All right. We are in the Plaintiff's case. Please call  
13 your next witness.

14 **MR. FOSTER:** Your Honor, the Plaintiff calls Dr.  
15 Charles Stratton.

16 **THE COURT:** Please come forward and take the oath of a  
17 witness.

18 **CHARLES WILLIAM STRATTON, M.D.,**  
19 being first duly sworn, testifies as follows:

20 **DIRECT-EXAMINATION BY MR. FOSTER:**

21 A. My name is Charles William Stratton, and Stratton is  
22 spelled S.t.r.a.t.t.o.n.

23 Q. Good morning, Dr. Stratton.

24 A. Good morning.

25 Q. How are you, sir?

1 A. Fine.

2 Q. Dr. Stratton, in order to move this along, would you  
3 briefly introduce yourself to the jury, tell them where you  
4 live, if you are married, if you have any children, and then  
5 kind of go through your educational history and your work  
6 history.

7 A. Well, as I mentioned, my name is Charles Stratton, and  
8 I live in Nashville, Tennessee. None of my family or work  
9 place, which is Vanderbilt, were affected by the flood,  
10 fortunately. But I live in Nashville, Tennessee, I'm married.  
11 My wife, Pia, has an antique shop. We have three grown  
12 children, the oldest of which is married and has -- we have  
13 three grandchildren, all this being five, our granddaughter,  
14 Carmen, and then grandson, Peter, and another grand who is  
15 four, and then a one-and-a-half year old granddaughter,  
16 Millicent, and I have two other grown sons, and neither of  
17 them are married. One of them, hopefully, is coming down from  
18 Mt. Rainier as we speak, because he went out to climb it this  
19 weekend.

20 I work at Vanderbilt University Medical Center where I  
21 am a faculty of the Medical School, so I am what is known as  
22 an Academic Physician.

23 My training is as follows: I went to college in Maine,  
24 at Bates College, graduated in 1967. Then I went to medical  
25 school at the University of Vermont College of Medicine,

1 graduated in 1971. I then did two years of internal medicine  
2 residency at the Medical Center Hospital of Vermont before  
3 going to the University of Colorado Medical Center in Denver,  
4 Colorado for a third year in Internal Medicine. That was  
5 completed in 1974, and I took my Boards in Internal Medicine,  
6 and then I began an Infectious Disease and Clinical  
7 Microbiology Fellowship also at the University of Colorado  
8 Medical Center, and that was a two-year Fellowship, which was  
9 completed in 1976. In 1976 I took my Boards for Infectious  
10 Diseases, and then I went to Charleston, West Virginia to the  
11 Charleston Area Medical Center, and I was a faculty member at  
12 West Virginia University School of Medicine, and in Charleston  
13 I directed the Clinical Microbiology Laboratory at the  
14 Charleston Area Medical Center.

15 In 1978 I took my Boards for Clinical Microbiology from  
16 the American Board of Pathology, and then in 1979 I took my  
17 Boards for Medical Microbiology from the American Board of  
18 Medical Microbiology. Also in 1979 I had an offer to move to  
19 Vanderbilt to direct the Clinical Microbiology Laboratory  
20 there, and I've been doing that since 1979, so at the end of  
21 next month it will be thirty-one years, but who's counting.

22 MR. FOSTER: Thank you, Dr. Stratton.

23 Q. Let me ask you this question, are you Board Certified  
24 in Internal Medicine?

25 A. Yes, I am.

1 Q. Are you Board Certified as an Infectious Disease  
2 Specialists?

3 A. Yes, I am.

4 Q. Are you Board Certified in Clinical or Medic -- Medical  
5 Microbiology?

6 A. I'm certified in Medical Microbiology by both the  
7 American Board of Pathology, and also by the American Board of  
8 Medical Microbiology.

9 Q. All right. And is that different from Clinical  
10 Microbiology?

11 A. Well, Medical Microbiology and Clinical Microbiology  
12 basically mean the same thing. Microbiology is the study of  
13 microorganisms, which can include bacteria, fungi, viruses.  
14 Medical Microbiology, or Clinical Microbiology is the study of  
15 those organisms that cause problem to humans.

16 Q. Okay. And how would you -- with -- if I'm keeping  
17 count correctly that's three different Board Certifications  
18 that you have.

19 A. Four.

20 Q. Four. Okay. Internal Medicine, an Infectious Disease  
21 Specialists, Medical Microbiology and ---

22 A. Medical Microbiology -- I am certified by two different  
23 organizations ---

24 Q. I've got you.

25 A. ---In Medical Microbiology.

1 Q. Okay. And how would you best describe your job at  
2 present at Vanderbilt?

3 A. Well, my job actually is what's known as a Clinical  
4 Pathologist, that is, pathologists can be forensic  
5 pathologist, in which case they are involved in the autopsies  
6 in medical cases, medical examiner type cases. They can  
7 involve Anatomic Pathology and Surgical Pathology, in which  
8 case they are looking at frozen sections, looking at tissue  
9 stains, looking at cancers, and things like that, so that's  
10 Surgical Pathology or Anatomic Pathology, or it can involve  
11 Clinical Pathology, and physicians who direct clinical  
12 laboratories are called Clinical Pathologists. That's  
13 basically what I do. I direct the Clinical Microbiology  
14 laboratory at Vanderbilt University Medical Center.

15 Q. All right, Dr. Stratton, did you ever have occasion at  
16 Vanderbilt and/or prior to attend patients as an infectious  
17 disease specialist?

18 A. Yes. I have attended on the Infectious Disease service  
19 both in Charleston when I was there, and then at Vanderbilt  
20 until 1979, when basically ---

21 Q. '79?

22 A. Excuse me -- 19 -- from 1979 till 1998, until the  
23 duties of attending on the Infectious Disease service  
24 conflicted with the duties of running the Clinical Micro Lab.  
25 In other words, it used to be that I could be attending and do

1 three or four hours a day, but over the years it became six or  
2 eight hours a day to be attending, which left no time to do  
3 what Vanderbilt was paying me to do, which was to direct the  
4 Clinical Microbiology Laboratory.

5 Q. All right, sir, and do you publish?

6 A. Yes, I do.

7 Q. What type of publications do you do? Do you do peer-  
8 review journals or books, or chapters in book -- or what type  
9 of publications do you do?

10 A. I've done all of those publications, research  
11 publications, clinical publications, and peer-reviewed  
12 journals. I've done chapters in books. I've been a co-editor  
13 of a book, so I have done all of those.

14 Q. Do you know how many total?

15 A. I have no idea.

16 Q. All right. A lot.

17 A. Again, I -- I don't count them.

18 Q. Okay.

19 MR. FOSTER: Your Honor, at this time we would offer  
20 Dr. Stratton as an expert in the areas of Internal Medicine,  
21 Infectious Disease, and Medical Microbiology, and Pathology.

22 THE COURT: All right. Four areas.

23 Are there questions from Counsel for Defense?

24 MR. AIKEN: Not from Dr. Law, Your Honor.

25 MR. LEE: For the hospital, a few questions, Your

1 MR. LEE: Thank you.

2 THE COURT: Further questions from anyone?

3 MS. SCALISE: Yes sir, Your Honor.

4 EXAMINATION BY MS. SCALISE:

5 Q. Dr. Stratton, are you Board Certified in Anatomical  
6 Pathology?

7 A. No, I'm not.

8 Q. Are you Board Certified in Clinical Pathology?

9 A. Not in Clinical Pathology. In Medical Microbiology,  
10 which is a subspecialty in Clinical Pathology, yes, but not in  
11 overall Clinical Pathology.

12 Q. Are you Board Certified in Forensic Pathology?

13 A. I am not.

14 MS. SCALISE: That's all the questions I have.

15 Thank you, Judge.

16 THE COURT: All right. Any objection now, based upon  
17 the questions that have been asked, and the responses  
18 received? Any objection to the request of Plaintiff to  
19 qualify the witness?

20 MR. LEE: No, Your Honor.

21 MS. SCALISE: No, Your Honor.

22 THE COURT: Hearing none then, the witness is so  
23 qualified as an expert in those areas, and you may proceed.

24 MR. FOSTER: Thank you, Your Honor.

25 THE COURT: Thank you.



1 DIRECT BY MR. FOSTER CONTINUED:

2 Q. Dr. Stratton, have you ever had the desire to do  
3 autopsies that -- which would regard the Forensic and the  
4 Anatomical Pathology and all that?

5 A. No. I selected my training to be in Internal Medicine  
6 and Infectious Diseases, and then Medical Microbiology, so my  
7 training from the beginning was not directed toward Forensic  
8 Pathology or Anatomic Pathology, or Clinical Pathology  
9 overall.

10 Q. And who, including -- and who would you consider to be  
11 the most qualified person to determine the timing of infection  
12 in a living human being? Let's say as between you and a  
13 forensic anatomical or clinical pathologist?

14 A. It would probably be a anatomic pathologist, and/or a  
15 forensic pathologist, someone who has looked at that and  
16 studied that, and does that on a daily basis.

17 Q. In a living -- in a patient that's living?

18 A. A patient living would be more of a surgical  
19 pathologist. If the patient had been living and then there  
20 was an autopsy, then a forensic pathologist.

21 Q. All right. Now let me ask you this. You've been  
22 reviewing cases for medical/legal purposes for how long?

23 A. For thirty-four years, approximately.

24 Q. And do you charge for your time, and coming up here and  
25 testifying, Dr. Stratton?

1 A. Yes, I do.

2 Q. All right, sir, and let me ask you this, were you, at  
3 some point, contacted by my firm and asked if you would review  
4 the records in Kelly's case, and tell us your opinion?

5 A. Yes, I was.

6 Q. Did you agree to review those records?

7 A. Yes, I did.

8 Q. All right. And did you ultimately form any opinions in  
9 this case, Dr. Stratton?

10 A. Yes, I did.

11 Q. All right. And were those opinions based on your  
12 education, your training and your experience in all the  
13 different areas of medicine that we've just talked about?

14 A. Yes, it was.

15 Q. All right. Are you still consulted at Vanderbilt on  
16 infectious disease and that sort of thing?

17 A. Yes, I am.

18 Q. Now, let me ask you this, Dr. Stratton, will all the  
19 opinions that you give here today to this jury, will they be  
20 to -- will you agree to give only the opinions that you can  
21 give with a reasonable degree of medical certainty, more  
22 likely than not?

23 A. Yes.

24 Q. All right. So if I ask you your opinion do you  
25 understand that that's the standard I'm asking you by, without

1 repeating those words every single time that we ask you a  
2 question?

3 A. Yes, I understand.

4 Q. All right, sir. All right, so you said -- did you  
5 ultimately form opinions. I think you said yes.

6 A. Yes, I did.

7 Q. All right. Can you tell the jury what opinions you  
8 formed, or would you like to use the board, or what would you  
9 like to do? Do you think you can just explain it to them in  
10 terms that we can all understand?

11 A. I'll explain, and then if we -- I think that we need --  
12 the board would help I'll use the board.

13 My job, or my part of this was to determine causation,  
14 and causation means what happened. So basically I looked at  
15 the medical records and the depositions in this case to find  
16 out what happened to this young woman, and it -- what she died  
17 of was a urosepsis and septic shock caused by a bacteria known  
18 as proteus mirabilis. Now, proteus mirabilis is an organism  
19 that is found in fecal material, so we all probably have  
20 proteus mirabilis in our stool, and it's actually an unusual  
21 cause of urinary tract infections in young woman. Eighty  
22 percent of urinary tract infections in young women are called  
23 by an organism called E. coli, or escherichia coli, so the  
24 first thing that I noted in this case was that the organism  
25 was not the most common organism that you would see causing

1 urosepsis and pyelonephritis, and pyelonephritis means a  
2 infection of the kidney, and urosepsis means that the bacteria  
3 has gotten into the bloodstream and caused what we call  
4 sepsis, and sepsis is a systemic inflammatory response caused  
5 by an infection, so she had an organism that infected her  
6 kidney, and also got into her bloodstream and caused urosepsis  
7 and septic shock, so the Pathology Report, the Autopsy Report,  
8 noted that this young woman had died of urosepsis, had  
9 pyelonephritis, and had septic shock, and she died of this,  
10 and it noted that this organism, proteus mirabilis, had been  
11 recovered before her death from both her urine and her  
12 bloodstream. So again, the first thing that I note is that  
13 this is a relatively unusual organism to be causing urosepsis  
14 in a young woman. In fact, less than five percent of acute  
15 pyelonephritis in a young woman is going to be caused by this  
16 particular organism, proteus mirabilis.

17 Now, I also noted that she ---

18 Q. Can I ask you one question before you go further?

19 A. Yes.

20 Q. How does the fact that it was unusual factor into your  
21 opinion?

22 A. Because it is important in terms of the type of stone,  
23 the type of kidney stone that, more likely than not, caused  
24 this particular problem, so this organism is associated with  
25 kidney stones, so that was -- and if we take a second to look

1 at kidney stones, kidney stones can be -- there are a number  
2 of different types of kidney stones, calcium oxalate is  
3 probably the most common kidney stone, and that there are most  
4 often no organisms involved. We still don't know why people  
5 get kidney stones made out of calcium oxalate, but we know  
6 that they do, but the -- although they can become infected or  
7 colonized, in fact usually calcium oxalate kidney stones are  
8 not associated with an infection on the front end, although  
9 they can, obviously, become infected. That's why somebody  
10 with a stone, and fever, is -- that's considered a urologic  
11 emergency.

12 So -- but the proteus organism is associated with a  
13 specific type of stone called a struvite stone. And what is  
14 thought to happen is that the proteus gets into the urinary  
15 tract system like any other organism can get into the urinary  
16 tract and -- system, and they generally get in through what we  
17 call an ascending route, so if you are going to get a micro-  
18 organism into your bladder, then up your ureters, and into  
19 your kidneys, it's going to generally come from an ascending  
20 route, meaning it goes in through the urethra and then ends up  
21 in the bladder, and then can go from the bladder to the  
22 kidneys.

23 I note from the medical records that this young woman  
24 had had urinary tract infections in the past, and also had had  
25 one stone in the past, and the stone had not been analyzed.

1 One of the things that your urologist will do if you have a  
2 stone is -- is to have you try to collect that stone. They  
3 like to get that stone to analyze it, so that they know what  
4 kind of stone it is, whether it is a calcium oxalate, or what  
5 we call a struvite stone, which it is a complex stone that has  
6 calcium and magnesium, phosphate and hydroxyapatite is  
7 material that is in your teeth, so these can be quite hard  
8 stones, similar -- calcium oxalate stones are hard as well.  
9 Stones develop in the kidney, and then they can fall into the  
10 ureter, so we talk about a kidney stone dropping. It doesn't  
11 drop out of the sky, it's formed in the kidney and then it can  
12 drop into the ureter, and then it goes down the ureter, and  
13 that's a very painful process, and as it goes down the ureter  
14 it is scraping that ureter, and it hurts. It's one of the  
15 most painful things known to humans, and in fact, you can  
16 always tell in the emergency room when someone has a stone  
17 because they move about a lot, and they -- because they --  
18 most of the time when you hurt you try to be very quiet, you  
19 don't want to move what's hurting, because it makes it hurt  
20 worse, but one of the unique things about a renal stone is  
21 that people move around. In fact, when my wife passed a renal  
22 stone I had to pull off at Cookville so that she could pace  
23 around, because she -- she was climbing the ceiling in the  
24 car, so it -- you know when someone has passed a renal stone  
25 because it's quite painful.

1           The -- as the stone goes down the ureter, as I've  
2 mentioned, it's going to scrape that ureter, and if urine can  
3 get past it one of the things that happens is you get red  
4 blood cells in the urine, and ---

5       Q.       Now what do you mean by red blood cells?

6       A.       Red blood cells are what is -- that's what blood is  
7 made of. Red blood cells carry oxygen, and that's what's in  
8 your bloodstream, is -- that's what blood is made of, is -- is  
9 plasm and red blood cells -- and when you scrape the ureters  
10 as the stone goes down you get bleeding, and unless the stone  
11 completely obstructs the ureter, which can happen, the blood  
12 goes down into the urine, and you can see it on a urinalysis,  
13 and that's one of the things in a emergency room you check  
14 for, with either a dip-stick or a urinalysis. You check for  
15 the presence of blood in the urine because it's a clue that  
16 this person has a renal stone. If you see no blood, which is  
17 the case in this patient, it means that the ureter is  
18 completely obstructed, and the blood that has -- from the  
19 scraping as the stone has moved down the ureter, is not  
20 getting past the stone to get into the urine.

21       Now, as I mentioned, the proteus is associated with the  
22 specific type of stone called the struvite stone, and these  
23 stones are problems in a small number of persons, but they can  
24 be major problems, and here's how we think those stones are  
25 formed. The proteus gets into the kidneys, into the -- it

1 gets in through the urethra and then into the bladder, and  
2 then up the ureters, and ultimately colonizes. It may not  
3 infect, but it may colonize, meaning it's just attached to the  
4 tissue. And when it's in the kidneys what happens -- at least  
5 this is what we theorize -- is that proteus has a urease, so  
6 it splits urea, and urea is what's in urine, that's why -- so  
7 it splits this urea, and it changes the pH around where the  
8 organism is, to the point where these different cations,  
9 calcium and magnesium and anions, phosphate, and other  
10 materials precipitate, so you end up getting what's called a  
11 struvite stone, and over time, in some patients, these  
12 struvite stones can actually form what are called staghorn  
13 calculi. These look like a big moose antler, because they  
14 take the shape of the renal pelvis, and parts of them can fall  
15 off, and if they do fall off -- now a young woman like this  
16 wouldn't be expected to have a staghorn calculus because her  
17 stones had just started, but in twenty or thirty years she may  
18 well have had a staghorn calculus, and one of the things that  
19 urologists try to do to prevent this is they try to get rid of  
20 that proteus in the urinary tract because they've noticed that  
21 if you can get rid of the proteus in these patients these  
22 patients don't go on to form these struvite stones. If you  
23 don't get rid of the proteus they have multiple stones, and  
24 the difference with these stones compared to a normal or more  
25 common stone, is that these stones can actually -- they form



1 around the bacteria, so the bacteria are there, and they are  
2 splitting the urea, and you are getting precipitation of these  
3 materials, and you are forming the struvite stone, and as this  
4 happens the organisms are trapped in that stone, and so now  
5 you have a stone that not only has these materials, calcium,  
6 magnesium, phosphate, hydroxyapatite, but also there are  
7 organisms that are trapped in this stone. So these are not  
8 sterile stones. Now the good news is that, as long as your  
9 urine is moving there's no problem, so you can have a staghorn  
10 calculous and the urine is washing over it, and yes, there's  
11 proteus there, and if you culture the urine you've find  
12 proteus, but in fact, you don't have what we call an  
13 infection, but as soon as you have stasis, as soon as the  
14 urine stops moving then you can have problems, and here's why.  
15 If you have a blockage, say in a ureter, and the urine is  
16 backing up, in that urine, if there are organisms in the stone  
17 -- if it's a struvite stone, and there are organisms in that  
18 stone, then every twenty minutes those organisms double in  
19 numbers, so if you start out with one, twenty minutes later  
20 you've got two, twenty minutes later you've got four, twenty  
21 minutes later you've got eight. If you do the math you'll see  
22 that it takes about four hours and forty minutes before you  
23 have a hundred thousand or more organisms in that urine. We  
24 know that you can have as few as a hundred organisms -- this  
25 is organisms per ml. We know that you can have as few as a

1 hundred organisms per ml and your body starts to get an  
2 inflammatory response, which, if you have a -- if it's in your  
3 bladder you get an inflammatory response which hurts, so when  
4 you urinate it burns, so we have what we call urethritis. If  
5 it's in the ureter ---

6 Q. Can I stop you right there, Dr. Stratton ---

7 A. Yes.

8 Q. ---And back up and clarify a couple of things. Do you  
9 have an opinion as to whether all struvite stones are staghorn  
10 stones?

11 A. No. Struvite is just the composition. A struvite  
12 stone can form a staghorn calculous in someone who has had  
13 them for twenty or thirty years. Early on they don't form  
14 staghorn calculi, they form just regular stones.

15 Q. Do you know what that's a picture of?

16 A. Yes. That's a picture of a struvite stone.

17 Q. Okay. All right. One other -- a couple of other  
18 things I wanted to clarify before you move on. I believe you  
19 said that the majority of stones are calcium oxalate, not  
20 struvite. Can calcium oxalate stones also become infected?

21 A. Yes, they can become infected too. For example, if  
22 there is a proteus, or an E. coli, or any organism in the  
23 kidneys they can infect those stones too. It's just that  
24 struvite stones are typically infected.

25 Q. Okay. And you talked about the stasis of urine. When

1 it's static?

2 A. It means it's not moving.

3 Q. All right. Is there -- is stasis of urine and Dr.  
4 Law's diagnosis of severe hydro -- I think it's on the other  
5 page -- of severe hydroureter, have anything to do with stasis  
6 of urine?

7 A. Yes. Basically hydroureter means that the ureter is  
8 swelling because the urine can't move past the stone.

9 Q. All right, sir. One other thing and I'll let you get  
10 back to your train of thought. I hope you didn't lose it, but  
11 I'll remind you of where you were. I think you were just  
12 getting ready to tell the jury, if the stone dropped down with  
13 one bacteria in it how it would multiply. My question to you  
14 is this, what are the odds of a stone that is colonized with  
15 bacteria dropping down into the ureter with only one bacteria?

16 A. That -- if it's a struvite stone, and therefore  
17 colonized with the proteus, there would be hundreds, if not  
18 thousands of proteus within that stone. It would be very  
19 unlikely to just have one organism, but the point is that,  
20 even if you only have one that within four hours and forty  
21 minutes you will -- that's one per milliliter -- that within  
22 four hours and forty minutes, if you do the math, you will  
23 have over a hundred thousand, and actually within a shorter  
24 period of time you will have over a hundred organisms per ml,  
25 which is where we first start to associate inflammation and

1 symptoms with urinary tract infections if they are in the  
2 bladder and the urethra.

3 Q. Okay. Continue, if you would, because I stopped you  
4 at, I think at a hundred organisms per milliliter.

5 A. Okay. So the problem is that, if you have a stone that  
6 is colonized, that drops into the ureter and occludes it, then  
7 that means that within a short period of time -- we are  
8 talking hours -- you are going to have infection in the  
9 ureter. We call it a ureteritis, meaning there's infection in  
10 the urine.

11 Now, this is an important thing to understand. If you  
12 have infection in urine, whether the urine is backed up behind  
13 the stone in the ureter, or whether the urine is in your  
14 bladder, that's not a major problem. People have cystitis,  
15 which we call an infection in the urine in your bladder,  
16 people have that all the time, women, obviously, more than  
17 men, but women have cystitis, and the infection is in the  
18 urine, and it's really not going into the tissue, and what  
19 that means is, because the tissue, although the tissue may be  
20 inflamed, but the organisms are not generally invading through  
21 the bladder wall to get into the bloodstream, so when you have  
22 cystitis you generally don't have urosepsis. You don't get  
23 septic shock when you have a simple cystitis. Women have  
24 burning when they urinate. They have this super-pubic  
25 sensation that hurts, but they don't end up getting urosepsis.

1           Now, if you have infection in the urine over time that  
2 infection can ascend, so whether it's in the bladder, with  
3 cystitis, or whether it's behind a stone as a ureteritis, that  
4 infection can ascend, and when it gets into the kidneys it can  
5 then cause pyelonephritis. That's a fancy name that means  
6 infection of the tissues in the kidney, and we call it acute  
7 pyelonephritis, and among the symptoms of acute pyelonephritis  
8 are shaking chills, or rigors, nausea, and vomiting.

9           Now the problem with acute pyelonephritis is now the  
10 organisms are in tissue, they are damaging tissue, they can  
11 spread into the bloodstream, so some of acute pyelonephritis  
12 patients get what we call urosepsis, which can involve septic  
13 shock, and septic shock, overall, has a thirty percent  
14 mortality, so septic shock is not good. The important factor  
15 in septic shock is how long you are hypotensive before you  
16 receive appropriate antibiotics, which is one of the reasons  
17 that when you come into the emergency room with what looks  
18 clinically like septic shock, that they start the antibiotics  
19 right then and there in the emergency room, they don't wait  
20 till you are admitted, they get the antibiotics going right  
21 then.

22           So what I note in reviewing the medical records of this  
23 young woman is that she has a proteus mirabilis, which is  
24 associated with these struvite stones, so more likely than  
25 not, her stone was already colonized when it dropped into the

1 ureter on Saturday morning, and within hours there was  
2 infection in that urine. Again, it was a ureteritis, meaning  
3 there was infection in the urine, but it was not in the  
4 kidneys at that time.

5 From the medical records and the depositions it appears  
6 that she had the shaking chills, the nausea, vomiting, and  
7 that all this occurred on Sunday morning, which tells me that  
8 she, more likely than not, had a colonized stone that dropped  
9 into the ureter, infected the urine above the stone, and that  
10 there was infection by the time she left the hospital, and she  
11 would have been febrile because, in fact, forty-five minutes  
12 to an hour later, when she gets home, she has a temperature of  
13 a hundred and one point two, so more likely than not she would  
14 have had a elevated temperature while she was in the hospital,  
15 because she was there from eight in the morning till noon, so  
16 during that time period -- she did not have a temperature when  
17 she came in, but more likely than not she would have, had a  
18 temperature been repeated because, in fact, she was noted by  
19 her husband to be febrile at around forty-five minutes to an  
20 hour after she left the hospital and returned home.

21 Again, the infection at that time was in the urine, and  
22 not in the kidneys. By Sunday morning -- so sometime Saturday  
23 evening, Saturday night or early Sunday morning, but sometime  
24 in that period of time the kidneys became infected -- or the  
25 kidney became infected, and when she has shaking chills,

1     nausea and vomiting on Sunday morning that's when she had  
2     pyelonephritis, which means it started sometime before that.  
3     And so that is when she had pyelonephritis, and then she  
4     became septic, and probably was hypotensive sometime after her  
5     husband left that morning, because she was up walking around,  
6     taking a shower and making breakfast, so it's unlikely that  
7     she was hypotensive at that time, because if you are  
8     hypotensive -- if you have septic shock you are going to have  
9     a low blood pressure, and if you have a low blood pressure if  
10    you get up and try to walk around you are going to fall over  
11    because your blood is not getting to your brain, so I don't  
12    think she was hypotensive when she was walking around in the  
13    morning, but sometime that morning she became hypotensive, and  
14    by the time she got to the Emergency Room and received the  
15    antibiotics, which was around almost three o'clock in the  
16    afternoon, she had been hypotensive long enough that she did  
17    not survive.

18    Q.     Dr. Stratton, let me ask you this, did you read the  
19    dictated note by Dr. Law?

20    A.     Yes, I did.

21    Q.     And contained within his differential diagnosis did you  
22    note that there was pyelonephritis?

23    A.     Yes.

24    Q.     Is that -- was that one of the diseases in the -- do  
25    you have an opinion as to whether or not that was one of the

1 reading this has some evidence that the urine is not getting  
2 through to the bladder. There's additional evidence when you  
3 look at the urine dip-stick because there's no red blood --  
4 there's no blood in it which, again, when you -- you have  
5 kidney stones, seventy, eighty percent of the time, unless  
6 it's obstructing the ureter, you are going to have red blood  
7 cells in the urine.

8 Q. Dr. Stratton, did you form any opinions based on all  
9 the medical records and all the materials that you reviewed,  
10 as well as your education, training and experience, as to --  
11 and I think you just mentioned this, but I want -- but I want  
12 to make sure --- as to when Kelly's infection began?

13 A. Yes. I believe ---

14 Q. The acute infection that she went to hos -- when it ---

15 A. The infection of the urine, behind the stone, in my  
16 opinion, began within one to six hours, and probably closer to  
17 one hour because these struvite stones have a lot of organisms  
18 in them, so the infection began within several hours after the  
19 stone had dropped and was obstructing the ureter, so the urine  
20 behind the stone was infected within hours, and then the  
21 kidney itself became infected ---

22 Q. Can I back you up?

23 A. Yes.

24 Q. All right. And have you formed any opinions as to when  
25 she would have been febrile after that stone dropped?



1 A. Yes. I believe she would have been febrile before  
2 twelve noon because, in fact, she was in the Emergency Room  
3 for four hours, and the stone dropped at least thirty minutes,  
4 and maybe as much as an hour or so before that, so -- and I'm  
5 not totally sure when the stone dropped, in that even with a  
6 lot of pain -- I know if my wife was woken up with a kidney  
7 stone that she would have to do her hair before she went to  
8 the emergency room -- so I don't know how long it was before -  
9 - when she had pain to when she got to the Emergency Room, but  
10 I do know that she was in the Emergency Room from eight to  
11 noon, and I believe that somewhere closer to, say ten o'clock,  
12 she had infection in the urine, behind the stone, that would  
13 have caused inflammation which, in turn, would have caused a  
14 fever, so -- and I know that by the time she gets home, forty-  
15 five minutes to an hour after she leaves at noon, that she's  
16 got a temperature of a hundred and one point two, so I believe  
17 that her stone was colonized, that the urine became infected  
18 within hours after it dropped, and that by ten o'clock in the  
19 morning, for example, she would have been febrile had her  
20 temperature been taken.

21 Q. All right. And did you form any -- just to make sure  
22 that we are clear on this, do you have any opinions as to when  
23 that ureteritis, or that infection of the urine in ureter,  
24 actually moved up the ureter and infected her kidney?

25 A. Yes. I believe that that process occurred somewhere,

1 say Saturday evening to early Sunday morning, because on  
2 Sunday morning she has nausea, vomiting and shaking chills.  
3 Shaking chills are also called rigors, and they are called  
4 shaking chills because the whole bed can shake, not a chilly  
5 feeling. Your teeth can chatter, so they are called -- and you  
6 shake, so those are called rigors, and she has rigors, nausea,  
7 vomiting Sunday morning, and those are classic symptoms of  
8 acute pyelonephritis, so I know Sunday morning that now the  
9 kidney is infected, and in fact it must have been infected  
10 sometime before Sunday morning because you don't -- it's not  
11 like you wave a wand and poof, the kidney is infected. It  
12 takes time for the pyelonephritis to reach the point where the  
13 patient becomes symptomatic, meaning they have nausea,  
14 vomiting and rigors.

15 Q. All right, sir, do you have -- did you form any  
16 opinions as to when she became septic, and could you explain  
17 to them what septic is again?

18 A. Well, sepsis is a term that means a systemic  
19 inflammatory response, which can be measured by a number of  
20 things including pulse, respiratory rate, blood pressure,  
21 lactic acid is a lab test that you can use, but we call it a  
22 systemic inflammatory response, or SIRS, and whenever SIRS is  
23 caused by an infection we call it sepsis, and sepsis often  
24 involves organisms in the bloodstream, and then we call it --  
25 and if it comes from the kidneys, comes from pyelonephritis,

1 we call it urosepsis, and then you would have septic shock.  
2 Sepsis just means inflammatory response caused by an  
3 infection, and you have a fever, you may have low blood  
4 pressure, you may not, but you have an elevated respiratory  
5 rate, you have a elevated pulse. If -- if -- then when you  
6 start to have low blood pressure we now call it septic shock,  
7 and if you are hypotensive it's hard to walk around, you  
8 will -- you will faint, because your body wants to get down  
9 level so the blood can get to your brain. So I don't believe  
10 that she had septic shock until sometime after 9, 9:30 when  
11 her husband left, because again, she was up making breakfast,  
12 walking around, getting a shower, so I don't think she was  
13 hypotensive at that time.

14 We know that when she gets to the Emergency Room  
15 sometime after two or so in the afternoon that she is in  
16 septic shock, she is hypotensive, and my -- more likely than  
17 not, this had gone on for hours simply because otherwise she  
18 would have survived given antibiotics, and she had antibiotics  
19 within -- she had antibiotics by three o'clock in the  
20 afternoon, so she had antibiotics relatively early, so if she  
21 were -- if she hadn't been hypotensive for a number of hours  
22 more likely than not she would have survived, given the  
23 antibiotics.

24 Q. All right. Let me ask you this, Dr. Stratton, did you  
25 form any opinions based on everything that you reviewed, the

1 medical records, the deposition testimony that you read of  
2 everyone, etcetera, do you have any opinion as to whether or  
3 not, if Kelly had been admitted to the hospital on Saturday  
4 instead of being sent home, whether she would be alive today?

5 A. My opinion is that she would be alive today.

6 Q. All right. Did you form any opinions as to whether or  
7 not, if she had been admitted to the hospital on Sunday would  
8 she be alive today?

9 A. More likely than not she would be alive today if she  
10 had been admitted to the hospital on Sunday.

11 Q. And same question as to very early Monday morning, say  
12 some wee hours of the day Monday morning, do you have any  
13 opinions as to whether or not ---

14 A. If she had been admitted Monday morning when she was  
15 still walking around, getting a shower and making breakfast,  
16 then more likely than not she would still be alive.

17 Q. All right. And now do you -- did you provide Counsel  
18 with any literature on that, as far as studies as to -- as for  
19 the proposition how long, and what your chances of survival  
20 are between the onset of hypotension and septic shock, and the  
21 administration of antibiotics and your likelihood of living?

22 A. Yes. We discussed that in my deposition, and I  
23 mentioned an article by Kumar, and they requested that, so I  
24 sent that to you, and I believe you gave that to them.

25 Q. Okay. And does -- does that contain any graphs or

1 JURY.)

2 THE COURT: And sir, if you want to come to the -- go  
3 ahead and be seated in the witness stand you are welcome to do  
4 so.

5 Did you get some lunch today?

6 A. Yes, I did.

7 THE COURT: All right. Well, good.

8 A. Riverwalk Cafe was very good.

9 (THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE  
10 JURY.)

11 THE COURT: All right. Welcome back, ladies and  
12 gentlemen. At the end of the morning hour we finished direct-  
13 examination. We now move to cross-examination.

14 Mr. Lee.

15 MR. LEE: Thank you, Your Honor.

16 THE COURT: Yes sir.

17 CROSS-EXAMINATION BY MR. LEE:

18 Q. Good afternoon, Dr. Stratton.

19 A. Good afternoon.

20 Q. Do you recall when we took your deposition, discovery  
21 deposition, we asked you a number of questions concerning your  
22 opinions. Do you recall that?

23 A. Yes, I do.

24 Q. Do you recall we also asked you whether we had received  
25 all of your opinions at that time.

1 A. Yes, you did.

2 Q. And you were under oath at that time, and I want to  
3 make sure that your testimony today is consistent with what  
4 you said during your deposition. Earlier today I thought I  
5 heard you say that the urine was infected, and that the  
6 infection occurred somewhere between one and six hours after  
7 the infection, and that more likely than not it was closer to  
8 one hour.

9 A. That's correct.

10 MR. LEE: Your Honor, may I approach the witness?

11 THE COURT: You may open the deposition, and you may  
12 approach.

13 Q. This is a copy of your deposition transcript. Let me  
14 ask you to turn to pages forty-six and forty-seven, please.  
15 Let me know when you get there, please.

16 A. I'm there.

17 Q. Go on to page forty-six and then the top of page forty-  
18 seven, lines two through five or six.

19 A. Yes.

20 Q. Wasn't it your testimony at the time of your deposition  
21 -- and I'll read the question to you. It says, "So you can't  
22 say, to a reasonable degree of medical certainty, whether it's  
23 closer to one hour, or closer to six hours." What was your  
24 answer?

25 A. My answer was, "I can't know."

1 Q. So today you are telling us that it's closer to one  
2 hours, whereas at the time of your deposition you said you  
3 couldn't tell.

4 A. Again, I don't know how many organisms were colonizing  
5 the stone. I just know that, in fact when I did the math,  
6 after our deposition, it basically should say between one hour  
7 and four hours and forty minutes, if you do the math. What I  
8 don't know is the number of organisms, but there are, more  
9 likely than not, going to be more than one. One organism  
10 would be four hours and forty minutes, so that would be closer  
11 to six, a hundred thousand organisms it would be an hour.  
12 Again, I don't know how many organisms there were, but even if  
13 you assume one, then it's going to be four hours and forty  
14 minutes. If you assume more than one, which is what I would  
15 assume, but I don't know, then it's going to be closer to one  
16 hour.

17 Q. So Doctor, isn't it fair to say, you really can't say  
18 whether it's one hour, four hours and forty-five minutes, or  
19 whichever your calculations were, you really can't say as you  
20 sit here today, isn't that correct?

21 A. I can't say because I don't know how many organisms  
22 were colonizing the stone, no.

23 MR. LEE: Your Honor, may I use the board -- easel?

24 THE COURT: You may.

25 Q. Let me talk to you about assumptions you are making.

1 One assumption you are making is that you are assuming a  
2 certain number of organisms. Is that correct?

3 A. I'm assuming at least one, and more likely than not,  
4 more than one.

5 Q. So you don't know the number of bacteria, correct?

6 A. No, I don't know the actual number of bacteria.

7 Q. Let's talk about some other things that you are  
8 assuming. What's the basis for your testimony that that stone  
9 was a struvite stone?

10 A. The basis is the fact that, number one, the young woman  
11 died of a proteus mirabilis septic shock and urosepsis, which,  
12 in itself, is distinctly unusual because eighty percent of  
13 urinary tract infections in young woman are going to be E.  
14 coli, and therefore urosepsis, if it happens, eighty percent  
15 of the time it's going to be escherichia coli. The fact that  
16 this occurred with a proteus mirabilis, which is known to be a  
17 stone-forming microorganism, the fact that this young woman  
18 had had at least one stone, symptomatic stone previously, and  
19 was also known to have recurrent urinary tract infections, so  
20 based on that information, more likely than not, this was a  
21 struvite stone.

22 Q. Can you show me one piece of objective clinical data in  
23 the medical records that you have -- and I'll be happy to  
24 provide them to you -- to support your position that it was a  
25 struvite stone.



1 proteus stone that led to this infection.

2 A. No. What leads me to the conclusion that it was a --  
3 more likely than not, a struvite stone, is that, number one,  
4 proteus mirabilis is a very unusual organism to be causing  
5 acute pyelonephritis and urosepsis in a twenty-five year old  
6 woman. Number -- eighty percent of those sorts of infections  
7 are caused by escherichia coli, so I would have expected -- if  
8 there were no colonized stone involved I would have expected  
9 that this young woman would have had an escherichia coli  
10 urosepsis and septic shock, not proteus mirabilis.

11 The other thing that leads me to suspect it's a struvite  
12 stone is that this whole sequence of events, from start to  
13 finish, occurred over a weekend, and the only way that I can  
14 explain that medically is that the stone, in fact, was  
15 colonized when it dropped, leading to rapid infection of the  
16 urine behind the stone, followed by infection of the kidney,  
17 followed by urosepsis and septic shock, all of this basically  
18 occurring over a two to three day period.

19 Q. Two to three day period.

20 A. Yes.

21 Q. But Doctor you mentioned earlier that -- if I don't --  
22 make sure I don't mistake your testimony -- did you say you  
23 thought it was a completely obstructing stone?

24 A. That is my opinion, yes.

25 Q. And what supports the opinion that the stone was

1 would be approximately nine o'clock in the morning.

2 Q. And when you become hypotensive you become faint, you  
3 might pass out, you get light-headed. Is that right?

4 A. Correct.

5 Q. And hypotensive just means that your blood pressure is  
6 dropping.

7 A. Correct.

8 Q. Now, if she became hypotensive at 9:15 Monday morning -  
9 - and the reason I'm going over this, Doctor, is because Mr.  
10 Foster was talking about, in the wee morning hours of Monday.  
11 I'm not going there, I'm going 9:15 Monday morning, okay, and  
12 that's about when she became hypotensive, from what you told  
13 us less than three months ago, right?

14 A. Correct.

15 Q. So, if Mr. Fay had taken his wife, and had made sure  
16 she was at the hospital by ten o'clock A.M. on the day she  
17 died, more likely than not -- if she was at the hospital by  
18 ten she would have survived?

19 A. Correct.

20 MR. AIKEN: Thank you. That's all I have.

21 THE COURT: And is there redirect?

22 MR. FOSTER: Yes, Your Honor.

23 THE COURT: All right, Counsel. How long do you  
24 believe your redirect will be?

25 MR. FOSTER: Not too long, Your Honor. I would say

1     probably seven or eight, ten minutes.

2           **THE COURT:**    Let's go ahead.  You may proceed.

3           **MR. FOSTER:**   Thank you, Your Honor.

4     **REDIRECT-EXAMINATION BY MR. FOSTER:**

5     **Q.**       Go again, Dr. Stratton.

6           Now, do you recall when Mr. Lee began cross-examining  
7     you about your deposition when you said -- when they asked you  
8     the question in the deposition -- and I quote, "Can you say to  
9     a reasonable degree of medical certainty whether it was closer  
10    to one hour or six hours from the time the stone dropped until  
11    she was infected?"  Do you recall that questioning?

12    **A.**       Yes, I do.

13    **Q.**       Okay.  In the deposition, is that exactly what they  
14    asked you, "Can you say to a reasonable degree of medical  
15    certainty ...?"

16    **A.**       That's what they asked on page forty -- "So you can't  
17    say to a reasonable degree of medical certainty whether it's  
18    closer to one hour or closer to six hours."

19    **Q.**       And here's my question.  Can you say, the a reasonable  
20    degree of medical certainty, more likely than not, whether it  
21    was closer to one hour than six hours?

22    **A.**       If I assume that the stone was a struvite stone and was  
23    colonized, then more likely than not it's going to have more  
24    than one organism.  It's going to have hundreds, if not  
25    thousands of organisms, which is the question you asked me in

1 when he said that I said, no, she had SIRS on Monday, she had  
2 acute pyelonephritis on Sunday.

3 Q. Okay. Now, they also went through the scenario, as I  
4 did with you if taken back to the -- he said, if taken back to  
5 the E.R. Kelly Fay probably would have survived, and then  
6 listed times. Do you recall that?

7 A. Yes. I think you asked me the same questions, except  
8 you said, I think, Monday at 9 A.M.

9 Q. Let me ask you this question. If Kelly had been  
10 admitted to the hospital on Saturday, would there be -- would  
11 there be any discussion about these times?

12 A. We wouldn't be here.

13 Q. All right. And, Dr. Stratton, do you have an opinion  
14 as to whether or not when someone has an infection that took  
15 the progression you opined that Kelly had, does their fever --  
16 do you have an opinion as to whether or not their fever goes  
17 up on a straight line, or what does it do?

18 A. Fever can go up and down. You can have -- it tends to  
19 go up in the evening and be down in the morning. There are  
20 very few infections where the fever goes up and stays up.  
21 Salmonella Type E is one infection where your fever goes way  
22 up and it stays up, but most of the time fever goes up, and it  
23 goes down. It can also be not only influenced by the time of  
24 the day, but it can be influenced on whether you take aspirin,  
25 or Tylenol, or other anti-pyretics. Non-steroidal anti-

1 inflammatory agents, for example, can make your fever go down.  
2 They don't mask it, but they can make it go down.

3 So, fever also depends on your age. Young people have -  
4 - tend to -- can have higher fevers than older people because  
5 their immune system is more robust.

6 Q. Without me turning to the graph do you recall Mr. Aiken  
7 asking you questions about early Sunday morning, and if Sean  
8 had taken her to the hospital early Sunday morning about  
9 whether she would still be here. Do you recall that?

10 A. Yes, I recall that.

11 Q. Do you have an opinion, Dr. Stratton, if Dr. Young had  
12 seen her early -- early Monday morning, instead of being in  
13 surgery, and her having an appointment on -- in the afternoon,  
14 do you have an opinion as to whether or not she would be alive  
15 today?

16 A. Again, if he had seen her before one-thirty in the  
17 afternoon, which I think is the time that I felt that she,  
18 more likely than not, would have survived, based on the length  
19 of time she was hypotensive, if he had seen her that morning  
20 than she would, more likely than not, be here.

21 MR. FOSTER: Just briefly, Your Honor.

22 Q. Now, you also were questioned several times about a  
23 type of stone, Dr. Stratton.

24 A. Yes.

25 Q. Let me ask you this. Do you have an opinion as to

1           **MR. FOSTER:** Your Honor, on page eighty-three,  
2 beginning with line eleven.

3           **THE COURT:** And let's give us the date and time that  
4 deposition was taken.

5           **MR. FOSTER:** I'm sorry. This depo -- Your Honor, this  
6 deposition was taken on December the 3rd, 2004, of Dr. Law.

7           **THE COURT:** All right.

8 **BY MR. FOSTER FROM THE DEPOSITION OF DR. LAW:**

9           **MR. FOSTER:** On page eleven the question was, "Okay,  
10 all right now, you read Dr. Young's deposition, correct?" The  
11 answer was, "Yes." Question: "And you saw where he said that  
12 he agreed with you, based on her age and pain control, that  
13 she was appropriate to discharge, is that correct?" And the  
14 answer was, "I recall, yes." Question: "You recall him  
15 saying that?" Yes. Answer: "Yes." Question: "Is that the  
16 way you recall the conversation?" Answer: "From my  
17 recollection of it, yes."

18           All right. And then on page eighty-four, the whole  
19 page. I guess we need to start a little bit before that. The  
20 question was, "Give me your recollection, let me ask you this.  
21 Mr. Fay has testified under oath you told him you had talked  
22 to Dr. Young and both Dr. Young and I believe, based on her  
23 age and health she should be fine until Monday with pain  
24 management or pain medicine, he wasn't sure which. Does that  
25 sound like what you told Mr. Fay?" Answer from Dr. Law, "That

1 sounds reasonable." Question: "After talking to Dr. Young?"

2 Answer: "Yes."

3 "Now, can you tell me the specifics of what you and Dr.

4 Young talked about?" Answer: "Specifically, no. I can tell

5 you generally what occurs when I speak to a consultant about a

6 case in the emergency department in relation to kidney stone,

7 particularly, we will go over the patient's presentation, any

8 associate symptoms, relief response to pain medications, any

9 lab findings, and disposition." Question: "I'm sorry,

10 presentation, associated symptoms?" Answer: "Lab findings

11 and disposition." Question: "Okay, and why do you -- why do

12 you call specialists?" Answer: "Number one, if it's

13 important -- if it's important to the patient to have close

14 follow-up that's a problem -- that it's a problem that cannot

15 be treated at the emergency department, being the inpoint

16 where they need to see somebody to monitor the progression of

17 their disease." Question: "But now you were discussing her

18 presentation, her associated symptoms, her lab findings and

19 what you intended to do, correct?" Answer: "That's what I

20 would typically do. I don't recall specifically what I

21 discussed with Dr. Young. Most times, in a typical scenario

22 that's what I would discuss with him." Question: "And how

23 did it come about that he agreed with you based on -- that

24 based on the fact that she was in good health, and her age and

25 her pain was under control that she was able to be discharged

1 and wait until Monday for follow-up? How did it come about  
2 that he agreed with you on that?" Answer: "I imagine during  
3 the course of our discussion." Question: "I mean, did you  
4 ask him, do you agree with me that she's able to wait till  
5 Monday, or do you think I need to admit her, or do you think  
6 she needs to be admitted, or how would you come about  
7 eliciting that information from him? We would have discussed  
8 the case and see if there were enough factors there to warrant  
9 admission, or if the patient would be safe for discharge."

10 On page eighty-six, question: "And what was his  
11 opinion, his being Dr. Young?" Answer: "As I recall he agreed  
12 that -- he agreed that we could discharge the patient home."

13 All right, and then on page eighty-seven, beginning with  
14 eight, question: "Do you remember when you talked to Dr.  
15 Young?" Again -- answer: "Again, I recall speaking to him  
16 prior to the patient's discharge." Question: "Just prior  
17 to?" Answer: "I'm not certain if it was just prior to or  
18 sometime before. I can't put a timeline on it." Question:  
19 "Not even within a hour, or thirty minutes, or fifteen  
20 minutes?" Answer: "I would imagine, and again, this is  
21 supposition, that it happened just prior to her being  
22 discharged." Question: "And basically one of the things you  
23 were trying to do was see if he agreed with your disposition,  
24 correct?" Answer: "Correct." Question: "And he did, based  
25 on what you told him?" Answer: "Yes."



1           Page eighty-eight, Your Honor, lines one through twenty.  
2       Question: "And he also -- did you tell him there was no blood  
3       in the urine?" Answer: "I don't recall specifically. Again,  
4       that would be part of the presentation that I would typically  
5       discuss with the consultant." Question: "Did you tell him  
6       that she had nausea but no vomiting?" Answer: "Again, I  
7       can't recall specifically, but I imagine yes, that would be  
8       part of the discussion." Question: "Of what you would have  
9       told him?" Answer: "Yes." Question: "What would you have  
10      told him about the lab findings, just that there was no blood  
11      in the urine?" Answer: "I would have reviewed the lab  
12      findings with him. Again, I can't ...". He's still continuing  
13      with his answer. "Again, I can't tel you exactly whether that  
14      was discussed, but that is my typical practice." Question:  
15      "So you would basically have told him everything you knew  
16      about the case at the time?" Answer: "Again, typically that  
17      is my practice." Question: "And since she was to follow up  
18      specifically with Dr. Young, would you have told her -- told  
19      him her name so that they ...". It should say her -- told him  
20      -- no, I'm sorry. Let me start over. "And since she was to  
21      follow up specifically with Dr. Young you would have told him  
22      her name so they would know at the office. Is that correct?"  
23      And the answer is, "Yes".  
24           Question on page -- on line three, page eighty-nine.  
25      "And he also agreed to accept her as a patient, is that

1 correct?" Answer: "I believe so, yes." Question: "In fact,  
2 there were papers signed by Ms. Fay allowing the hospital to  
3 forward her records straight to Dr. Young, correct?" Answer:  
4 "I believe so, yes."

5 And then on page ninety-five, Your Honor, lines two  
6 through twelve. Question: "And you copied Dr. Young on this  
7 E.R. report?" Answer: "That's correct." Question: "Would  
8 that have been sent to him that day?" Answer: "I'm not  
9 certain." Question: "How does that work?" Answer: "The  
10 hospital provides a transcription service that we use, and  
11 when we dictate the chart we ask that the chart be forwarded,  
12 a copy of the chart be forwarded to the consultant, or to  
13 whomever the patient requests."

14 Then on page one forty two, lines eleven through  
15 nineteen. Question on line eleven: "Would that have changed  
16 your course of treatment in any way?" Answer: "Perhaps."  
17 Question: "In what way? Well, I don't know. I would have  
18 informed our consultant of that, and I don't know if that  
19 would have altered our decision-making." Question: "You say  
20 our decision-making?" Answer: "Yes".

21 And then on page one fifty-eight, Your Honor, lines  
22 eight through twenty-five. Question: "Do you know what the  
23 relationship is between on-call specialists with South Strand  
24 and following up with a patient?" Answer: "It's my  
25 understanding of the by-laws of the hospital that, if you are

1 going to be on staff at the hospital you are required to make  
2 emergency department calls, meaning they are required to  
3 evaluate the patient if they are referred from the emergency  
4 department." Question: "Which he did on the phone?" Answer:  
5 "Yes". Question: "So he had fulfilled his duty?" Answer:  
6 "I believe so, yes." Question: "And he also made room for  
7 her on Monday with an appointment so he could complete  
8 fulfilling his duty as far as making an evaluation and  
9 agreeing to see her -- agreeing to see her?" And the answer  
10 was, from Dr. Law, "That's correct". And that's all I have  
11 from Dr. Law.

12 And briefly, from Dr. Young's, if you would, Your Honor.

13 THE COURT: All right. Well, let's actually take the  
14 responsive testimony from Dr. Law at this time.

15 And Mr. Aiken.

16 MR. AIKEN: Well, actually, Your Honor, on second  
17 thought, I'll waive reading at this time. Thank you.

18 THE COURT: Very good.

19 MR. FOSTER: Thank you, Your Honor. We will just  
20 briefly read from Dr. Young's.

21 MS. SCALISE: I think, Your Honor, I've got a few.

22 THE COURT: From Dr. Law?

23 MS. SCALISE: Yes sir, from Dr. Law.

24 THE COURT: Just a moment. Let me look at the Rule.

25 All right. You may do so.

1           **MS. SCALISE:**   Thank you, Your Honor.

2           **BY MS. SCALISE FROM THE DEPOSITION OF DR. LAW:**

3           Q.       On page eighty-nine, line twelve. Did you -- this is  
4 asking Dr. Law, "Dr. Law, did you ask Dr. Young to come see  
5 her that day and take a look at her?" Answer: "No, I did  
6 not."

7           Then on page ninety-seven, line twenty, "So was one of  
8 the questions you asked Dr. Young, do you think she needs to  
9 be admitted?" Answer: "I don't believe -- I'm not certain  
10 if I asked him that specific question."

11          Then on page one eighty-eight, "Based on your testimony  
12 it's my understanding that when you called Dr. Young you had  
13 already determined that the patient had a kidney stone, is  
14 that right?" Answer: "That's correct." "And that there was  
15 no evidence of infection?" Answer: "That's correct."  
16 Question: "She didn't have a fever?" Answer: "That's  
17 correct". Question: "And her pain was controlled?" Answer:  
18 "Yes". Question: "And had you already made the decision that  
19 she could be discharged before you called Dr. Young?" Answer:  
20 "That was my plan". Question: "And when you called Dr. Young  
21 were you calling him to arrange for a follow-up?" Answer: "I  
22 think. Typically when I would call a consultant I would  
23 present the case and then give an opinion as to whether I  
24 thought she could go home or require admission. From my  
25 recollection of the case I felt that she was stable for

1 discharge." Question: "Would you agree that your call to Dr.  
2 Young ... ---

3 MR. FOSTER: Your Honor, I object to the leading. She  
4 was questioning her own witness.

5 MS. SCALISE: He's not my witness. Dr. Law.

6 THE COURT: Counsel, that -- I'm -- overrule. You  
7 may ---

8 MR. FOSTER: Thank you, Your Honor.

9 MS. SCALISE: Question: "Would you agree that your  
10 call to Dr. Young was an informal consult?" Answer: "It  
11 would be, as it wasn't requiring him to come in to see the  
12 patient." Question: "And in fact, there was nothing about  
13 Ms. Fay's visit that morning, on Saturday morning, that you  
14 felt like Dr. Young needed to come in and evaluate him --  
15 evaluate her himself, is that right?" Answer: "I think, in  
16 my opinion, the proper way to state it is that she needed  
17 urgent urologic consultation, but not emergent." Question:  
18 "And by urgent you thought that she could wait until Monday to  
19 be seen by a urologist?" Answer: "That is correct".

20 That's all I have.

21 THE COURT: All right. Thank you.

22 And now from Dr. Young's deposition.

23 MR. FOSTER: Thank you, Your Honor.

24 All right, Your Honor, beginning on page twenty-nine,  
25 lines two through nine. This is Dr. Young -- this is the

1 deposition of Dr. Richard Young. It was taken on October  
2 21st, 2004.

3 **BY MR. FOSTER FROM THE DEPOSITION OF DR. YOUNG:**

4 Question on two, "Do the E.R. doctors at Grand Strand  
5 have admitting privileges?" Answer: "No". Question: "So if  
6 the patient -- if he consults with you in regards to a  
7 patient, and that patient is going to be admitted, it would  
8 have to be upon your orders, correct?" Answer: "I have to  
9 order it, yes."

10 Then on page fifty-one, beginning on line nineteen, Your  
11 Honor, question to Dr. Young, "And then you agree -- and then  
12 you agreed to see her on Monday even though you didn't have  
13 her in -- you didn't have your schedule with you, correct?"  
14 Answer: "Yeah, I'm sure I agreed to see her. You know, a  
15 patient in acute pain we will see at any time, but I don't  
16 know if we specifically settled on Monday that night on the  
17 phone, but we admitted, we agreed that she would be follow-  
18 up -- we agreed that she would need follow-up care."

19 Then on page fifty-two, Your Honor, question: "And you  
20 agreed to see her?" Answer: "Yeah".

21 Then on page one oh two, beginning on line twelve,  
22 question: "But did you tell him that you thought it would be  
23 okay to discharge her and follow up with you on Monday?"  
24 Answer: "Yes, I mean, that's what we decided, that yeah, the  
25 pain is controlled, apparently there is no other reason to

1 admit her, she doesn't have a fever, it's okay to go home with  
2 the instructions that were given."

3 And that's all we have from Dr. Young, Your Honor ---

4 THE COURT: All right. Are there ---

5 MR. FOSTER: ---To publish right now.

6 THE COURT: Thank you.

7 Are there responsive portions? Go ahead.

8 MS. SCALISE: Yes sir, Your Honor.

9 BY MS. SCALISE FROM THE DEPOSITION OF DR. YOUNG:

10 MS. SCALISE: This is page twenty-eight. "What do you  
11 do when you receive a page from the E.R. wanting advice or a  
12 consult?" Answer: "I talk to the physician on the phone."  
13 Question: "And as a result of your conversation with the E.R.  
14 physician on the phone what do you do?" Answer: "Well,  
15 usually you do whatever the E.R. physician asks you to do. I  
16 would say that most of the conversation involved, I have a  
17 patient here, I'm doing such and such with him, I'm going to  
18 let him go home, but I think he's going to need a urolo --  
19 need to see a urologist in a week or two, and that's what most  
20 of the conversations are from the Emergency Room.  
21 Occasionally it will be, I have a patient here, such and such  
22 is going on, I think he needs to be admitted to the hospital,  
23 in which case you go in and admit the patient, and then  
24 occasionally I have a case where he doesn't know what is going  
25 on, he's not comfortable with it, and needs your help, in

1     which case he asks you to come into the hospital and evaluate  
2     the patient and see if he needs to be admitted or not."

3             Then on page thirty-nine. "Tell me what Dr. Law told  
4     you." Answer: "Again, I don't remember the specifics of the  
5     conversation, but I remember him saying that he had a patient  
6     in the Emergency Room with a stone that he saw on the CAT  
7     scan, and that he thought the pain was well-controlled and he  
8     was going to send them home, and that he didn't think there  
9     was any sign of a fever, and he thought she would be okay to  
10    go home, but he said the stone was about five or six  
11    millimeters in size, and he thought that she would probably  
12    need follow-up."

13            Then go to line nineteen. "He was calling me because he  
14    thought that he had a patient that would need urological  
15    care."

16            And then line twenty-five, "Again, I don't recall the  
17    specifics of this conversation, but when the E.R., emergency  
18    room physicians call me about a patient with a kidney stone  
19    it's usually either to tell me that they have a patient they  
20    think is going to need urologic follow-up, which usually means  
21    that they think they have a patient who has a stone that's  
22    going to be too big to pass, they have a patient who has so  
23    much pain that they can't control it and would like to admit  
24    it, and occasionally they have a patient who has a fever that  
25    needs to be admitted, and to the best of my knowledge, to the



1 best of my recollection, I guess Dr. Law told me he had a  
2 patient that he was going to be sending home, but he thought  
3 would need urologic care. And you agreed to see her on  
4 Monday? Yes, I assume. That's what I usually do is, I  
5 usually tell them to have the patient call the office early  
6 Monday morning so that we can get them on a schedule as soon  
7 as possible." Did he indicate -- question: "Did he indicate to  
8 you that this was an emergency situation, that you needed to  
9 see her right away?" Answer: "No". Question: "Did he  
10 indicate that you needed to see her right away on Monday?"  
11 Answer: "No". Question: "Did he indicate to you that you  
12 even needed to see her on Monday or some other day would do?"  
13 Answer: "Well, he indicated that he thought she had a stone  
14 that she probably wouldn't pass. And she would probably need  
15 urologic follow-up. Yeah." Question: "So no urgency as far  
16 as Dr. Law was concerned?" Answer: "I don't think so, no. I  
17 recall him discussing what he had on the CAT scan. He was  
18 pretty certain of the diagnosis and what-not, but no, no  
19 urgency."

20 Then on page sixty -- I think on forty-nine. "Did he  
21 tell you that she had a history? Did he tell you her name,  
22 Dr. Law? Did he say, I have a patient here, Kelly Fay,  
23 twenty-five year old white female? What did he say?" Answer:  
24 "I would guess he did not tell me her name, but I don't know  
25 for sure if he did or not. Oftentimes I will have them either

1 write it down, or have a record so that my office can contact  
2 them, but that's not invariable, but usually if he calls, I  
3 guess -- I'm trying to think how patients usually follow up in  
4 the emergency room, because some are just told that, you know,  
5 if you are not feeling better in a few days call a urologist,  
6 whereas others, like this, where they think the stone is  
7 probably not going to pass, call us typically, and so we can  
8 arrange a follow-up." Question: "So you believe more than  
9 likely he told you her name because he wanted her to follow-up  
10 with you on Monday?" Answer: "Yes, most likely. May even  
11 have given me her phone number, for that matter."

12 And on page fifty-one, answer: "I have to go back to  
13 review the record, but I think that during the conversation I  
14 had with him that he said, yeah, she's got a five or six  
15 millimeter stone and it's probably not going to pass, she will  
16 probably need to see you."

17 Then on page fifty-three, line five, "And did the  
18 hospital forward a copy of her records to your office on  
19 Monday?" Answer: "I don't think so. Usually they wouldn't  
20 do that, no." Question: "Now when did you receive a copy of  
21 Dr. Law's dictated note from the emergency room and counter?"  
22 Answer: "I never received one".

23 Page sixty, question on line two: "And Dr. Young,  
24 forgive me, but I'm just trying to get it straight in my mind  
25 why he's calling you on Saturday saying I've got a patient who

1 needs follow-up care on Monday. Why wouldn't they just have a  
2 patient follow up on Monday and come to see you?" Answer:  
3 "As I've indicated earlier, we get calls very commonly in this  
4 situation, especially if they think the patient is going to  
5 need follow-up to prepare me. If they think they have a  
6 patient who might not pass their stone they oftentimes, just  
7 to make -- frankly, it's just to make sure the patient gets  
8 appropriate care, that they don't just forget about their  
9 stone and up -- down the road have a non-functional kidney  
10 because the pain went away but the stone was still there. So  
11 yeah, it's basically just to ensure good care for the  
12 patient." Question: "So if the patient didn't show up Monday  
13 you would have called the patient?" Answer: "Well, we did, I  
14 mean, yeah." Question: "I mean, like you would have called  
15 to say, why didn't you come in?" Answer: "Right, right, you  
16 know, you know, you still -- yeah."

17 Then I believe it's page seventy-one, line nineteen,  
18 "But you are absolutely certain he didn't say, Dr. Young, you  
19 know, I think I'm going to let her go home, I don't see any  
20 reason to keep her, you agree or disagree? He didn't ask you  
21 about your opinion one way or the other?" Answer: "I don't  
22 recall him asking one way or the other about my opinion, no.  
23 I recall discussing that she probably had a stone she wasn't  
24 going to pass, she would need follow-up." Question: "All  
25 right, so I can clear this up, do you agree or disagree that

1 you were a consulting physician on Kelly Fay's case?" Answer:  
2 "You asked the question before and I said, depends exactly  
3 what you mean by consulting physician. I agree I had a  
4 telephone call with Dr. Law to discuss and to arrange follow-  
5 up."

6 And then page one oh two, question on line five. "Did  
7 Dr. Law ever ask you to come in ---

8 MR. FOSTER: Ms. Scalise, can you hold on one second  
9 and let us catch up with you?

10 MS. SCALISE: Oh, sure.

11 MR. FOSTER: Thank you. Okay.

12 MS. SCALISE: All right. Page one oh two, line five.

13 "Did Dr. Law ever ask you to come in and see the patient?"

14 Answer: "No. If I'm asked to come in and see a patient I

15 come in and see a patient." Question: "He never asked you

16 for any opinion as far as you can recall?" Answer: "No".

17 Question: "But did you tell him that you thought it would be

18 okay to discharge her and follow up with you on Monday?"

19 Answer: "Yes, I mean, that's what we decided, that's -- yeah,

20 the pain is controlled. Apparently there's no other reason to

21 admit her. She doesn't have a fever. It's okay to go home,

22 and with the instructions that were given."

23 That's it. Thank you, Judge.

24 THE COURT: All right. Thank you.

25 Plaintiff, please call your next witness.

1           **MR. FOSTER:**    Beg the Court's indulgence one moment,  
2   Your Honor.

3           **THE COURT:**    Yes sir.

4           **MR. FOSTER:**    Plaintiff rests, Your Honor.

5           **THE COURT:**    All right.  Plaintiff rests.

6           Counsel, let's step up and talk about scheduling for  
7   just a moment, please.

8           **(BENCH CONFERENCE TAKES PLACE OFF THE RECORD.)**

9           **THE COURT:**    All right, ladies and gentlemen, at this  
10   point in every case, at the conclusion of one of the party's  
11   cases the Court has certain matters I have to review, and  
12   things I need to take up with the lawyers.  We're almost at  
13   the end of the business day.  There's no reason for you all to  
14   stay here to wait to begin at witness that we can't finish  
15   before five o'clock, so we're going to quit for the day.

16           I'm going to ask you to be back in the jury room  
17   tomorrow morning at 9 o'clock, all right.  Can everybody be  
18   there at nine o'clock tomorrow morning?  And we'll see about  
19   having some donuts or some sort of refreshments for you in the  
20   morning when you come in.

21           Have a nice evening, and we will just look to see you  
22   tomorrow morning at nine o'clock.  Any questions now about  
23   scheduling?  Very good.  We'll see you at nine o'clock in the  
24   morning.

25           Please don't call the jury line.  There's -- we've got a

1 whole new jury panel we are working with. It's not for you  
2 guys, so we will just see you at nine o'clock tomorrow  
3 morning.

4 Let's all remain where we are while our jury departs for  
5 the day.

6 All right, Mr. Foreman, have a good evening, sir. See  
7 you tomorrow.

8 (THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE  
9 JURY.)

10 THE COURT: Counsel, you all want to take a break for a  
11 moment or two before we go into arguments, maybe release some  
12 witnesses, if you wish, or however you wish to proceed.

13 Let's stand down about five minutes. We'll come back  
14 then for motions.

15 Court's in recess.

16 (THE FOLLOWING TAKES PLACE AFTER A BREAK, AND OUTSIDE  
17 THE PRESENCE OF THE JURY.)

18 THE COURT: All right. Thank you, and please be at  
19 ease, everyone.

20 All right. Well, let's see, we will wait -- we'll wait  
21 on a couple of attorneys to return.

22 All right, Counsel, are we ready?

23 MR. TODD: Grand Strand is ready, Your Honor.

24 THE COURT: Well, shall we go in the order of the  
25 pleadings, as we have for presentation of witnesses? So,

1 Counsel, I'll be glad to hear from you, Mr. Todd.

2 MR. TODD: Your Honor, on behalf of Grand Strand  
3 Hospital and South Strand, we would move for a directed  
4 verdict on Plaintiff's claim for punitive damages at this  
5 time. To recover on punitive damages the Plaintiffs have to  
6 show a conscious disregard for the rights of others,  
7 willfulness and wantonness. There's not evidence in the case  
8 to support such a claim.

9 THE COURT: Well, let me just stop you right there.  
10 Does Plaintiff persist in the punitive damages claim?

11 MR. FOSTER: Yes, Your Honor.

12 THE COURT: Go ahead then, Mr. Todd.

13 MR. TODD: Even in -- as you know, if punitive damages  
14 were awarded they have to survive a post-verdict review by the  
15 Court, and there is not sufficient evidence to support the  
16 claim for a conscious disregard for the rights of others, nor  
17 is there sufficient evidence for it to survive a post-verdict  
18 review by this Court.

19 THE COURT: All right. Let me stop you. That's fine.  
20 Thank you. No need to argue further.

21 What evidence is there of the Defendant's ability to pay  
22 a punitive damages award for any Defendant in this claim,  
23 Counsel, in the evidence?

24 MR. FOSTER: Your Honor, we didn't introduce evidence  
25 of net worth of any of the Defendants in our case-in-chief, h

1     however, I think there is case law that says that even in the  
2     entire case -- which we intend to ask them in their case-in-  
3     chief, but I think there's case law -- and I don't happen to  
4     have that case right here by me -- but there's case law to the  
5     effect, in South Carolina, good case law, unless there's been  
6     some change I don't know of, that says that you don't have to  
7     ask the question of net worth to be able to proceed on  
8     punitive damages.

9           **THE COURT:**   Well, perhaps not net worth, but what  
10    financial information whatsoever do we have, any evidence,  
11    even a scintilla, of any Defendants' ability to pay any  
12    punitive damages award

13           **MR. FOSTER:**   I -- Your Honor -- none, Your Honor. I  
14    don't think we have -- I don't think we have to ask financial  
15    questions of, or submit financial at this point in order to be  
16    able to proceed on punitive damages.

17           Your Honor, my understanding of the law is that we have  
18    to present evidence that there was some -- that there was some  
19    kind -- there was gross negligence, willfulness, recklessness  
20    in their care and treatment of Kelly Fay in order to go  
21    forward on punitive damages. I believe the law is that we  
22    don't have to submit the financial information.

23           **THE COURT:**   Let me hear back from the Defendants now  
24    that we've narrowed the issue.

25           What say you about that? Any Defendant may join in --



1 this, of course, bears as to all Defendants with regard to  
2 punitive.

3 **MS. MAGEE:** Your Honor, we certainly join in in the  
4 motion for a directed verdict on punitive damages. Certainly  
5 there has been no testimony regarding Dr. Young in a conscious  
6 or willful disregard for Kelly Fay, and there's certainly been  
7 no evidence of any ability to pay, or any ---

8 **THE COURT:** Right. Well, this is what I'm focused on  
9 right now, the ability to pay. Mr. Foster tells us there's an  
10 unnamed case that says he doesn't have to put it up at this  
11 point. Let me hear from you, what precedent or case law you  
12 have, any of you who may have a case on point on that issue  
13 before I ask Mr. Foster to produce the case to which he  
14 refers. So go ahead, Counsel, anything in reply?

15 **MR. TODD:** I can't produce -- I can't -- as I sit here  
16 I wouldn't want to say one way or another on the ability to  
17 pay, whether or not that -- the lack of evidence on the  
18 ability to pay would be grounds to throw out punitive damages.

19 **THE COURT:** You don't agree -- you say you don't know  
20 one way or the other?

21 **MR. TODD:** I don't know one way or the other.

22 **THE COURT:** Mr. Aiken, you want to be heard on that?

23 **MR. AIKEN:** I certainly want to join in the motion for  
24 a directed verdict on behalf of Dr. Law. I don't have any  
25 case with argument to submit to the Court at this time.

1           **MS. MAGEE:**   Your Honor, I'll just say, I think you have  
2 to have evidence of some conscious, willful failure before you  
3 get to that question, and I don't think there's been that.

4           **THE COURT:**   Well, I understand that, but what you are  
5 asking me to do, Ms. Magee, is now start dividing up among the  
6 Defendants. I'm looking at it collectively right now, to  
7 decide whether or not there's evidence of the Defendant's  
8 ability to pay.

9           Now, Mr. Foster, that is -- my understanding is, when  
10 you get to the end of the Plaintiff's case it's either there  
11 or it's not, and you don't have an opportunity to go back in  
12 on reply, or on cross, and get into the issue of the ability  
13 to pay, so tell me what case law you have, or what precedent  
14 you have.

15           **MR. FOSTER:**   Begging your indulgence one second, Your  
16 Honor.

17           **THE COURT:**   All right. And while we are talking about  
18 it, just to look at this from another angle, of course Dr.  
19 Wood was prepared to testify about HCA, and the Court denied  
20 his ability to do so. I just had the assumption that Dr. Wood  
21 would then come in and testify about one of these Defendants,  
22 which is the standard course of business, at least if not the  
23 individual Defendants, certainly the hospital Defendant, about  
24 their financial capabilities, but there was no such testimony.

25           **MR. FOSTER:**   Oh, I'm sorry.

1           **THE COURT:**   Go ahead.

2           **MR. FOSTER:**   I apologize.

3           Your Honor, in Welch versus Epstein, which is 536 S.E.  
4           2d 408, 342 S.C. 279 -- and I'm reading the headnote right  
5           now, so I'm doing a little head -- because we are -- it's in  
6           this hurry, but what the headnote -- I think headnote nineteen  
7           reads is, "While the wealth of the defendant is a relevant  
8           factor in assessing the punitive damages it is not necessarily  
9           controlling. The financial worth of a defendant is a fact  
10          properly to be considered by the jury in determining the  
11          amount of the award as punitive damages, but evidence of net  
12          worth is not a pre-requisite to a punitive damage award. The  
13          defendant's financial ability to pay is always a factor to be  
14          considered by the jury in awarding punitive damages, yet  
15          evidence of ability to pay is not a sine qua non of a punitive  
16          damage award. There is no requirement that the defendant be a  
17          man of means before the jury is justified in awarding punitive  
18          damages.

19          **THE COURT:**   All right. Anybody have anything  
20          responsive?

21          **MR. TODD:**    We think the jury has to have some basis --  
22          some criteria for -- if it were an issue there would have to  
23          be some criterion. I think that the financial ability to pay  
24          is one of the criteria that needs to be considered.

25          **THE COURT:**   All right. May I see your case you are

1 referring to, Mr. Foster.

2 MR. FOSTER: Yes sir.

3 THE COURT: Let me just take a look at that. Thank  
4 you.

5 MR. FOSTER: Your Honor, might I add one other case?

6 THE COURT: Yes sir. Go ahead.

7 MR. FOSTER: South Carolina Supreme Court, Rogers  
8 versus Florence Printing Company, December 10, 1958, and I  
9 quote, "In Charles versus Texas Company, 199 S.C. 156, 18 S.E.  
10 2d 719, it was held that, while the financial worth of the  
11 defendant was a fact properly to be considered by the jury in  
12 it' determination of the amount to be awarded by way of  
13 punitive damages evidence of such worth was not requisite to  
14 such award." They also said that, "Since information as to  
15 his worth was a matter peculiarly within the defendant's  
16 possession he should not be heard to complain if the jury made  
17 it's award without such information." And I'm leading up to  
18 another point on that, Your Honor.

19 THE COURT: Yes sir.

20 MR. FOSTER: Your Honor, we asked each of them to  
21 produce -- we asked them in Interrogatories back -- to Dr. Law  
22 back in -- on June 8 -- we received the Answer on June 8,  
23 2005. "Interrogatories: Provide Defendant's present net  
24 worth and Defendant's annual income." Answer was: "This  
25 Defendant objects to this interrogatory on the basis it is

1 unduly burdensome, irrelevant and potentially prejudicial.  
2 It's potential prejudicial impact on a jury is fully  
3 outweighed by any probative value, especially since there is  
4 sufficient ..." -- are there any witnesses in here, Your  
5 Honor?

6 ----...Sufficient insurance to cover any potential  
7 adverse jury verdict or settlement."

8 **THE COURT:** All right. Let me stop you there. On that  
9 issue I think you've convinced the Court that it's not fatal  
10 not to put in the financial evidence.

11 And now let's take a look at the -- Mr. Todd has made  
12 the motion, but really for all the Defendants it's going to be  
13 the same, so let's start with the hospital. Why do you  
14 believe you are entitled to punitive damages against the  
15 hospital? What evidence do you have, Mr. Foster, that would  
16 overcome his motion?

17 **MR. FOSTER:** Your Honor, as to the hospital, through  
18 the nurses, there was direct testimony, I think from Ms.  
19 Knight, that said that she thought it was -- I can't remember  
20 the exact terminology, but it was a reckless disregard for her  
21 rights, or it was reckless, or it willful, or something along  
22 those lines. There was direct testimony, we think. That  
23 would be imputed to Dr. Law as well because he is the one  
24 that's in charge of -- and that was in the not taking of the  
25 temperature, I believe. We think that's imputed to Dr. Law

1 because he's ultimately the one that has to decide whether she  
2 was stable enough for discharge, and he makes that decision in  
3 light of the fact that -- in light of the fact that a fever  
4 and a kidney stone is an emergency, and nobody bothered to  
5 find out if she had a fever before she left the hospital.

6 **THE COURT:** All right. Stop you right there. That's  
7 good. I hear you.

8 Why is a violation of the hospital standard not  
9 sufficient to get punitive damages to the jury against the  
10 hospital, Mr. Todd?

11 **MR. TODD:** Well, Your Honor, there's case law out there  
12 that violation of the statute is evidence. There's not any  
13 case law which says violation of the hospital policy is  
14 sufficient, and this case is not -- it's not a case of  
15 willfulness. It's not a case of the conscious disregard of  
16 the rights of others. At best, for the Plaintiffs, this is  
17 just a case of negligence. It's not a case for punitive  
18 damages.

19 **THE COURT:** All right. And so what do you say to that  
20 in replay, Mr. Foster?

21 **MR. FOSTER:** Two things, Your Honor. We talked -- when  
22 we read Grace New's deposition we asked her, why didn't you  
23 take -- you know, if -- she said the standard of care was to  
24 do this, the policy was to do that, said, why didn't you do  
25 it. She said she didn't think she needed to. No excuse, no

1     impediment, no emergency on the other side of the room that  
2     she had to attend to, she just flat didn't do it.

3             Dr. -- I'm still on the hospital now. If my  
4     understanding is correctly, the way I recall -- I don't know  
5     if you charge both charges or not, but most times -- most  
6     often I've heard both charges charged. One definition of  
7     gross negligence is failure to use the care necessary under  
8     the circumstances. The other charge is failure to use even  
9     slight care. I think we've certainly met the burden -- there  
10    is evidence -- let's put it that way, and I think it's not --  
11    I think the Court, at this time, is not weighing the evidence,  
12    it's determining the existence of evidence. And we certainly  
13    think we have put in at least enough direct-evidence, as well  
14    as circumstantial evidence, that this was pretty much played  
15    off as a normal kidney stone, instead of an obstructing  
16    etcetera, etcetera, etcetera kidney stone, and sent home  
17    without anybody in that hospital knowing if she had a fever,  
18    when in fact they all knew -- the doctor knew, at least one of  
19    -- the treating nurse knew that a fever and a kidney stone is  
20    an emergency, and they sent her home in the face of not  
21    knowing whether she had a fever, and we think that's  
22    sufficient at least to get to the end of the case, to hear all  
23    the evidence, if not sufficient to go all the way to the jury  
24    on punitive damages.

25            **THE COURT:** Dr. Young want to be heard, Ms. Magee?

1           **MS. MAGEE:** Your Honor, we don't think the -- first of  
2 all, if he's relying on his nursing expert, regarding her  
3 testimony as to a conscious or reckless disregard, she can't  
4 testify as to a physician's standard of care, so her testimony  
5 would be inapplicable to Dr. Young. I don't think she said  
6 that anyway, for Dr. Young, but still, there has been no other  
7 physician expert testimony that said that there was any kind  
8 of reckless, willful, conscious disregard on the part of Dr.  
9 Young in his care and treatment.

10           **THE COURT:** All right. Okay. Thank you.

11           **MR. FOSTER:** Can I respond to that briefly?

12           **THE COURT:** You may.

13           **MR. FOSTER:** Your Honor, Dr. Siroky testified as to Dr.  
14 Young, something to the effect -- and I don't remember the  
15 exact words, and of course I was questioning him so I -- but  
16 he testified something to the effect that Dr. Young didn't  
17 even bother to come in to see her, and that he al -- and I  
18 know he testified that he thought he should have, and that he  
19 was a consult, and that she should have -- he should have come  
20 in -- he should have admitted her to the hospital, but he  
21 didn't even bother to come in and look at her.

22           **THE COURT:** All right.

23           **MR. AIKEN:** I need to at least get on the record for  
24 Dr. Law, if I may.

25           **MR. FOSTER:** No. I was talking about Dr. Young.



1           **MR. AIKEN:**    I understand.

2           **THE COURT:**   Go ahead.

3           **MR. AIKEN:**   Well, Mr. Foster keeps saying she was sent  
4 home, such and such. Well, she was sent home with specific  
5 instructions, Your Honor. "I did explain to the patient,  
6 however, that if he pain becomes out of control, or if she has  
7 increasing nausea, vomiting, any fevers or chills, that she is  
8 to return to the emergency department immediately." That is  
9 what they failed to do. That's the Plaintiff. There has  
10 certainly been no evidence of any, I don't think, negligent  
11 conduct on behalf of Dr. Law, certainly no reckless conduct on  
12 his part.

13           **THE COURT:**   All right. Just a moment, please.

14           **MR. FOSTER:**   Your Honor, might I add just two brief  
15 points?

16           **THE COURT:**   You may.

17           **MR. FOSTER:**   As to what Mr. Aiken just said, Your  
18 Honor, obviously that's been one of the biggest factual  
19 disputes -- one of the biggest factual disputes in the case,  
20 whether that was ever said or not to them. I know it was  
21 typewritten, but whether it was ever said to them or not, by  
22 Dr. Law.

23                   And the other thing is, Your Honor -- which hasn't come  
24 out yet in too much detail. I think you've got a little bit  
25 of flavor for it, but there are going to be questions elicited

1 -- if you would reserve judgment on the punitive damage issue  
2 until the end of the case there are going to be questions  
3 elicited from the Defendants in regard to certain documents  
4 that are referred to that aren't anywhere in the file. If  
5 that's the case then we may have a spoliation of evidence  
6 charge at the end of the case, and that would certainly  
7 warrant punitive damages.

8       **THE COURT:** All right. Very good. Mr. Foster, in part  
9 your argument was that one of the definitions of gross  
10 negligence which would entitle you to punitive damages is the  
11 failure to even use slight care. Well, of course, you know,  
12 Ms. Fay came in the hospital. She was triaged. She was given  
13 a CT scan, she was appropriately worked up for kidney stones.  
14 It just appears that she -- apparently there was a missed  
15 temperature at the end of the case. At this juncture I'm  
16 going to take under advisement the punitive damages claim  
17 which you have, the motion to dismiss against Dr. Law and the  
18 hospital, I'm going to dismiss punitive damages claim against  
19 Dr. Young. I don't find that there's any evidence before me,  
20 even Dr. Siroky's testimony notwithstanding, for which there  
21 would be a conscious disregard on the part of Dr. Young, so  
22 I'm going to dismiss punitive damages as to him, and retain  
23 under advisement the decision as to Dr. Law and the hospital.  
24 All right.

25       Any further ---

1           **MR. FOSTER:**   Thank you, Your Honor.

2           **THE COURT:**   Any further motions?

3           **MR. TODD:**   Yes sir, Your Honor.   Yes sir.

4           Your Honor, the Defendant, Grand Strand, would also move  
5 for a directed verdict on the issue of liability on this  
6 grounds. The Plaintiff has not proved -- presented competent  
7 evidence to meet the new reliability standard issued by the  
8 Supreme Court as to expert testimony on the issue of  
9 causation. Now there was testimony that -- and basically the  
10 Plaintiffs' theory is if the Plaintiff had an infection while  
11 she was in the hospital that infection would have shown up  
12 through a temperature. There was conflicting testimony about  
13 whether or not the Plaintiff actually had a temperature. Dr.  
14 Siroky and Dr. Sheppard testified that they could not, to a  
15 reasonable doubt of medical certainty, testify that the  
16 Plaintiff did, indeed, have a fever or an infection during the  
17 time she was at the hospital.

18           There was a witness this morning who testified that she  
19 did, but when you put in the reliability the conflicting  
20 evidence demonstrates that the opinions did not meet the  
21 standard of reliability that the Supreme Court has said  
22 applies to expert testimony, and for that grounds we would  
23 move for a directed verdict on the Plaintiffs' claim against  
24 Grand Strand.

25           **THE COURT:**   All right. And without taking argument

1 back from the Plaintiff on that, I'm going to respectfully  
2 deny. I do find there's sufficient evidence in the case, and  
3 that it is sufficiently reliable under Supreme Court  
4 precedence to proceed forward in the negligence claim against  
5 the hospital.

6 **MR. TODD:** We would also move -- Grand Strand would  
7 also move for a directed verdict on the grounds that the only  
8 reasonable inference that can be drawn from the testimony,  
9 taking the testimony as a whole, and viewing it in the light  
10 most favorable to the Plaintiff, is that the cause of Kelly  
11 Fay's death was her not coming back to the Emergency Room when  
12 her condition worsened on Sunday, as she was directed to do by  
13 Dr. Law and the written discharge instructions.

14 **THE COURT:** All right. Given the testimony in the  
15 record about the appropriateness of whether calling back, and  
16 the potential telephone call that was made and testified to by  
17 the Plaintiff, and the response made by the hospital, again,  
18 the Court denies, at this juncture, that motion by the  
19 hospital.

20 Anything further?

21 **MR. TODD:** No sir, Your Honor.

22 **THE COURT:** All right. Let's move now to Dr. Law.

23 **MR. AIKEN:** I would also move, Your Honor, for a  
24 directed verdict on behalf of Dr. Law on the liability of this  
25 case in addition to sole negligence of Mr. Fay. We have also

1     pled comparative negligence. We have stated in our pleading  
2     that he was comparatively negligent in failing to exercise due  
3     care, reasonable care, or any care for the decedent's safety  
4     in failing to seek follow-up medical care in a timely fashion,  
5     as instructed upon leaving the hospital, in failing and  
6     omitting to follow discharge instructions, advice and orders  
7     given by Dr. Law or the hospital nursing staff, in failing to  
8     contact a physician, or return to the hospital when the  
9     patient became worse, in failing and omitting to take proper  
10    cautions for decedent's health and physical well-being, which  
11    he knew, or should have known, would affect her health and  
12    well-being.

13           Your Honor, even if -- even if Dr. Law is considered  
14    negligent and reckless, which is denied, clearly the evidence  
15    taken in this case, and the most reasonable inference to be  
16    drawn, even in light of giving all favorable inferences to Mr.  
17    Fay, is that his negligence exceeded that, if any, of Dr. Law.  
18    Their own expert testimony said if Mr. Fay had taken her back  
19    Saturday she would be alive, if he had taken her back Sunday  
20    should would be alive, if he had taken her back Monday morning  
21    by ten o'clock, not going to work leaving his wife ill at  
22    home, she would be alive. Clearly that has to account for  
23    over fifty percent of the negligence of any party. So I would  
24    respectfully submit that we -- respectfully seek a directed  
25    verdict for Dr. Law on that basis.

1           **THE COURT:** All right. Do you want to reply to that,  
2 Mr. Foster?

3           **MR. FOSTER:** Just briefly, Your Honor.

4           If my understanding is correct I believe the Court's  
5 function at this time is to determine the existence of  
6 evidence, and not to weigh the evidence. Your Honor, however,  
7 in regard to his argument, Your Honor, we think there is more  
8 than sufficient evidence as between the three nurses that were  
9 in the operating room, Dr. Law, and Dr. Young, but there has  
10 certainly been enough testimony about their negligence to go  
11 around that would far outweigh any negligence, if any, which  
12 is denied on Sean Fay, because the testimony was that there  
13 was never -- I mean, the testimony has been there was never  
14 any urgency expressed to him about bringing her back, that he  
15 complied with the discharge instructions which said call, and  
16 all he was told was, if she thinks she needs to come back then  
17 bring her back, not given any meaningful advice when they  
18 called back. Each doctor -- the first two doctors have both  
19 testified as to their negligence, and we just don't think at  
20 this point -- that the Court can -- that the Court will be  
21 able to weigh that, and say as a matter of law that because  
22 Sean Fay, who doesn't have any medical training, didn't take  
23 his wife back to the hospital when he had just been the day  
24 before, and called the hospital and was told that if his wife  
25 thought she needed to come back then bring her back, if not,

1 just -- and he proceeded on the if not because she didn't  
2 think so after she got out of the shower. He did ---

3 **THE COURT:** Well, now how -- let me ask you, Counsel,  
4 how can you assign that telephone conversation with the  
5 hospital somehow either for or against Dr. Law? He was not  
6 involved in that conversation.

7 **MR. FOSTER:** As to Dr. Law, Your Honor.

8 **THE COURT:** Yes sir. Your client testified he called  
9 back on Sunday morning.

10 **MR. FOSTER:** Oh, oh, I'm sorry. I understand. I  
11 understand.

12 **THE COURT:** You know

13 **MR. FOSTER:** I understand. Because, Your Honor, the  
14 testimony is, he should never have let her go on Saturday to  
15 start with, so that should never have taken place, there  
16 should never have been any chance for any comparative  
17 negligence, if any, if the jury believes on Sean's part,  
18 because she should have been admitted on Saturday, and then  
19 this whole Sunday thing, and Monday thing, wouldn't even be an  
20 issue.

21 **THE COURT:** All right. Well, gentlemen, what I'm  
22 really hearing are factual arguments that are for the trier of  
23 fact.

24 Mr. Aiken, you asked me to find as a matter of law that  
25 what the Plaintiff did or did not do supersedes any negligence

1 that your physician may have committed, which is denied that  
2 he committed any, but simply stated, that's asking the Court  
3 to weigh evidence, and determine credibility and  
4 believability, all of which are within the provence of the  
5 jury. I decline to do that, and I would deny your motion on  
6 that point, for those reasons.

7 Anything further?

8 **MR. AIKEN:** Thank you, Your Honor.

9 Yes sir. And then I would just, I guess to clean up the  
10 pleadings, Your Honor, move for a directed verdict on behalf  
11 of Carolinas HealthCare Specialists. There has been no  
12 evidence of any involvement with them. They happen to be an  
13 umbrella company that happened to put different physicians, of  
14 different specialties, in different places. As a practical  
15 matter I think I can safely say, it would make no difference  
16 to Mr. Foster, regardless of how this case ends up, if they  
17 are in or out.

18 **THE COURT:** All right. We've had some discussion about  
19 that party, outside the presence of the jury. What evidence  
20 is there, at all, that would hold that party in, and assign  
21 them any level, or even determine who they are, much less  
22 assign them any level of culpability here, Mr. Foster?

23 **MR. FOSTER:** Your Honor, we think they are liable as a  
24 matter of law, and it does matter to us if they are in there,  
25 because -- for several reasons, but we think, as a matter of



1 law they are responsible for the actions of their employee.

2 **THE COURT:** Well, okay, but we is the evidence that  
3 would tie them to be the basis of some ruling based on a  
4 matter of law? What evidence is in the case as to who they  
5 are, what their role was here, and thus, what their level of  
6 culpability, if any, may be?

7 **MR. FOSTER:** Your Honor, we did not call Dr. Law and  
8 Dr. Young, by agreement by Counsel, in our case. They asked  
9 me if we intended to call them in our case and I said we  
10 wouldn't, so we couldn't bring that evidence out.

11 **THE COURT:** Well now, was this not discussed in their  
12 deposition? Was this not discussed in their deposition?

13 **MR. FOSTER:** No sir, I don't think so.

14 **THE COURT:** And there's not some other way you couldn't  
15 have put that proof up? I mean, ---

16 **MR. FOSTER:** Your Honor, not without calling somebody  
17 from either Carolina Health Specialists, or Dr. Young or Dr.  
18 Law, to bring that up and put it in, but we think that they  
19 are responsible, as a matter of law.

20 **THE COURT:** All right, sir. I'm going to go ahead and  
21 rule. Counsel, I -- you may be absolutely correct, but I have  
22 no evidence to that effect at this juncture. There's no  
23 evidence against that Defendant in this case. There was some  
24 discussion about it in a -- as I recall, in some colloquy that  
25 occurred outside the presence of the jury, about ---

1 MR. AIKEN: Dr. Chi ---

2 THE COURT: ---About the parties ---

3 MR. AIKEN: Yes sir.

4 THE COURT: ---But not any evidence whatsoever, and  
5 thus, there is no basis upon which a judgment could be  
6 rendered. I'm going to grant the motion.

7 MR. AIKEN: Thank you, Your Honor.

8 THE COURT: Thank you.

9 Anything further now, Mr. Aiken?

10 MR. FOSTER: Your Honor -- I'm sorry, Your Honor.

11 THE COURT: Go ahead.

12 MR. FOSTER: Begging your indulgence one moment.

13 Your Honor, we would ask if you would just give us --  
14 take that part under advisement, and let us see overnight if  
15 we can produce to you where that's in -- that was in any of  
16 the testimony of Ms. Farrelly, or in her deposition.

17 MR. AIKEN: Too late..

18 THE COURT: Well, let me just put it this way, Counsel.  
19 I have ruled. If you come in tomorrow with some evidence that  
20 would require the Court to reconsider that ruling then I'll  
21 hear from you, which I would do that in the general course of  
22 any ruling that the Court makes, but otherwise, I'm not aware  
23 of any evidence, and certainly could not open the record at  
24 this time to take any further ---

25 MR. FOSTER: Thank you. Thank you, Your Honor.

1           **THE COURT:**   Very good.  Anything further now from Mr.  
2   Aiken?

3           **MR. AIKEN:**   No sir.  Thank you, Your Honor.

4           **THE COURT:**   Now, from Ms. Magee.

5           **MS. MAGEE:**   Your Honor, similar to Mr. Aiken's last  
6   motion, we would also make a motion for a directed verdict as  
7   to Grand Strand Urology, that group, that there's been no  
8   testimony or evidence that they had any negligence in this  
9   case.

10          **THE COURT:**   What say you, Counsel?

11          **MR. FOSTER:**   Your Honor, we did not introduce any  
12   evidence of the agency, but again, we think it's a matter of  
13   law that we are just not required to call the Plaintiff  
14   (SIC) -- and I understand -- I understand what you are saying,  
15   Your Honor, is that we didn't put any direct evidence in in  
16   our case-in-chief, but we think as a matter of law they are  
17   responsible -- but that the corporation is responsible for the  
18   acts of it's employee, and we would submit it to you on that  
19   basis, that they still need to be a Defendant in this case,  
20   and should be a Defendant in this case.

21          **THE COURT:**   All right.  Respectfully, I don't have any  
22   evidence to that effect.  I don't know who they are, or who  
23   owns them, I don't know that Dr. Young works with them.  I  
24   suspect that he does, but I don't have the evidence of that.  
25   I'm going to grant the motion.

1           MR. FOSTER:   Thank you, Your Honor.

2           THE COURT:   Very good.

3           MS. MAGEE:   Thank you, Your Honor.

4           Our next motion is a directed verdict as to Dr. Young,  
5 and lack of a physician/patient relationship. We think that,  
6 in viewing the testimony in whole, even taking it in a light  
7 most favorable to Mr. Fay, the only reasonable inference here  
8 is that there was no physician/patient relationship. The  
9 facts, as they were presented in their entirety, is that Dr.  
10 Young took the phone call and agreed to see the patient in the  
11 future. He did not give any advice, did not render any  
12 treatment, he did not see the patient. The testimony, read in  
13 it's entirety, of Dr. Law and Dr. Young, is that Dr. Law had  
14 made the diagnosis of the patient, had done his assessment,  
15 and had already decided to discharge her when he called Dr.  
16 Young. That phone call was a point of reference for Dr. Young  
17 so that if and when she made the phone call on Monday to come  
18 and see him he would have a point of reference as to who she  
19 was.

20           Earlier when we made the summary judgment motion I  
21 believe your ruling was based on the release that Ms. Fay  
22 signed as far as sending her records to Dr. Young's office.  
23 Dr. Young never received those records. And just as a doctor  
24 cannot be -- or excuse me -- just as a hospital cannot be an  
25 agent for the doctor -- I think that's the Newell versus

1     Trident case -- I don't have a copy of it with me because I  
2     kind of just did some on the point research -- that case  
3     involved informed consent. The physician could not pertain  
4     informed consent for the hospital. The hospital cannot create  
5     that physician/patient relationship through that release for  
6     Dr. Young.

7             And again, just the public policy considerations. We  
8     think that under Plaintiffs' assertion that there is a  
9     physician/patient relationship that this significantly extends  
10    the duties of the physician who has had no contact with the  
11    patient, and it's just not supported by the public policy.  
12    And even though an expert cannot create an issue of fact in  
13    their testimony as to whether or not a physician/patient  
14    relationship exists, I think even if you look at Dr.  
15    Stratton's testimony earlier today, his testimony was that he  
16    does these phone calls and does give advise, does make  
17    diagnoses, and he doesn't consider that to be a  
18    physician/patient relationship.

19            Dr. Siroky's testimony basically was, you know, he's the  
20    on-call physician, if you don't like it, tough. Well, that's  
21    not the standard. Being the on-call physician is clearly not,  
22    by virtue of that fact, creating a physician/patient  
23    relationship.

24            **THE COURT:** Let me ask you, Counsel, why did you not  
25    object when that question was posed, when Dr. Siroky was asked

1 STATE OF SOUTH CAROLINA ) COURT OF COMMON PLEAS

2 COUNTY OF HORRY ) (08-CP-26-9047)

) (08-CP-26-9368)

3 SEAN D. FAY, as Personal )  
4 Representative of the )  
Estate of Kelly L. Fay, )  
5 deceased. )

TRANSCRIPT OF RECORD

6 )  
7 GRAND STRAND REGIONAL ) May 17, 18, 19, 20, 21, 2010  
MEDICAL CENTER, LLC, dba ) May 24, 25, 26, 27, 28, 2010  
8 SOUTH STRAND AMBULATORY ) Conway, South Carolina  
CARE CENTER, et al )

9  
10 B E F O R E:

11 HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.

12  
13 A P P E A R A N C E S:

14 RUSKIN C. FOSTER, ESQ.  
15 BRADLEY HEWITT, ESQ.  
ATTORNEYS FOR PLAINTIFF

16 MONTEITH P. TODD, ESQ.  
17 RANDOLPH L. LEE, ESQ.  
ATTORNEYS FOR DEFENDANTS, GRAND STRAND

18 J. BOONE AIKEN, III, ESQ.  
ATTORNEY FOR DEFENDANTS, LAW AND CAROLINA HEALTH

19 MARIAN SCALISE, ESQ.  
20 LYDIA L. MAGEE, ESQ.  
ATTORNEYS FOR DEFENDANT, YOUNG

21  
22 DIXIE COX EUBANK  
CIRCUIT COURT REPORTER  
23 FIFTEENTH JUDICIAL CIRCUIT

24  
25 VOLUME 6 OF 8  
(SEE VOLUME 1 FOR INDEX)

1 have to have a medical license that's current. To write  
2 prescriptions that are controlled substances, like narcotics  
3 or amphetamines you have to have a D.E.A. license.

4 Q. As your D. -- strike that -- is your D.E.A. license  
5 current?

6 A. Yes.

7 Q. Has your D.E.A. ever been suspended, revoked, limited  
8 in any fashion?

9 A. No sir.

10 Q. Now Doctor, what is board certification?

11 A. After you take a residency in a given specialty, and  
12 you successfully complete that residency, you are able to sit  
13 for their boards. Most sub-specialties and specialties have  
14 their own set of boards that they have to -- that you have to  
15 take and pass in order to become board certified.

16 For Emergency Medicine, after the -- after you finish  
17 your residency you have to sit for both an oral and a written  
18 examination.

19 Q. When did you apply or take the oral and written boards  
20 so you could be board certified?

21 A. I finished my residency in June of 1998. I believe I  
22 took my written boards that Fall, and then my oral boards the  
23 following Spring.

24 Q. Did you pass the written boards on the first try?

25 A. Yes.

1 Q. Did you pass the verbal boards on the first try?

2 A. Yes.

3 Q. Have you had to re-certify since that time to maintain  
4 your board certification?

5 A. Yes. One of the things that's happened in medicine is,  
6 a lot of -- thirty years ago if you took the boards you were  
7 board certified for life. The way that it's changed is,  
8 they've -- most specialty boards have required that you  
9 recertify every ten years. In addition, Emergency Medicine  
10 has a yearly exam called the L.L.S.A., which you have to take  
11 a certain number within a ten year period before you can sit  
12 for your ten-year recertification, and I just recently took my  
13 re-certification exam and passed.

14 Q. All right. Will you be required to take it again down  
15 the road?

16 A. Yes. Yes.

17 Q. Where do you currently work, Dr. Law?

18 A. I work at Saint Barnabas Medical Center in Livingston,  
19 New Jersey. It's a tertiary care hospital, meaning that we  
20 have a large number of specialties there at the hospital. We  
21 have residents, and we have residents in Surgery, Internal  
22 Medicine, Radiology, Pathology, OBGYN, and we also have a  
23 Neurosurgical Residency and a Pediatric Residency.

24 Q. Do you do hearts there? I'm just curious?

25 A. We do open heart surgery. We don't do heart



1 transplants. Also St. Barnabas is a large transplant  
2 hospital, mostly for kidney transplants.

3 Q. But you do open heart surgery?

4 A. Yes.

5 Q. Since you have neurosurgeons you would do surgery on  
6 the brain and other parts of the anatomy, your spine?

7 A. Yes.

8 MR. AIKEN: Your Honor, I would, at this time, offer  
9 Dr. Law as an expert physician on Emergency Medicine.

10 THE COURT: What says -- are there questions for the  
11 witness?

12 MR. FOSTER: None, Your Honor.

13 THE COURT: And what say the other parties? Any  
14 objection?

15 MS. SCALISE: No objection, Your Honor.

16 MR. TODD: None, Your Honor.

17 THE COURT: Plaintiff. Any objection?

18 MR. FOSTER: No sir.

19 THE COURT: All right. Without objection then, so  
20 qualified. You may proceed.

21 MR. AIKEN: Thank you, Your Honor.

22 Q. Where were you working, Dr. Law, before moving to the  
23 Myrtle Beach area?

24 A. I was working at Clare Maass Medical Center in  
25 Belleville, New Jersey.

1 Q. And what brought you here?

2 A. At the time I was married with my first wife and we  
3 were trying to get out of New Jersey. New Jersey is very  
4 crowded, very congested, and we were looking for a smaller  
5 town, preferably on the coast, and I started looking in the  
6 ads, and started asking around to see if there were any job  
7 opportunities available along the southeast coast.

8 Q. Okay. And when did you, in fact, move to Myrtle Beach?

9 A. I believe it was March of '2000.

10 Q. How long were you here?

11 A. About two years and five months.

12 Q. Your entire time in the Myrtle Beach area, Doctor, at  
13 what hospitals did you have privileges?

14 A. When I first started down at the beach I initially  
15 started at Grand Strand. I believe South Strand opened soon  
16 after I started, and so my privileges at Grand Strand carried  
17 over to South Strand, and I believe I did have to actually  
18 apply for privileges at South Strand.

19 And also -- we also were the emergency department group  
20 at Marion Hospital.

21 Q. Were you privileges at any of these institutions ever  
22 suspended or limited?

23 A. No.

24 Q. And you left sometime in 2002? Did I understand that  
25 correctly?

1 A. August of 2002.

2 Q. Okay. And what was the reason for your move from  
3 Myrtle Beach?

4 A. My first marriage was starting to fall apart. My wife  
5 had been born and raised in New Jersey, and she wanted to get  
6 back home, close to her family, and so we decided as a group  
7 to move back to New Jersey.

8 Q. Were you asked to leave by Grand Strand or South  
9 Strand?

10 A. No.

11 Q. Completely voluntary on your part?

12 A. Yes.

13 Q. Doctor, do you remember the time frame of January of  
14 2002?

15 A. Yes.

16 Q. When we are talking about Kelly Fay's presentation to  
17 the emergency department at South Strand on January 26 ---

18 A. Right.

19 Q. ---Were you working that day?

20 A. Yes. I had come in -- at South Strand there were two  
21 shifts, seven A.M. to seven P.M., and of course the overnight  
22 shift, seven P.M. to seven A.M..

23 Q. Do you know if you worked, Doctor, the next day,  
24 Sunday, January 27?

25 A. I did not.

1 Q. When you think back, Doctor, can you independently  
2 remember, or recollect Kelly Fay, her visit, what you did?

3 A. Memory is -- memory is kind of a funny thing. If you  
4 had asked me what I had eaten for lunch the next day there's  
5 no way I could possibly tell you, and I would challenge  
6 anybody to really kind of remember that. When something like  
7 this happens, and it's something traumatic, or something that  
8 really sort of sticks out in your memory certain memories  
9 crystalize, and things will -- things that you remember doing  
10 will stay in your memory, and that happens to be the case in  
11 this situation.

12 Q. I'm going to talk to you a little bit, Doctor, about  
13 your emergency dictation that day.

14 A. Okay.

15 MR. AIKEN: Your Honor, may I have permission for Dr.  
16 Law to step down and review with the jury the blow-up of the  
17 emergency examination?

18 THE COURT: Yes sir, you may.

19 MR. AIKEN: Thank you.

20 I'll let you stand over there, Doctor, and remember, the  
21 Court Reporter has to take everything down that you say, so  
22 you need to talk loud and slow.

23 Q. Do you recognize this, Doctor?

24 A. This is my dictated notes from that day.

25 Q. Okay. I just want to walk through it, sentence by

1 sentence, and I'll probably then -- I'll probably stop you  
2 from time to time, okay.

3 Tell me first, the date shows January 26, 2001.

4 A. That's incorrect. It should be 2002.

5 Q. We enter a new year in January.

6 A. Right.

7 Q. And it shows, dictating physician, Stephen Law. How  
8 many physicians were working that Saturday?

9 A. There's only one physician on in any one given time at  
10 South Strand. Sometimes the physician who is overnight may be  
11 there completing charts, finishing up on patients, but for the  
12 most part there's very little overlap between the two doctors.

13 Q. Okay. And how many nurses do you remember being there,  
14 if you do remember?

15 A. What I recall -- and the nursing shifts at South Strand  
16 I think were sort of staggered, so I think beginning first  
17 thing in the morning we had a nurse out at triage, and then  
18 the two in the main department.

19 Q. We'll start off, Doctor, it says CC. What does that  
20 mean?

21 A. Chief complaint. That's what the patient tells you  
22 that he feels is going on.

23 Q. And what was Kelly Fay's chief complaint?

24 A. Abdominal pain and back pain.

25 Q. And by the way, Doctor, as we go through this sheet, if

1 there's -- if you need to refer to the E.D. Core Encounter,  
2 which has been referred to, I'm going to ask you to put that  
3 on the board.

4 A. Okay.

5 Q. And we are talking about the radiographs. And I've  
6 also have, if it would help you to explain this to the jury,  
7 the blow-up of the anatomy of that area.

8 A. Okay.

9 Q. Does that look like an accurate representation of the  
10 anatomy?

11 A. Yes, a blown-up version of it, yes.

12 Q. All right. Okay. Let's walk through -- what's HPI?

13 A. History of present illness.

14 Q. Tell the jury what that is.

15 A. Okay. A history of present illness. When somebody  
16 comes into the emergency department you want to know why they  
17 are there, so they will tell you certain aspects of what their  
18 history is. The vast majority of times when people come into  
19 the emergency department it's just that they feel if they are  
20 having an emergent problem, they present to the hospital. So  
21 we ask them historical questions based upon just what their  
22 chief complaint is.

23 Q. Would you review then the HPI?

24 A. Sure.

25 Q. And I might stop you.

1 A. Okay. This is a twenty-five year old female with  
2 sudden onset of right flank pain beginning at approximately  
3 one and a half hours prior to arrival.

4 Q. Okay. Now, first, would you please show the jury where  
5 right flank pain is?

6 A. Okay. Right flank usually refers to an area, usually  
7 on this side, and into the back, right where your short ribs  
8 are. You can actually sort of feel that area on yourself,  
9 right in through this area.

10 Q. Doctor, when you say an hour and a half prior to  
11 arrival ---

12 A. Right.

13 Q. ---Do you understand that a nurse recorded something  
14 different?

15 A. Right, and that ---

16 Q. What did she record?

17 A. She recorded it a half hour.

18 Q. Okay. And what is the significance of that, if at all?

19 A. None. Typically when people come in it's not unusual  
20 for you to have a slightly different history from the triage.  
21 For example, I work at a medical center where we teach medical  
22 students and residents. It's not unusual for the triage nurse  
23 to get one history, the medical student to get a different  
24 history, the resident to get a different history, and then  
25 when I go in it's something, not completely different, but

1 something that doesn't jive completely with what the previous  
2 three examiners have said.

3 Q. Okay. If this had said thirty minutes prior to  
4 arrival, would that have made any difference on how you  
5 treated Kelly Fay?

6 A. No.

7 Q. Okay. Please continue.

8 A. She described the pain as being sharp, seven to eight  
9 out of ten on a pain scale, radiating around to her right  
10 periumbilical area.

11 Q. Tell the jury what that is, radiating to periumbilical.  
12 Explain that.

13 A. When people have pain it's not unusual for those --  
14 that pain to irritate other nerves within the body.  
15 Classically people think of people who have heart attacks,  
16 will often complain of left arm soreness. There's nothing  
17 going on in their left arm. They are having pain that  
18 radiates down into the arm.

19 In a case of somebody with flank pain it's not unusual  
20 for the pain to sort of wrap around. You feel like it's  
21 coming up into the front.

22 Q. Where is the periumbilical area?

23 A. Right around your belly-button.

24 Q. Okay. All right, sir.

25 A. Let's see. She denies any palliative or provocative



1 factors.

2 Q. What do those big words mean?

3 A. Palliative factors are things that make the pain  
4 better, and provocative factors are things that make the pain  
5 worse.

6 Q. Okay.

7 A. A lot of times when people have kidney stones they will  
8 often have the tendency to try to move around to try to find a  
9 comfortable position. Usually it doesn't really help.

10 Q. Okay. Please continue.

11 A. Provocative factors. Sometimes when people have a  
12 problem with either their intestines or appendicitis they may  
13 feel better lying on a certain side. Because the appendix in  
14 most people is in the right lower part they will roll onto the  
15 left side. That will usually take off some of the pressure  
16 that they are feeling in the right lower quadrant.

17 Q. Now Doctor, she states the pain is waxing and waning.

18 A. Right. She states the pain is waxing and waning in  
19 character, however, it is progressive in a crescendo fashion.

20 Q. Explain that.

21 A. Okay. The pain that people get is -- for example, of  
22 you break your arm -- an arm, that pain is going to be  
23 continuous. It's going to be exactly the same, given all  
24 other factors as being equal.

25 When people have a kidney stone the pain will sometimes

1 go up and down, almost in like a wave-like pattern. In her  
2 case she had pain in a crescendo fashion, which means that  
3 instead of staying at one single level it was actually  
4 starting to go up, and getting progressively worse.

5 Q. Okay. Does that tell you anything?

6 A. Yes. I was always taught as a resident that if you ask  
7 the right questions people will tell you exactly what's going  
8 on with them, and so a lot of times when people come in with a  
9 painful process you ask them about factors related to pain,  
10 and the most of the time you can make a preliminary diagnosis  
11 based upon what they are telling you.

12 Q. Okay. What do you have next about nausea, vomiting?

13 A. She does complain of some mild nausea, but no vomiting.

14 Q. Now, what did the nurse say on -- what is emesis?

15 A. Emesis is vomiting.

16 Q. Did the nurse, in her triage notes, differ from what  
17 you've recorded?

18 A. Yes.

19 Q. And is that significant?

20 A. No.

21 Q. All right. If you had put emesis times one, would that  
22 have changed any treatment that you rendered to Kelly Fay, or  
23 expected to render?

24 A. No.

25 Q. Okay.

1 A. She denies any fevers, chills, dysuria, hematuria, or  
2 menstrual irregularities.

3 Q. What is dysuria?

4 A. Dysuria is painful urination.

5 Q. And what is hematuria?

6 A. Blood in the urine.

7 Q. Okay. What is PMH?

8 A. Past medical history.

9 Q. And tell us about that.

10 A. Significant for stones and depression..

11 Q. And you've got stones, plural, do you know if she had  
12 one previous, two previous, or how many?

13 A. It's usually just repeating what the patient has told  
14 me. I don't recall specifically if she told me she had had  
15 one stone or multiple stones.

16 Q. And then what's next, please?

17 A. The first day of her last menstrual is currently on.

18 Q. Now, does her current menstrual period have any impact  
19 on what you decide to do, and your method of examination?

20 A. Yes. Yes. If she had told me that her first day of  
21 her last menstrual period was three months ago, it would make  
22 me a lot more suspicious for other things, like an atopic  
23 pregnancy or possibly even pregnancy causing her pain.

24 Q. Okay. Now, she was on some meds.

25 A. Right.

1 Q. ALA, what does that mean?

2 A. Allergies.

3 Q. What does that mean when you say none?

4 A. Well, usually when we have patients that have allergies  
5 we are not asking about cat dander or hayfever, we are asking  
6 more specifically about medication, and she reported no  
7 medical allergies.

8 Q. Well, when you put none, Doctor, does that mean that,  
9 for instance, she can take any medicines, like penicillin, any  
10 antibiotic, anything of that nature?

11 A. No.

12 Q. Does that foolproof her ability to take those  
13 medicines?

14 A. No. People need to be exposed to a substance in order  
15 to have an allergic reaction to it and, you know, a lot of  
16 times people will have -- we'll see them for infections, or  
17 we'll see them for a process that they need to take  
18 antibiotics, and we'll start them on an antibiotic, and  
19 although it's rare, people do come back with allergic  
20 reactions to antibiotics.

21 Q. Okay. SH, would that be social history?

22 A. Yes.

23 Q. And what is about?

24 A. Basically asking, you know, if she has any other  
25 factors that would be contributing to an illness. People that

1 are alcoholics may start the morning by drinking a fifth of  
2 Jack Daniels. We need to know about that.

3 Q. So she was a non-drinker and non-smoker.

4 A. That's correct.

5 Q. Okay. And what was her pre-existing state of health?

6 A. She was healthy.

7 Q. Okay. PE, is that physical examination?

8 A. Yes.

9 Q. Patient afebrile, what does that mean?

10 A. That's a word that we use to describe a patient without  
11 a fever..

12 Q. And your -- Doctor, what is a fever?

13 A. It depends on the text that you -- that you look at,  
14 and most commonly a fever is defined as anything over a  
15 hundred point four degrees Fahrenheit.

16 Q. And is there a difference on fever and what you might  
17 call a significant fever?

18 A. Some textbooks refer to a hundred and one point five as  
19 being a significant fever.

20 Q. Okay. Now, vital signs are stable, and where did you  
21 get -- did you get that from the Core Encounter sheet?

22 A. Yes. That would be right here at the beginning portion  
23 of the triage note. This would be at the time of arrival  
24 typically.

25 Q. All right. Tell us what the vitals were, if you can

1 read that, at the time of arrival.

2 A. Temperature is ninety-eight point one, blood pressure  
3 is one twenty over eighty-four, heart rate is eighty-eight --  
4 it's not legible.

5 Q. That's hard to read.

6 A. And respiratory rate is sixteen.

7 Q. Is there anything unusual about any of these findings?

8 A. No.

9 Q. Nothing unusual about the blood pressure, heart rate or  
10 respirations?

11 A. No.

12 Q. What is heart rate again?

13 A. Heart rate is how fast your heart is beating per  
14 minute.

15 Q. And again, respirations.

16 A. How many times you are breathing per minute.

17 Q. All right, sir.

18 A. Okay.

19 Q. What's next?

20 A. General. Pleasant, uncomfortable-appearing twenty-five  
21 year old female.

22 Q. HDEMT, what is that?

23 A. Head, eyes, ears, nose and throat exam.

24 Q. Did you actually examine all those areas?

25 A. Yes.

1 Q. And what did you find?

2 A. Normocephalic/attraumatic, meaning that her head is  
3 normal size and normal shape, and no evidence of trauma to her  
4 head.

5 Q. Okay.

6 A. Conjunctivae are pink. Typically what we do is, we  
7 flip down an eyelid, just to look at the patient's eye, and if  
8 it's nice and pink then you have an idea that they are not  
9 anemic at all.

10 Q. Okay. What is that big word?

11 A. Oropharynx, the mouth and -- that is part of the  
12 throat.

13 Q. And how -- what did that examination tell you?

14 A. It's clear, with moist mucous membranes, meaning that  
15 she look -- appears to be adequately hydrated.

16 Q. Okay. Then clear -- we go to -- no, I'm sorry. Okay.  
17 Keep going.

18 A. Okay.

19 Q. And the neck examination is no JVD, which stands for  
20 jugular venous distension. Sometimes if people have a fluid  
21 overload you can actually see their neck being -- starting to  
22 bulge out.

23 Q. Then you've checked cardiac. And these are all -- this  
24 is your physical examination of Kelly Fay.

25 A. Correct.

1 Q. How was her cardiac?

2 A. She had a regular heart rhythm without ectopy or  
3 murmurs. Ectopy stands -- is abnormal beats, or extra beats.  
4 Sometimes when people drink too much coffee, or sometimes with  
5 other cardiac conditions you can actually hear an irregularity  
6 with their heart beat.

7 Q. Did you say regular or irregular?

8 A. She's regular.

9 Q. Regular. Okay. And then you heard the lungs.

10 A. Right.

11 Q. You say clear to auscultation bilaterally. What does  
12 that mean?

13 A. Means that I listened with a stethoscope.

14 Q. Okay. All right. Abdomen. Did you exam Kelly Fay's  
15 abdomen?

16 A. Yes.

17 Q. And before you read that, what was the result of your  
18 abdominal examination?

19 A. She had a normal abdominal examination.

20 Q. Read what you actually recorded.

21 A. Okay. Patient has moderate to severe flank tenderness  
22 noted in her right CVA, which refers -- CVA stands for costa-  
23 vertebral angle, which is right here at the edge of where the  
24 ribs meet the spine.

25 Q. When you say her abdomen was soft, nontender and



1 nondistended, without rebound, or guarding, or rigidity, what  
2 does that mean?

3 A. That actually reads, patient has -- her abdomen is  
4 soft, nontender and nondistended, without rebound, rigidity or  
5 guarding. Essentially what you are looking for is, you are  
6 looking to see what could possibly be causing the pain. In  
7 somebody who comes in like this, that has this presentation,  
8 you want to make sure there is nothing going on in the abdomen  
9 that's actually physically causing the pain, so you palpate  
10 around, you palpate all four quadrants of the abdomen. You  
11 listen for bowel sounds, to make sure that they are active,  
12 and you actually examine to see if it feels like it's  
13 distended.

14 Q. Okay. All right. And you said no question, there are  
15 active bowel sounds. What is the significance of that?

16 A. When people have a blockage in their intestines,  
17 instead of hearing normal, like your stomach growling type of  
18 bowel sounds you'll actually hear high-pitched, almost like a  
19 tinkling sound. That can indicate an obstruction.

20 Q. Okay. And you've deferred the GU and rectal  
21 examination.

22 A. Right.

23 Q. You found that was not necessary for what she was there  
24 for?

25 A. Correct.

1 Q. Extremities. No clubbing, cyanosis or edema. Tell us  
2 what that is, please.

3 A. Essentially what you are looking for on the extreme  
4 examination, to see if there is any evidence of something  
5 going on with her blood supply to her extremity. That finding  
6 indicates usually there is either poor venous return, or  
7 sometimes poor arterial flow to the fingers and to the  
8 extremities. The edema indicates there is poor venous return  
9 from the legs, and cyanosis is a color change that people  
10 sometimes get when there's a lack of oxygen in the  
11 bloodstream.

12 Q. Okay. How does an emergency physician go about  
13 establishing a -- that's a differential diagnosis.

14 A. Correct.

15 Q. First tell us what that is, secondly, tell us how you  
16 go about that process.

17 A. Differential diagnosis. Typically in the emergency  
18 department you want to sort of focus your testing in -- on  
19 what you think may be causing the problem, and with somebody  
20 with right flank pain that radiates around to the abdomen, the  
21 three top differentials, at least looking at this chart, were  
22 ureterolithiasis, which is a ten cent word for a kidney stone.

23 Q. In the ureter?

24 A. Yes. It could be either in the ureter or -- and it  
25 doesn't tell you where in the ureter.

1 Q. Okay.

2 A. Pyelonephritis, which is kidney infection, and  
3 cholecystitis, which is an infection and inflammation of the  
4 gallbladder.

5 Q. And then you ordered some lab work.

6 A. Correct.

7 Q. What did you order?

8 A. I ordered an urinalysis and a KUB.

9 Q. Now Doctor, you remember Mr. Foster taking your  
10 deposition some years ago.

11 A. Correct.

12 Q. And when he first asked you what tests you ordered what  
13 did you tell him?

14 A. I told him I ordered a CVC, a chem panel, a KUB, and a  
15 urinalysis.

16 Q. And is that what you ordered?

17 A. No.

18 Q. Was that a mistake?

19 A. Yes.

20 Q. Did you clarify that later?

21 A. Yes.

22 Q. But on this case, Doctor, you didn't order -- what is a  
23 CVC?

24 A. A complete blood count.

25 Q. Why didn't you order that?

1 A. I didn't think it was necessary.

2 Q. What's a chem panel?

3 A. A chem panel is a basic chemistry panel that gives you  
4 your electrolytes, BUN, which is a blood urea and nitrogen,  
5 glucose, and also creatinine, which the BUN and creatinines  
6 are measures of kidney function.

7 Q. Okay. And why didn't you order that?

8 A. Didn't need it.

9 Q. Tell us what the lab results were.

10 A. Okay. The urinalysis -- okay, I'm sorry -- the KUB --  
11 I'm sorry. Her urinalysis was a cath specimen. The reason  
12 that she was cathed is she was currently menstruating. If I  
13 had taken just a sample that she would have given us from the  
14 bathroom there would have been blood in it, but it would have  
15 been, most likely, menstrual blood, and there would be no way  
16 to sort of differentiate that. So I asked the nurse to do a  
17 catheterized specimen, so they pass a small tube up into the  
18 bladder to obtain the urine.

19 Q. And what was the result of the urinalysis?

20 A. It was normal.

21 Q. Can we -- the jury has looked at this. Is that the  
22 read-out from the urinalysis?

23 A. That's correct.

24 Q. Was this done with a dip-stick?

25 A. Well, when they do this in the lab ---

1 Q. I want you to explain that to the jury.

2 A. When they do this in the lab what they do is, they take  
3 a urine sample that the nurses send over to the lab, and they  
4 put it on one of those little dip-sticks that was earlier  
5 talked about. At South Stand what they do is, they put it  
6 into an automated reader, and the reason that they do that is  
7 it takes away from operator error.

8 Fifteen years ago the way they used to do this is dip it  
9 in the urine and then actually compare it to the side of the  
10 bottle where there is indications that -- what the color  
11 changes mean, but now they have machines that can do that and  
12 give you a much more consistent reliable result.

13 Q. Is there anything unusual, abnormal or surprising on  
14 the urinalysis?

15 A. Is it unusual, or abnormal, no.

16 Q. Okay. Now, did you find blood in the urine?

17 A. No.

18 Q. Did that surprise you?

19 A. A little, yes.

20 Q. All right. Then when that surprised you a little then  
21 what did you do next?

22 A. Well, I had already ordered the KUB. I looked at the  
23 KUB and found that she had a kidney stone. One of the things  
24 that we get worried about ---

25 Q. Keep going. I'm going to show you. Finish that

1 sentence and let's look at the KUB.

2 A. One of the things we get worried about is whether she  
3 has a completely obstructing stone.

4 Q. The fact that she didn't have blood in the urine, does  
5 that tell you she was completely obstructed?

6 A. No. About twenty percent of the patients who have  
7 kidney stones can pass them with no blood.

8 Q. Okay. Are you board certified in radiology?

9 A. No.

10 Q. Are you -- do you read x-rays films day in and day out?

11 A. Yes.

12 Q. Do you usually look at them before they are sent to x-  
13 ray?

14 A. Yes..

15 Q. Before a radiologist looks at them?

16 A. Yes.

17 Q. And then you are asking for confirmation of what you  
18 think it is?

19 A. Correct.

20 Q. Could you find for the jury, Doctor, the KUB -- and  
21 let's use the view box, and let you tell us what you observe  
22 on it. Go through it slow if you would. I'm going to see if  
23 I can see it too.

24 A. Can everybody see that?

25 Q. What does that show you?

1 A. This is a KUB. Typically when it's done it's an x-ray  
2 image that's taken from, in fact, the lower portion of the  
3 chest down to the bottom of the pelvis.

4 Q. Let me ask you this, Doctor, when you look at a film  
5 like that on the view box is the image magnified?

6 A. Yes.

7 Q. Do you know ---

8 MR. FOSTER: Your Honor, we are getting in --  
9 objection, leading. We are getting into substantive matter  
10 now.

11 THE COURT: All right. Counsel, do not lead your  
12 witness.

13 A. Typically what you are looking at are -- you are  
14 looking at the bony structures of the abdomen, including --  
15 you can see the short ribs up through here. These are the  
16 vertebral body, these are the bones that make up your back,  
17 and this is your iliac crest, which is the main bone that you  
18 feel right here in your pelvis.

19 What you are looking for, specifically in this case,  
20 were any abnormal calcification. Kidney stones can be radio-  
21 dense, meaning that you can see them on an x-ray, sometimes  
22 they are radio-elusive, meaning you can't see them on an x-  
23 ray.

24 In Kelly's case you can see here right by the vertebral  
25 body, the spinose process, or the transverse process of her

1 lumbar spine, this little calcification. Usually what we do,  
2 when we see this we will actually take a measuring stick  
3 that's connected to the view box and measure it, see how long  
4 it is or how wide it is. When we do that we have an idea that  
5 this is most likely a kidney stone, her presentation is  
6 consistent with a kidney stone, and her x-ray exam is  
7 consistent with a kidney stone.

8 Q. Okay. And did you measure what you found there?

9 A. Yes. And typically what happens, when you measure this  
10 you also know that there's a certain degree of magnification.  
11 When you take an x-ray -- for example, if this was an x-ray  
12 machine, and the patient was lying right here, well, the  
13 kidney stone is not actually lying flat right on the board,  
14 it's actually sitting up a little bit, so what happens as the  
15 x-ray beam passes that the shadow that it creates on the film  
16 is actually a little bit wider than what you are seeing on the  
17 -- on the film.

18 All right. The shadow that you see on the film is  
19 actually wider than what the kidney stone would have be in  
20 life.

21 Q. Did you record the size of what you saw on the KUB?

22 A. Yes. KUB reveals that there appears to be a kidney  
23 stone noted at the right ureteropelvic junction, measuring  
24 approximately four to five millimeters on the plain KUB.

25 Q. Now, first, can you show the jury where the



1 ureteropelvic juncture is on this.

2 A. Looking at the diagram again, this is your right  
3 kidney, this is your left kidney. This is the renal  
4 collecting system coming down into the ureter. This is  
5 typically -- this area right in here is usually described as  
6 the UPJ, or ureteropelvic junction.

7 Q. Okay. Four to five millimeters. Can you give the jury  
8 some visual example, how big or how small is that?

9 A. A lot of times we will measure things you could have  
10 sort of as a reference point. My pinkie nail measure exactly  
11 one centimeter across, or ten millimeters across, so comparing  
12 my pinkie finger to the stone you can see that it's wider.  
13 Just as an estimation looking at this I would measure this out  
14 at about four to five millimeters.

15 Q. Okay. Using my pencil can you give the jury any visual  
16 information about how -- how big four to five centimeters  
17 might be.

18 A. Millimeters.

19 Q. Millimeters.

20 A. We measured this this morning. This pencil eraser, or  
21 the diameter of this pencil eraser is six millimeters. So  
22 that will give you an estimation about how big four to five  
23 millimeters is, a little bit smaller than that.

24 Q. The eraser ball?

25 A. Yes.

1 Q. What used to be the eraser?

2 A. Yes.

3 Q. Okay. After you've looked at the KUB what did you do  
4 next, Doctor?

5 A. Because the patient is in severe pain, with lack of  
6 blood in the urine, I did not -- she did have a CT performed  
7 to rule out the possibility of hydroureter. Essentially what  
8 I was looking at is, we know that there's a stone there, or it  
9 looks like a stone, and she had no blood in her urine, so I  
10 wanted to make sure that she wasn't completely obstructed, one  
11 -- one of the things that we get worried about, so I ordered a  
12 CT scan.

13 Q. What is a hydroureter?

14 A. Hydroureter refers to the degree of distention or  
15 dilation behind the kidney stone.

16 Q. Now, so you ordered a CT?

17 A. Correct.

18 Q. And did you look at the CT yourself?

19 A. No.

20 Q. What happens? Does the patient go to an area in the  
21 hospital where a CT is performed?

22 A. At South Strand the treatment rooms are around the  
23 front, and then toward the back, going back in the back  
24 hallway there's a lab, and then behind that is radiology.  
25 Typically patients will be wheeled back to CT scan in order to

1 have the CT performed.

2 Q. Now, do you know who the radiologist was that read the  
3 CT at some point?

4 A. Dr. Chomyn.

5 Q. Did you know him?

6 A. Yes.

7 Q. Had you worked with him?

8 A. Yes.

9 Q. Now, let's look for a minute, Doctor, at the -- that's  
10 the -- is that the CT of the abdomen?

11 A. That is ---

12 Q. No, that's not.

13 A. That's the KUB.

14 Q. KUB. It is, I think -- is that the CT of the abdomen?

15 A. This is the CT of the abdomen.

16 Q. Did you have a discussion with Dr. Chomyn that Saturday  
17 morning, January 26, about what he saw?

18 A. Typically when we get a CAT scan like this the  
19 radiologist will call us with what's known in the business as  
20 a wet read. Back in the days when films would come out they  
21 would still be wet from going through the processor the  
22 radiologist would take a look at it and give us a call.

23 Q. Okay. Now, again, going back to the K -- that's a KUB?

24 A. Correct.

25 Q. What does this "A" mean right there?

1 A. That -- when we get x-rays like this I'll write down an  
2 interpretation on the sheet that comes along with the x-ray  
3 image, and then I'll write down my preliminary interpretation,  
4 they will go over to radiology, radiologist will read it. If  
5 there's any disagreement, or agreement, then I will note it by  
6 putting a letter.

7 Q. Now Doctor, this says at the bottom -- when was this  
8 dictated, if you can tell?

9 A. This was dictated on January 27, 2002, at 11:53 A.M.,  
10 yes A.M..

11 Q. That's the Sunday?

12 A. Yes.

13 Q. And can you tell from this when it was transcribed or  
14 typed up?

15 A. It was transcribed the same day at 14:35, or 2:35 P.M..

16 Q. So that was the next day?

17 A. Correct.

18 Q. So did you have a copy of this in the E.D.?

19 A. No.

20 Q. Do you remember, Dr. Law, what Dr. Chomyn told you?

21 A. I would have to refer back to my notes. Typically when  
22 radiologists will call us they will call us with the pertinent  
23 details of the CT scan.

24 Q. Do you recall whether anything was mentioned about  
25 extravasation of urine?

1 A. I don't recall specifically, but I didn't write it in  
2 my notes so I don't think it was mentioned.

3 Q. Okay. And let me ask you this. I don't think we've  
4 covered this before. It says the ureter has a normal caliber.  
5 What does that mean?

6 A. That means the ureter is -- has a normal caliber,  
7 meaning that they not over-distended, and that's distal to the  
8 area that we are talking about, meaning it's past the area of  
9 the stone.

10 When people have a kidney stone, and when it's complete  
11 obstruction, usually what happens is that the ureter past that  
12 area will collapse. There's no urine to hold it open, so  
13 usually what you will see is contraction of the ureter, with  
14 no urine in it.

15 Q. Okay. Do you recall receiving information -- don't say  
16 what he said -- receiving information about obstructing,  
17 partial obstructing, complete obstruction, anything of that  
18 nature?

19 A. Again, referring back to my notes ---

20 MR. FOSTER: I'm going to object again to the leading,  
21 but ---

22 THE COURT: I'm going to sustain as leading.

23 MR. AIKEN: All right. Thank you, Your Honor.

24 MR. FOSTER: Thank you, Your Honor.

25 A. Essentially what I have put in my note is what the --

1 the body of the conversation would entail.

2 Q. And let's brief that, please, what you've put in your  
3 notes.

4 A. According to the radiologist there is the right UPJ  
5 stone, which is abbreviation for ureteropelvic junction, with  
6 moderate to severe obstruction.

7 Q. Did you make an independent assessment of obstruction  
8 or non-obstruction?

9 A. No. I didn't have the CT images to look at.

10 Q. Okay. All right. EDC, what does that mean?

11 A. Emergency Department Course.

12 Q. Tell me about that.

13 A. Patient had good pain relief with 30 milligrams of IV  
14 Toradol, and twelve point five milligrams of Phenergan, and  
15 one milligram of IV Dilaudid.

16 Q. Can you tell us when you ordered, Doctor, those  
17 different medicines, and we'll use this. What did you order  
18 first, and what time?

19 A. Okay. Well, this -- these are the times that the  
20 medications were given. IV Toradol was given to IV push at  
21 8:35 in the morning, Phenergan, twelve point five milligrams,  
22 which is an anti-nausea medication, was given at 8:45. I  
23 can't really make out the number -- and then one milligram of  
24 Dilaudid was given at 9:35.

25 Q. Why did you give the Dilaudid?

1 A. She had incomplete pain relief with the Toradol.

2 Q. And tell me -- tell the jury, one milligram, is that a  
3 lot, not a lot?

4 A. Everything is relative. When you have -- if she came  
5 in with a splinter under her finger that would be a lot of  
6 pain medication for a splinter, but she had one of the most  
7 painful processes known, which is a kidney stone. When you  
8 see people with kidney stones they have a lot of pain  
9 associated with it, so that was an appropriate medication  
10 given her level of pain.

11 Q. Is this your writing?

12 A. Yes.

13 Q. Could you please tell the jury what that says?

14 A. IV access.

15 Q. All right. What does that mean?

16 A. Means that I wanted the nurses to start an IV line.

17 Q. Why?

18 A. So I can give her pain medication.

19 Q. Okay.

20 A. And then underneath that is thirty milligrams of IV  
21 Toradol, twelve and a half milligrams of IV Phenergan, normal  
22 saline solution MSS times one liter.

23 Q. What is normal saline solution?

24 A. Normal saline solution is a solution that we give  
25 patients for an IV fluid. It has a hundred and fifty-four

1 milligrams of sodium chloride in it to sort of match what's in  
2 our bloodstreams normally.

3 Q. Okay.

4 A. CT abdomen and pelvis with renal stone protocol.

5 Q. What does that mean?

6 A. Renal stone -- when we send somebody for a CAT scan,  
7 and you are concerned about a given thing you will order the  
8 CAT scan on radiology protocol. If she -- if I was concerned  
9 about appendicitis in her I would have ordered a contrasting  
10 CT scan, with oral and IV contrast, but because she had a  
11 kidney stone typically we will use either a KUB or a CT scan  
12 to diagnose kidney stone without a contrast. When you give  
13 somebody contrast it sort of obliterates, or contrasts the  
14 rest of the intestines, and you can't really see the stone  
15 that well, so that's why we usually use it without contrast.

16 Q. Okay. Let's move on over here, second page. What does  
17 CONS mean?

18 A. Consultation.

19 Q. And tell us about that.

20 A. Okay. Case was discussed with Dr. Richard Young, the  
21 on-call urologist, who requests to see the patient on Monday  
22 since the patient's pain is under control.

23 Q. At that point had you decided whether you were going to  
24 discharge Kelly Fay?

25 A. Yes.



1 Q. That was your decision.

2 A. My decision was to send her home. She had gotten  
3 adequate pain relief. She did have a stone that was seen on  
4 CT scan which explains her pain. Of course there was still a  
5 concern that she may have an obstructing stone because she  
6 didn't have any blood in her urine, but I felt that she was  
7 clinically well enough to go home, and when I say clinically,  
8 you have to go back in the room several times when a patient  
9 is in the emergency department for that amount of time. You  
10 go in, see how they are feeling, re-examine them if needed,  
11 and then go from there to decide and make your disposition.

12 Q. Did you -- before that -- read that last sentence.  
13 When you were going through that last sentence where was Kelly  
14 Fay?

15 A. Kelly Fay was in the emergency department.

16 Q. Was she in a room or in the ---

17 A. She was back in a room in the emergency department.

18 Q. Did you give Kelly Fay and/or Sean Fay, any discharge  
19 instructions?

20 A. Well, when people come in with kidney stones,  
21 especially if they are high kidney stones, or if they are  
22 large kidney stones, or you are worried about the degree of  
23 obstruction, there's a good chance that they won't pass their  
24 kidney stone, so there's instructions that I typically give  
25 patients that include, as I said, increasing nausea, vomiting,

1 fevers and chills, or increasing pain she's suppose to come  
2 back.

3 Q. Do you remember giving those instructions?

4 A. Yes.

5 Q. Who did you give them to?

6 A. Sean Fay, and also Kelly Fay.

7 Q. Did you give those instructions when she was in x-ray  
8 by any chance?

9 A. No.

10 Q. When she was in CT by any chance?

11 A. No.

12 Q. And what does this mean, you've got a D, the day, and  
13 some time?

14 A. Means that I dictated the chart at 1/26/02, at  
15 11:38:27.

16 Q. What time was she discharged?

17 A. Noon.

18 Q. That was before she was discharged?

19 A. Correct.

20 Q. Now, how long, before or after 11:38:20 would you have  
21 given these discharge instructions?

22 A. I would have given them -- typically my charting  
23 fashion at South Strand was to go in, tell the patient what I  
24 thought was going on, explain to them what I thought was  
25 happening, and then go and dictate the note, and then start

1 writing off on the front of the chart the EPIC discharge  
2 instructions I wanted the patient to get. After it was  
3 dictated I would put the chart up in the discharge rack.

4 Q. When it says "T", what does that mean?

5 A. That means the time that it was transcribed.

6 Q. And that's some twenty-two minutes later?

7 A. Correct.

8 Q. Is that unusual?

9 A. No. It depends. Sometimes if the transcription  
10 service is getting a lot of charts at once you may not see  
11 this chart show up for a few hours. Sometimes you may not  
12 even see it show up until the next day.

13 Q. Now, down here, what does this mean when it says,  
14 "Electronically signed"? When was it electronically signed?

15 A. When we do charts like this we actually dictate them  
16 freestyle, meaning that it's not a set template or anything  
17 else to go through, and so what will happen is, those charts  
18 will start to build up, and in the emergency department it's  
19 not unusual for me to dictate a chart and go see another  
20 patient, and then do that throughout the day. At the end of  
21 the day if there's charts available sometimes I'll sign off on  
22 them, sometimes they will actually build up, and it's not  
23 unusual to have a time period with a lag between when the time  
24 -- when the chart is dictated and when the chart is  
25 electronically signed off.

1 Q. All right. After you dictate, and after it's  
2 transcribed -- do you have -- ever have the ability, Doctor,  
3 to change these?

4 A. You can go back in and change this, but really you are  
5 not suppose to. I mean, for example, I mean, the date is  
6 wrong. I didn't change that. Usually most charts I would  
7 just sign off once the chart was available. If there's --  
8 sometimes there would be wrong information in the chart and  
9 that would have to sometimes be fixed, and sometimes charts  
10 were inadvertently merged together, those would have to be  
11 fixed, but for the most part we would just sign off on them.

12 Q. What is an addendum?

13 Q. An addendum is where you have a completed chart, and  
14 then what you will do is, you will type an addendum sheet,  
15 describing the time and date that you are adding the addendum,  
16 and then add that on and electronically sign that as well.

17 Q. Okay. Doctor, after you dictated this note did you  
18 ever go back and make any changes?

19 A. No.

20 Q. Why don't you cut this view box off. I'm going to let  
21 you take your chair back, if you don't mind.

22 What is this, Doctor?

23 A. This is the nurse's progress notes.

24 Q. Okay. At 9:10 does it have any listing of -- no,  
25 strike that. At 10:20 does it have any listing of your blood

1 pressure, your heart rate and your respirations?

2 A. Yes.

3 Q. Now can you read that?

4 A. Blood pressure is one twenty over eighty, heart rate is  
5 seventy-two, and respiratory rate is seventeen.

6 Q. Now, in your experience and training and practice, what  
7 generally happens, if anything, if you have a fever, with  
8 regard to your heart rate?

9 A. Typically you will see the heart rate go up. Usually  
10 for every degree over a hundred degrees you will see about a  
11 ten percent increase in the heart rate.

12 Q. Over a hundred degrees?

13 A. Yes.

14 Q. Over one degree or a hundred degrees?

15 A. Well, for every -- every one degree over a hundred  
16 degrees you will see a ten percent increase in the heart rate.

17 **MR. FOSTER:** Your Honor, I'm going to object to the  
18 leading.

19 **THE COURT:** Overruled in that instance.

20 **MR. AIKEN:** Thank you, Your Honor.

21 Q. Now, the blood pressure, is that good, bad or  
22 indifferent?

23 A. That's normal.

24 Q. How is your heart rate?

25 A. Seventy-two. That's normal as well.

1 Q. How about your respirations?

2 A. Seventeen, which again, is normal.

3 Q. Now Doctor, can you tell this jury again about what  
4 time it was, approximately, when you gave Kelly and Sean these  
5 discharge instructions?

6 A. I would imagine it would be before I dictated my note,  
7 so I'm -- in estimation, would probably be around 11:20 to  
8 11:30.

9 Q. Now, did you order a fever, or a temperature to be  
10 taken?

11 A. No.

12 Q. At 10:20 was there a temperature taken?

13 A. No.

14 Q. When you normally consider vitals, is or is not a  
15 temperature in that vital category?

16 A. Temperature is considered part of the vital signs.

17 Q. Do you know if she had a fever when you discharged her?

18 A. I can say with a reasonable degree of certainty that  
19 she did not.

20 Q. And what do you base that on?

21 A. I based it upon, that you have several examiners going  
22 in and actually making contact with the patient. Most adults  
23 can tell when they have a temperature. They will say, I feel  
24 like I'm warm. You will also see alterations in their vital  
25 signs. You will see elevations in heart rate, which you

1 didn't see in this case.

2 Q. Doctor, is fever and kidney stone a urologic emergency?

3 A. Yes.

4 Q. Is infection and kidney stone a urologic emergency?

5 A. Yes.

6 Q. Doctor, what did you do in the E.D. to rule out  
7 infection, if anything?

8 A. Well, I based it upon her clinical exam, I based it  
9 upon her urinalysis, and I based it upon her CT findings.

10 Sometimes when people have an early pyelonephritis you  
11 can't see stranding or inflammation around the side of the  
12 kidney.

13 Q. Doctor, did you order any antibiotics before Kelly was  
14 discharged?

15 A. No. There was no indication to give this patient  
16 antibiotics.

17 Q. Well, explain that. Why not? What's the harm in it?

18 A. Well, -- and that's a fairly common question. Usually  
19 when people come in and they have no signs of a fever, no sign  
20 of an infection, nothing in the clinical or laboratory  
21 examination to suggest infection, there's really not a large  
22 indication to give somebody antibiotics.

23 There are downsides to giving patients antibiotics. They  
24 can develop resistant infections over a period of time. They  
25 can have allergic reactions to the medication, and you could

1 also develop other infections.

2 Commonly when women get urinary tract infections and  
3 they're given an antibiotic, it's not unusual for them to get  
4 a yeast infection.

5 Q. Okay. Doctor, there's been a lot of discussion on this  
6 case on your verbal discharge instructions and these EPIC  
7 instructions, and what is your view on that?

8 A. When I discharge somebody, I know that they're going to  
9 be getting written discharge instructions, and I go back into  
10 the room to try to reinforce what is really important about  
11 the discharge instructions, and patients with kidney stones  
12 that are large that may not pass, they need to know that they  
13 need to come back if they have fever, nausea or vomiting, and  
14 the reason that's important is because if somebody is  
15 vomiting, they're not going to be able to take their pain  
16 medication and they're not going to be able to stay adequately  
17 hydrated.

18 If they also start to have pain that's out of proportion,  
19 that it starts to get much worse, Percocet is a fairly strong  
20 pain medication, but it's not the end all-be all, and a lot of  
21 times people will come back to the hospital to be admitted  
22 because their pain is out of control.

23 Q. And you've already confirmed, I think, you were not  
24 working Sunday?

25 A. That's correct.



1 Q. Monday?

2 A. I was working at Grand Strand on Monday. My shift  
3 started at around three o'clock.

4 Q. Did you see Sean Fay on Monday?

5 A. I did.

6 Q. And where did you see him?

7 A. I saw him actually in the bereavement room.

8 Q. And approximately what time?

9 A. It was right around three o'clock.

10 Q. In the afternoon?

11 A. Yes.

12 Q. And why did you go to the bereavement room?

13 A. I had heard what had happened to Kelly and I just  
14 wanted to find out what had happened and also express my  
15 condolences.

16 Q. And did you expect that to happen?

17 A. No, not at all.

18 Q. Doctor, in the next two or three days, did you -- did  
19 you review the chart with Dr. Young and Dr. Molnar?

20 A. I re- ---

21 Q. I don't want you to tell me what anybody said. Did you  
22 review it with them?

23 A. Dr. Molnar was the Director of the Grand Strand  
24 Emergency Department. I wanted him to take a look at the  
25 chart and talk to me about -- talk with me about the case.

1 Q. As a result of that discussion, Doctor, did you second-  
2 guess yourself?

3 A. Given the information that I had based on her clinical  
4 examination, based upon her history and her presentation, and  
5 based upon the lab testing that was done, I wouldn't have done  
6 anything differently.

7 Q. Well, now, we're eight years out from that tragedy.  
8 Looking back on it, do you second-guess yourself for not  
9 admitting Kelly Fay?

10 A. Do I second-guess myself? Every time I see a kidney  
11 stone patient, I think of Kelly, and I think is it going to  
12 change my practice, is it going to change what I know about  
13 kidney stones and how to treat them and work them up in the  
14 emergency department. It's always in the back of my mind, but  
15 quite honestly, it hasn't changed my practice.

16 I don't do any additional testing or anything else, but I  
17 do tell them pretty much the same instructions, and the only  
18 thing that's changed is that I make sure that I write out  
19 those instructions on our discharge instructions now.

20 Q. When you think back on this case, Doctor, did you do  
21 anything in your mind to cause her death?

22 A. No.

23 Q. Did you feel like you failed in your duty to ---

24 **MR. FOSTER:** Your Honor, I'm going to object to  
25 leading ---

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1 A. I believe the question was is there a protocol for  
2 doing tests on a patient with a kidney stone.

3 Q. Okay. I'm going to ---

4 **MR. FOSTER:** Your Honor, may I open the deposition?

5 **THE COURT:** You may open it.

6 Q. Can you open your original deposition, Dr. Law.

7 A. (Witness opens original deposition.)

8 Q. Turn to page -- let me know when you get to page forty-  
9 eight, if you would. I'm going to start on line three and ask  
10 the question, and you read the answer, okay?

11 A. Okay.

12 Q. Line three, I said, okay, and you ordered what tests?

13 A. Initially, and this is from independent recollection, a  
14 CBC, a chemistry panel, urinalysis, and a KUB.

15 Q. Question: Would that be standard protocol for a  
16 suspected kidney stone?

17 A. Yes.

18 Q. Okay, so you did tell me it was standard protocol, did  
19 you not?

20 A. Yes.

21 Q. All right, and if you will turn to forty-nine, then you  
22 had a little -- two pages later in your deposition, your story  
23 sort of changed about what standard kidney stone protocol was,  
24 didn't it?

25 A. Page forty-nine?

1 Q. Yes sir. Maybe I'm on the wrong page. Hold on one  
2 second. Okay, I'm sorry, on fifty. Three pages later, let me  
3 read the question on line two. Let me just ask you one thing  
4 before I move on to the next question. So that I understand,  
5 your standard protocol for a suspected kidney stone is a CBC,  
6 a chem panel, a urinalysis, and a KUB?

7 A. My answer was, I wouldn't call it a standard protocol.  
8 Sometimes treatment is tailored to individuals and at that  
9 time that's what I ordered on Ms. Fay.

10 Q. So not only did you testify that it was standard  
11 protocol to do all these tests, but then three pages later you  
12 said, well, maybe not standard protocol, but for her that's  
13 what we individually tailored for her and ran those tests for  
14 her?

15 A. That's correct.

16 Q. Okay, and now you say that was a mistake, correct?

17 A. Yes.

18 Q. All right, because you never ordered those tests, did  
19 you?

20 A. No.

21 Q. All right. The -- if you would have ordered a CBC,  
22 this would have been circled right here, CBC?

23 A. That's correct.

24 Q. All right, and you did order the KUB, did you not?

25 A. Yes, I did.

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1 Q. If you had ordered a chem panel on her, that would be a  
2 basic panel ---

3 A. That -- yes ---

4 Q. --- right here or a comprehensive panel?

5 A. Well, the difference between the basic and the  
6 comprehensive panel is the comprehensive panel also has liver  
7 function tests, and it would have been most likely a basic  
8 panel. If I were to order it, that's what I would order.

9 Q. Okay, and the reason you would want to order a basic  
10 panel is because you would want to know her creatinine to see  
11 what her kidney function was, correct?

12 A. That's correct.

13 Q. And if she had a bad creatinine, that would test --  
14 that could give you indications or evidence that she had some  
15 kidney damage and would lead you further toward her ureter  
16 being obstructed, correct?

17 A. It's possible, and most of the times when people have  
18 an obstructed stone, even if it's been long-standing, what  
19 happens is the other kidney takes over production of the urine  
20 and you don't typically see an elevation in the creatinine  
21 initially.

22 Q. But it is possible that you could tell that from the  
23 creatinine, correct?

24 A. That's correct.

25 Q. All right. Now, isn't it also true -- we just had a

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1 but sometimes they can feel it radiating around into their  
2 back, so that's also part of the differential.

3 Q. Okay, and the pyelonephritis, the kidney infection, and  
4 the cholecystitis, the gall bladder infection, those are both  
5 abdominal processes, aren't they?

6 A. Well, the kidney is what's called a retroperitoneal  
7 organ. I mean, it's back behind where the intestines are and  
8 it sits in -- its mesenteric attachments are the fibrous  
9 tissue that holds it in place, and it also sits in sort of a  
10 bed of fat to keep it sort of shock-absorbent. Is it  
11 considered an abdominal organ? Yes, it is an abdominal organ.

12 Q. Okay, and the closest thing -- you don't have -- South  
13 Strand didn't have a vital sign policy on retroperitoneal  
14 problems, did they?

15 A. No, no.

16 Q. All right, so the closest thing as far as policy and  
17 procedure that they had is abdominal pain for a presentation  
18 like Kelly's, correct?

19 A. As far as the discovery ---

20 Q. For vital signs?

21 A. Yes, from -- that's come out in testimony.

22 Q. Okay, and you were also talking about -- well, let's  
23 talk about a kidney stone and a fever. Let's get some things  
24 out of the way. You admit a kidney stone and a fever is an  
25 emergency?

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1 A. Absolutely.

2 Q. They get admitted right then. A urologist comes in and  
3 drains it, and after they drain it -- they put them on  
4 antibiotics, they drain it, and that pretty much takes care of  
5 things most of the time, correct?

6 A. Yes. That would be a good characterization.

7 Q. And the same question with a kidney stone and an  
8 infection, it's an emergency, correct, ---

9 A. Yes.

10 Q. --- for the same reason?

11 A. Yes.

12 Q. Actually, the fever -- okay; all right. Now, you  
13 talked about if she had had a fever that her heart rate would  
14 have gone up and these sorts of things, and did you bring --  
15 did you bring any authority for this ten degree -- this ten  
16 beats per degree, or whatever that was you said?

17 A. You mean the rise in the heart rate? Did I bring any  
18 authority? No. I'm sure I could find literature that support  
19 that statement.

20 Q. Okay. Let me ask you this. The truth is, if you  
21 looked in -- if you looked in the Physician's Desk Reference,  
22 or anywhere where these drugs are talked about, Dilaudid will  
23 lower your heart rate and respiration rate, will it not, and  
24 sometimes blood pressure?

25 A. Well, when people have pain, they usually have

1       When somebody comes in with chest pain and you work them  
2 up and you find out that it's not a heart-related issue, I  
3 have the same conversation with them, that if the pain gets  
4 worse, it changes suddenly, if you have any new symptoms like  
5 fevers or shortness of breath, you need to come back  
6 immediately.

7       In cases of kidney stones, especially in cases where you  
8 have a high degree of obstruction, you want them to be aware  
9 of what they need to return for, and that's why I recall that  
10 conversation.

11      Q.       All right, and again, you were worried about infection  
12 or obstruction, correct?

13      A.       It's always a concern when you have a kidney stone.

14      Q.       But the only thing that you did to rule out infection  
15 was to have a dipstick urinalysis, correct?

16      A.       That's correct.

17      Q.       All right, and there's a thermometer in every room, is  
18 there not?

19      A.       That's correct.

20      Q.       So a fever and kidney stone is an emergency, correct?

21      A.       Yes.

22      Q.       And, Dr. Law, ultimately it's your duty, is it not,  
23 it's your ultimate responsibility to determine whether or not  
24 the patient is stable for discharge?

25      A.       Yes.



1 Q. And then you tell the nurse to go discharge the  
2 patient, correct?

3 A. Yes.

4 Q. Did you ever look at this nurse's chart before you  
5 discharged Kelly Fay and sent her home?

6 A. I imagine I was looking at that as -- when I was doing  
7 her dictation, yes. It's -- typically what would happen is I  
8 would take the chart and go to dictate it, ---

9 Q. Okay.

10 A. --- so can I say specifically that I looked exactly at  
11 that sheet, I can't say with a hundred percent certainty.

12 Q. All right, but you knew nobody had ever taken her  
13 temperature since she got there, hadn't you?

14 A. Again, at that time, I can't say yes or no.

15 Q. Well, if a kidney stone and a fever is an emergency,  
16 you'd agree, would you not, that you had a duty to know  
17 whether or not she had a fever before you said she was stable  
18 to send home?

19 A. Well, most adults when they have a fever can tell you  
20 that they have a fever. Also, you do get vital sign  
21 alterations and you had people actually making physical  
22 contact with Kelly, and there has been a lot of literature  
23 that has been printed about the ability to determine by touch  
24 whether somebody has a fever or not.

25 Q. Are you saying Kelly is supposed to be taking care of

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1 herself in the emergency room?

2 A. No, but most adults will tell you that I feel feverish,  
3 or I feel like I'm coming down with a fever.

4 Q. But everybody with a fever doesn't feel hot, do they?

5 A. No.

6 Q. And everybody -- people with a fever can feel cold,  
7 correct?

8 A. Yes. You can have shaking chills with it.

9 Q. And you can have shaking chills, and everybody with a  
10 fever doesn't necessarily have to be sweating or diaphoretic,  
11 do they?

12 A. No. It's -- when I say that, I say that as part of --  
13 when patients have their complaints of a fever, if she had  
14 complained of a fever, we would have rechecked her  
15 temperature.

16 Q. The truth is, Dr. Law, if a fever and kidney stone or  
17 an infection and a kidney stone is a true urologic emergency,  
18 she needed to be admitted to the hospital on Saturday. The  
19 most important vital sign she could have had checked during  
20 her four hour stay in the emergency room was her temperature,  
21 was it not?

22 A. In order to determine if somebody has a fever, you have  
23 to take their temperature.

24 Q. All right, and that would be the most important vital  
25 sign that should have been checked, correct, with her

1 presentation?

2 A. With her presentation, another set of -- another  
3 temperature should have been checked.

4 Q. Did you ever order the nurses to do it?

5 A. No.

6 Q. Did you think they had done it?

7 A. At the time, I'm not certain.

8 Q. Now, if anybody had checked and told you that Kelly had  
9 a fever before she left, you wouldn't have let her leave,  
10 would you?

11 A. No.

12 Q. You would have called Dr. Young and said you need to  
13 come down and admit her and get her to the O.R., correct?

14 A. Yes.

15 Q. Now, the test that you could have done to suggest  
16 infection, other than taking her temperature to see if she had  
17 a fever, would be a CBC, correct, to see if there were any  
18 white blood cells in her blood?

19 A. Well, the CBC is -- the CBC is probably the least  
20 useful test, and even Dr. Sheppard testified to that. It's  
21 one of the least useful tests we have in the emergency  
22 department.

23 Q. Okay. You could have done a blood culture or a urine  
24 culture and at least you would have had a preliminary report  
25 by the next morning, correct?

1 A. I typically don't order tests that I can't follow up  
2 on, and the reason being is a preliminary result on a urine  
3 culture or blood culture takes at least twenty-four hours.  
4 You may have either contamination in those or you may have a  
5 reading that's initially negative at twenty-four hours. If  
6 I'm going to order a test, it's going to have to be something  
7 that I can follow up on and have the result on with given the  
8 information that I have there available to me.

9 Q. Okay, and you told the jury a while ago you didn't know  
10 if there was extravasation or not?

11 A. Based upon my documentation, I don't think that there  
12 was extravasation, or at least I don't think that information  
13 was relayed to me.

14 Q. Okay, and you remember Dr. Chomyn's deposition,  
15 correct?

16 A. That's correct.

17 Q. So even if he dictated this the next day, even if he  
18 saw it the next day, it would have been sent to the emergency  
19 room, correct?

20 A. That note?

21 Q. Yes sir.

22 A. Yeah.

23 Q. And if you weren't there, there was another E.R.  
24 physician there, correct?

25 A. Correct.

1 Q. At -- for Grand Strand?

2 A. Yes.

3 Q. That would have worked at Grand Strand?

4 A. Either that or Conway, yes.

5 Q. Okay, and if that were the case -- if that were the  
6 case, that he didn't tell you that on the phone, then whoever  
7 -- whoever got that should have picked up the phone and called  
8 them and told them, correct, maybe you need to come in and be  
9 looked at?

10 A. For the extravasation, not necessarily. It doesn't --  
11 I mean, sometimes you'll see a small amount of extravasation  
12 with a kidney stone. That doesn't make or break whether  
13 somebody needs to come in or not.

14 Q. Okay. Well, when that urine -- all right, let's talk  
15 about it for a second, extravasation. What happens is when  
16 you've got an obstruction, a complete obstruction, the urine  
17 builds up pressure behind that stone in the ureter, correct?

18 A. Yes.

19 Q. And then it goes into the kidney and swells up the  
20 kidney, correct?

21 A. Yes.

22 Q. And then at some point there's a little place up at the  
23 top in the ureter where it pops and that urine goes out,  
24 right, ---

25 A. That's correct.

1 Q. --- into the retroperitoneal cavity, ---

2 A. Yes.

3 Q. --- correct, and when that urine leaks out into the  
4 retroperitoneal cavity, that is a perfect place or a very good  
5 place for bacteria to grow, isn't it?

6 A. Any time that you have an area that you don't have  
7 movement around, yes, you can have bacterial growth in there.  
8 I wouldn't call it the most perfect milieu to grow bacteria  
9 in, but it is -- it can grow there.

10 Q. Haven't you previously testified that it's a very good  
11 place for it to grow?

12 A. Yes.

13 Q. Okay, and the same would be true for the urine that's  
14 backed up in her ureter before it leaks out, but what's left  
15 sitting there in the ureter, that's static urine, too, isn't  
16 it?

17 A. Yes.

18 Q. And that's a really good place for an infection to  
19 start, isn't it?

20 A. It can be, yes.

21 Q. Okay, and if -- if -- you didn't know whether or not  
22 the kidney stone had bacteria in it, did you?

23 A. No.

24 Q. You didn't have the stone, right?

25 A. That's correct.

1 Q. So if the kidney stone has bacteria in it, then it  
2 starts to grow, doesn't it, starts to multiply in that static  
3 urine?

4 A. If you're talking about like a struvite stone or a  
5 stone that has bacteria as part of its composition, yes.

6 Q. Okay, in any stone -- I mean, a calcium oxalate stone  
7 can have bacteria in it, correct?

8 A. It can, but it's less likely to have. It's not ---

9 Q. It's less likely. A struvite stone, on the other hand,  
10 is also called an infection stone, isn't it?

11 A. I haven't heard it referred to that.

12 Q. You've never heard it referred to as an infection  
13 stone?

14 A. Well, struvite stones are created because of how the  
15 bacteria splits urea, and what happens is that urea because  
16 it's got a -- it's -- it will attract other -- other cations  
17 to it and start forming the stone, and so you will have a  
18 stone that's starting to build up around this area of  
19 colonization.

20 Q. And the main bacteria or the primary bacteria, or maybe  
21 the only bacteria, you tell me, that is contained within a  
22 struvite stone is proteus mirabilis, isn't it?

23 A. Proteus has been known to form struvite stones, yes.

24 Q. Okay. Proteus makes struvite stones, and, in fact, in  
25 your differential diagnosis of the pyelonephritis, that's what

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1 she -- that was part of the chain of what she died from,  
2 correct?

3 A. Yes.

4 Q. And the truth is, Dr. Law, when you -- even when you  
5 ordered that dipstick, that was done to look for blood and not  
6 infection, correct?

7 A. When you're doing a dipstick analysis on somebody,  
8 you're not just looking at one thing in isolation.

9 Q. The reason you ordered it, truthfully, is to look for  
10 blood, not infection, correct?

11 A. I wanted to see if there was blood in her urine, yes.

12 Q. Okay, and you'll agree with me, will you not, Dr. Law,  
13 that basically she had a stone before and you were treating  
14 this like your everyday stone that you see all the time,  
15 correct?

16 A. I don't think that's a fair characterization, no. I  
17 mean, when people come in, yes, we do see common things happen  
18 commonly, but sometimes patients' presentations will change.  
19 Sometimes there will be other things on their clinical exam  
20 that will change, and is it routine? Is it something we see  
21 on an everyday basis? Yes. Do I just say, oh, this is just  
22 another kidney stone. I can just circle off the lab tests and  
23 just leave it at that, no.

24 Q. Well, let me ask you this. If a patient comes in with  
25 a small kidney stone, let's say a two or three millimeter



1 stone that's in their ureter somewhere, that you believe is  
2 probably going to pass, right, on its own if you just give it  
3 some time and drink fluids? All kidney -- you're still going  
4 to do a urinalysis on that patient, correct?

5 A. Yes.

6 Q. All kidney stone patients get a urinalysis?

7 A. Yes.

8 Q. All kidney stone patients are going to get a KUB?

9 A. Not necessarily, no.

10 Q. Well, they all get a CT, ---

11 A. For the most part, yes.

12 Q. --- correct?

13 A. The only -- the only time that there's an exception to  
14 that is sometimes people will come back in and either if on  
15 previous visits of if they've seen a urologist and they say,  
16 look, I've got a stone; I know how big it is. Then the CT  
17 scan is not ordered, or the KUB is not ordered, but sometimes  
18 the KUB is ordered only just to go -- to see if the stone has  
19 moved at all if we have any previous records on the patient.

20 Q. What did you do extra for Kelly with the knowledge that  
21 it was probably not going to pass, that it was at least  
22 moderately obstructing, that you had diagnosed severe  
23 hydroureter, ---

24 A. Right.

25 Q. --- that she had mild pyelonephrosis, and all those

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1 other things, extravasation of urine. What did you do extra  
2 for Kelly that you wouldn't do for the run of the mill,  
3 average, everyday kidney stone?

4 A. That's a -- that's a very good question, and the  
5 difference is that I called the urologist to make sure that  
6 she could get followed up closely.

7 Q. Okay, so you and he -- you called up and y'all  
8 discussed her case, correct?

9 A. Typically when I call a consultant or call a specialist  
10 to see a patient as an outpatient, there's a couple of things  
11 that I want to know. I didn't know if Dr. Young was going on  
12 vacation next week. I wanted to make sure that he could  
13 follow up with her. I just wanted to sort of just give him a  
14 thumbnail sketch of the case so he would know what to expect  
15 when she came into the office.

16 Q. And you heard the excerpts we read yesterday out of  
17 your and Dr. Young's depositions, correct?

18 A. Yes.

19 Q. You'll agree with me, will you not, Dr. Law, that was a  
20 joint decision that she was -- that you could send her home?

21 A. By the time that I had called Dr. Young in this case, I  
22 had already made the decision that she could probably go home,  
23 and the main portion of my phone call in calling him was to  
24 make sure that he could closely follow her up.

25 Q. I'm not talking about the main portion. I'm just

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1 asking about the portions that I'm asking about now. Wouldn't  
2 you agree with me that that was a joint decision between the  
3 two of you that she could wait until Monday to be seen?

4 A. Yes.

5 Q. Okay, and you were very specific with Sean that you  
6 wanted -- that you wanted him to call the urologist around  
7 eight-thirty Monday morning?

8 A. Right, so she could get an appointment for that day.

9 Q. Okay, and you wanted her to be seen as soon as  
10 possible, did you not?

11 A. Within, you know, the next few days, yes.

12 Q. Okay, and had Kelly -- the truth is if Kelly had been  
13 seen on any other day than Saturday, she most likely would be  
14 alive today, wouldn't she?

15 A. Most likely, yes.

16 Q. Because if she had been seen on Sunday, she would have  
17 seen Dr. Law (sic) the very next day?

18 A. Dr. Young.

19 Q. Dr. Young the very next day?

20 A. Yes.

21 Q. Or if Dr. Law (sic) had come in on Saturday and drained  
22 that obstruc- -- had gotten rid of that obstruction, she would  
23 be alive today, would she not?

24 A. Meaning Dr. Young, yes.

25 Q. Did the nurse that drew the two vials of blood ever

1 tell you that she drew two vials of blood?

2 A. No. That's fairly standard practice for most nurses.  
3 Usually when you are going to start an IV on a patient, you're  
4 going to draw what they call in the business a rainbow, which  
5 is usually tubes of various colors that they'll sometimes, you  
6 know, draw.

7 A CBC usually comes in a purple top, and a chemistry  
8 panel usually comes in a red top. If the patient is on  
9 certain medication, sometimes a blue top will also be drawn,  
10 but -- and if the patient is running a fever, they'll also  
11 draw blood cultures at the same time just so they don't have  
12 to go back and re-stick the patient for more blood.

13 Q. All right. Now, a rainbow is four tubes of blood,  
14 though, right?

15 A. Right, and in Kelly's case, the nurses had drawn two  
16 tubes of blood.

17 Q. Okay, and that would just be for a CBC and a chem  
18 panel, right, like you originally testified was the standard  
19 protocol for a kidney stone?

20 A. Yes, initially I did testify to that.

21 Q. All right. Now, you also told me that hydroureter  
22 means that there is an impacted stone with a column of urine  
23 behind it. That's the way you described it, correct?

24 A. Yes.

25 Q. All right. Now, so you knew there was obstruction

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1 making her nauseous, she should -- or is causing her to have  
2 vomiting, she should come back in.

3 Q. Okay, and back to this thing with Dr. Young, y'all both  
4 agreed on the phone, did you not, that based on her age and  
5 her health, which was good, was it not, ---

6 A. Yes.

7 Q. --- that she ought to be okay until Monday since her  
8 pain was under control, ---

9 A. Right.

10 Q. --- isn't that correct?

11 A. Yes.

12 Q. So then the burden of monitoring Kelly until Monday,  
13 y'all were putting on Kelly, correct, and/or Sean?

14 A. And Sean, yeah.

15 Q. Did you ever -- before you discharged them, did you  
16 ever tell Kelly and Sean that Sean should sit with her, or  
17 stay home from work, or sit with her twenty-four hours a day  
18 and watch over her like this?

19 A. That wouldn't be part of my -- my discharge  
20 instructions, no.

21 Q. Did you ever tell Sean or Kelly before you sent Kelly  
22 home that day, that look, if you get a fever and kidney stone,  
23 that's an emer- -- you could die from that? I mean, that's  
24 serious. That's an emergency.

25 A. Did I use those words, no, but did I tell them to

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1 return if she had a fever, yes.

2 Q. But you also told her to return if she had nausea,  
3 right?

4 A. Right.

5 Q. Okay, but you never -- you never told them it was an  
6 emergency, correct?

7 A. I told them the reasons to return to the emergency  
8 department.

9 Q. You never told them it was an emergency, correct?

10 A. Again, no, I didn't tell them it was an emergency, but  
11 I did tell them that if she develops a fever, she needs to  
12 come back in.

13 Q. You never told her she could die from it, did you?

14 A. Not to my knowledge, no.

15 Q. All right, but do you know of anybody else that  
16 stressed the urgency if a fever or chills developed of them  
17 getting back to the hospital?

18 A. Just me.

19 Q. But you didn't -- didn't tell them either one of those  
20 words?

21 A. Did I say that she was going to die if she developed a  
22 fever with a kidney stone?

23 Q. Yes sir.

24 A. No, I did not say that.

25 Q. Now, also before she left, she was made to sign over

1 papers, correct, that were allowing the hospital to send her  
2 records to Dr. Young, correct?

3 A. That's correct.

4 Q. So he had asked to see her on Monday, had he not?

5 A. Uh huh (**indicating positive**).

6 Q. And she agreed to see him on Monday, by her signature,  
7 before she left the hospital, had -- did she not?

8 A. That's correct.

9 Q. And then they did, in fact, -- and then you also copied  
10 Dr. Young on your dictation, did you not?

11 A. Yes.

12 Q. Okay. Now, let me ask you this. When Dr. Young  
13 called, Dr. Law, you do agree with me, do you not, that it had  
14 to be after ten-twenty A.M. in the morning?

15 A. Yes, because that would be when the patient returned  
16 from CAT scan.

17 Q. Okay, so you talked to him after that, and Dr. Young  
18 was aware of the CT results, correct?

19 A. He was aware of the CT results as I knew the CT  
20 results.

21 Q. All right. Now, you heard the testimony of the  
22 experts, ---

23 A. Yes.

24 Q. --- that you've been sitting in court all week? What  
25 happened? Did you tell Dr. Young that she did not have a

1 fever or did he even ask?

2 A. I don't believe he asked. That wouldn't be -- but I  
3 would mention to him as part of my discussion the patient is  
4 afebrile, which means without a fever, and that she has stable  
5 vital signs, and that I believe that she could be discharged  
6 home.

7 Q. Dr. Law, the truth is if you told him she was afebrile,  
8 that was not true, was it, unless you told him she was  
9 afebrile at eight o'clock in the morning because nobody knew  
10 what her temperature was after eight o'clock in the morning?

11 A. That's correct. To -- you know, we don't have a  
12 number. We don't have a number to show you or the jury that  
13 this was her temperature at discharge. We have other  
14 information based on her clinical exam and based upon her  
15 other vital signs that she did not have a fever at discharge.

16 Q. All of which could be affected by medication?

17 A. Yes.

18 Q. And I think you agree there's a thermometer in every  
19 room and it doesn't cost anything to stick a thermometer in  
20 their mouth, does it?

21 A. That is correct.

22 Q. And it was hospital policy, was it not, on abdominal  
23 pain patients they get at least two sets of vitals?

24 A. Right.

25 Q. Everybody agrees temperature is a vital?



1 A. Yes, it is.

2 Q. Now, let's get into Monday. When Kelly came back to  
3 the hospital on Monday, Dr. Young, -- Dr. Law, you were there  
4 at the hospital working, correct?

5 A. I was coming in for a three o'clock shift.

6 Q. And I think at that point Dr. Hocker and Dr. Chi were  
7 working with Kelly when she came in?

8 A. Yes, they had -- Dr. Hocker was one of my partners who  
9 had seen Kelly and was taking care of her.

10 Q. And he had called in Dr. Chi, correct?

11 A. Dr. Chi was one of the hospital's -- at the hospital,  
12 and I guess he was on call for internal medicine that day or  
13 was admitting patients who didn't have physicians.

14 Q. Right. He was a hospitalist. I mean, his specialty  
15 was internal medicine, correct?

16 A. Well, hospitalists are -- they're a group of internists  
17 who specialize only in taking care of patients at a hospital.  
18 They don't have an outside practice with an office, and the  
19 beneficial thing about a hospitalist is usually somebody from  
20 the group is in the hospital twenty-four hours a day.

21 Q. Okay, and when -- when he -- when she came in, Sean, to  
22 the best of your -- to the best of your recollection, was not  
23 there, was he, because he was following the ambulance?

24 A. I'm not certain about the timing of that. I mean, I  
25 had come in at three o'clock, and I think Kelly came in a

1 little bit before three.

2 Q. Okay, but you talked to Dr. Chi and gave him some  
3 historical facts ---

4 A. Yes.

5 Q. --- from Saturday, correct?

6 A. That's correct.

7 Q. Now, and then things took place like they did and we  
8 know what happened, do we not, on Sunday night. Now, after --  
9 I mean on Monday night. Now, after Monday night, you, and Dr.  
10 Young, and Dr. Molnar, went over to South Strand -- or did you  
11 have to go over to South Strand? Could you just pull the  
12 records up at Grand Strand?

13 A. We could pull up the records electronically at Grand  
14 Strand.

15 Q. Okay, so y'all got -- y'all got together and you pulled  
16 up the records to look at them to see if you did anything  
17 wrong, correct?

18 A. Well, what I asked Dr. Molnar to do is to review the  
19 chart. Any time that you have an unexpected outcome or an  
20 unexpected death in the emergency department, you want  
21 somebody else to take a look at the chart to see if there was  
22 anything that either is wrong with the diagnostic work-up or  
23 was questionable about the presentation.

24 I didn't -- I think you're giving the impression that  
25 when we met, all three of us together. I had met with Dr.

1 Molnar independently of Dr. Young. I had spoken to Dr. Young  
2 sort of casually, not actually sitting down in a formal  
3 meeting, about the case.

4 Q. Okay, but the three of y'all -- but the three of y'all,  
5 whether you met together or apart, were concerned enough  
6 whether maybe you had done something wrong that you went and  
7 looked at the records, correct?

8 A. Yes.

9 Q. And then on this typewritten report on Kelly, you did  
10 not electronically sign it until three weeks after she died,  
11 and you knew she had died, correct?

12 A. That's correct.

13 Q. Electronically signed on two -- February 18th, '02,  
14 correct?

15 A. That's correct.

16 Q. And if you had so chosen, you had the opportunity to  
17 change that report, did you not?

18 A. Yes.

19 Q. If you -- I mean, you pulled it up and looked at it,  
20 right?

21 A. Right.

22 Q. And if you wanted to put this last paragraph in here or  
23 change something in that paragraph, or this paragraph, or this  
24 paragraph, you could change it, couldn't you?

25 A. Yes, I could, but your implication is that I did, and I

1 don't agree with that.

2 Q. Okay. I'm just asking you if you could?

3 A. Yes, I could.

4 Q. And -- all right. And sometimes they're just signed  
5 off as is, and sometimes you amend them, don't you?

6 A. That's correct.

7 Q. And as far as your conversation with Dr. Young, Dr.  
8 Law, if Kelly was going to be admitted on Saturday, that would  
9 have had to have been Dr. Young to admit her? You couldn't do  
10 that? You don't have those rights at the hospital?

11 A. Emergency department physicians don't have admitting  
12 privileges. We don't admit people to the hospital and then go  
13 up to the floors and see them. Our basis of practice is only  
14 in the emergency department.

15 Q. And I forgot; there was something I wanted to ask you  
16 about, too. You were talking about how people -- sending  
17 people home on antibiotics sometimes, although it's rare, have  
18 allergic reactions to antibiotics?

19 A. That's correct.

20 Q. She had written no allergies, correct?

21 A. Correct.

22 Q. And isn't it also true, Dr. Law, that if a person has a  
23 reaction to an antibiotic, the first time usually it's pretty  
24 mild, isn't it?

25 A. It depends.

1 keep just the small pieces of paper when there's other --  
2 other records that agree with it.

3 Q. Haven't you seen those in other medical records,  
4 though, those little slips?

5 A. I have, yes.

6 Q. Okay, but is there -- have you seen one in the medical  
7 records here?

8 A. I have not.

9 Q. Can you agree that if Kelly's temperature had been  
10 taken before she left the hospital and it was over a hundred  
11 point four, she would have been admitted, correct?

12 A. Yes.

13 Q. It didn't have to be a hundred and one point two, or  
14 three, or four, ---

15 A. No.

16 Q. --- or five, or six?

17 A. No.

18 Q. In fact, Dr. Law, the truth is if her temperature had  
19 been taken again and it was trending up, you would have kept  
20 her in the hospital to see what was going on with her  
21 temperature, wouldn't you?

22 A. If it was -- let's say if her repeat temperature was  
23 ninety-eight point two, no, I don't think I would have kept  
24 her in the hospital, even though that is trending up. If it  
25 was above a hundred degrees or ---

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CROSS BY SCALISE

1 Q. Based on your knowledge of the way that the emergency  
2 room functions at Grand Strand, were they open twenty-four  
3 hours a day?

4 A. Yes.

5 Q. If, in fact, Sean Fay had brought his wife back to the  
6 emergency room Sunday morning, would there have been someone  
7 there to see her as a patient?

8 A. Absolutely.

9 Q. Would there have been someone there Sunday night?

10 A. Yes.

11 Q. Would there have been someone there Monday morning?

12 A. Yes.

13 **MR. LEE:** One moment, Your Honor.

14 Nothing further, Your Honor.

15 **THE COURT:** Very good.

16 Would you like to proceed now with Cross?

17 **MS. SCALISE:** Yes sir.

18 **THE COURT:** Go ahead. Cross-examination.

19 **CROSS-EXAMINATION BY MS. SCALISE:**

20 Q. Dr. Law, as I've understood your testimony, before you  
21 called Dr. Young, you had already obtained a history, already  
22 obtained lab work, already obtained vital signs, already done  
23 radiology studies, and you actually had already decided that  
24 this patient was stable for discharge?

25 A. That's correct.

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1 Q. All right, so you had made all those decisions, had all  
2 that information before you ever called Dr. Young, is that  
3 right?

4 A. That's correct.

5 Q. All right, and, in fact, when you called Dr. Young,  
6 were you calling to get his advice on Kelly Fay?

7 A. No. I was pretty much calling to make sure that she  
8 could get closely followed up.

9 Q. Okay. Were you calling Dr. Young to come in and  
10 evaluate this patient?

11 A. No.

12 Q. Were you calling Dr. Young to admit this patient?

13 A. No.

14 Q. And, in fact, I believe it's your testimony that there  
15 was nothing about her presentation that morning that led you  
16 to believe she needed to be admitted, is that right?

17 A. That's correct.

18 Q. And is that your opinion even still today? Looking  
19 back at what you knew at that time, was there anything about  
20 her presentation where she should have been admitted?

21 A. Given the same scenario, given the same patient, given  
22 the same information that I had available to me, I would still  
23 make the same decision to send her home.

24 Q. All right, and we talked about -- actually, let me go  
25 back and ask you -- you were shown this tubing?

1 A. Correct.

2 Q. Does the ureter -- is it -- does it have this same  
3 consistency as this tubing?

4 A. No.

5 Q. And you were asked questions and I think you had agreed  
6 that this particular tube from the inside was a little --  
7 somewhere between two and three millimeters?

8 A. That's correct.

9 Q. And if you -- and I guess if you take the Plaintiff's  
10 theory, their theory would be anything greater than this two  
11 or three millimeters would totally obstruct the ureter? Is  
12 that kind of their theory as you understand it?

13 A. As I understand it, yes, and it's not consistent with  
14 what goes on anatomically.

15 **MR. FOSTER:** We would object to the speculation about  
16 our theory, Your Honor.

17 **THE COURT:** Overruled.

18 A. Typically the human anatomy or the ureter itself is not  
19 just a straight tube. It actually changes in diameter  
20 depending upon where you are in the urinary collecting system.  
21 It's also elastic, where this tube has some elasticity to it,  
22 but the elasticity of the ureter is actually a little bit more  
23 than what you are seeing right here.

24 Also, the wall of the ureter has muscles in it to allow  
25 it to have the peristaltic wave, and so trying to make a



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1 direct comparison to a tube, while it's good for a visual aid,  
2 it doesn't really completely capture what you're trying to  
3 express.

4 Q. All right, and as I -- I understand the theory, if the  
5 Plaintiff -- they're saying that any stone greater than two or  
6 three millimeters, that that would be an obvious obstruction,  
7 total complete obstruction, such that the patient would have  
8 to be admitted. Is that how you understand that theory to be?

9 A. Well, again, completely -- even when patients have  
10 complete obstructions, they don't necessarily need to be  
11 admitted to the hospital. While that's a factor to consider,  
12 it's not the end all-be all. It's not -- there's only a few  
13 certain things with -- in regards to kidney stones that keep  
14 you in the hospital.

15 Again, one of them, of course, is fever. I think  
16 everybody is in agreement with that. One of them is if -- if  
17 I can send her home with pain medication and the pain  
18 medication is not going to help her pain or give her enough  
19 relief, then she needs to come back in for IV pain medication,  
20 or if you develop an infection with the stone, then you need  
21 to come back in.

22 Q. How frequently do you see patients that have kidney  
23 stones?

24 A. I would guess that it averaged out to about one a  
25 shift, so it's a pretty frequent reason for people to come to

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1 the emergency department.

2 Q. All right. So in your career, how many kidney stone  
3 patients would you have seen?

4 A. Probably thousands.

5 Q. All right, and in those thousands, have there been  
6 kidney stones that are greater than three millimeters?

7 A. Yes.

8 Q. And are every single one of those patients admitted?

9 A. No.

10 Q. All right, and, Doctor, every single one of those  
11 patients, do they have a stent immediately placed?

12 A. No.

13 Q. Are every single one of those patients given  
14 antibiotics if they are going home?

15 A. No.

16 Q. I want to talk to you about the conversation that you  
17 had with Dr. Young, and I believe you testified that that was  
18 for follow-up, correct?

19 A. Yes.

20 Q. And you said that you gave him a thumbnail sketch. As  
21 I understand your testimony, you would have told him that this  
22 was a five millimeter kidney stone, is that correct?

23 A. Yes.

24 Q. You would have told him that it was in the right UPJ?

25 A. Yes.

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1 Q. You would have told him that it was moderately to  
2 severely obstructing?

3 A. Yes.

4 Q. You would have told him that her pain was well-  
5 controlled?

6 A. Yes.

7 Q. And you would have told him that the patient was  
8 afebrile?

9 A. Yes.

10 Q. You would have told him that the lab was normal?

11 A. Uh huh (**indicating positive**) -- yes.

12 Q. And that you planned to send her home?

13 A. Yes.

14 Q. All right. Now, let's talk about in particular this --  
15 this topic of afebrile. Have you ever in your entire career  
16 ever had a physician when you tell them that the patient is  
17 afebrile the doctor questions you, well, what time was that  
18 temperature taken?

19 A. No. I've never had that occur.

20 Q. Have you ever in your career ever had a physician  
21 question you when you say a patient is afebrile that says,  
22 well, make sure you take a discharge temperature?

23 A. No.

24 Q. So if Dr. Young did not specifically ask you what time  
25 that temperature was taken, does that mean he did something

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1 wrong?

2 A. No. It means he didn't ask and I wouldn't expect him  
3 to ask.

4 Q. And, in fact, the information you gave him, he has a  
5 right to rely on that, doesn't he?

6 A. Yes.

7 Q. And the information you gave him was accurate as far as  
8 you knew, correct?

9 A. That's correct.

10 Q. Now, did Dr. Young specifically say to you I agree she  
11 can go home, or was he telling you, just have her call my  
12 office on Monday at eight-thirty to make an appointment?

13 A. I don't recall specifically, but typically when I call  
14 a consultant like that, I'm basically trying to assure that  
15 the patient can get followed up, and again I earlier testified  
16 that what I was trying to do is to make sure that he would  
17 have time available on Monday to see her and also that he was  
18 going to be in town.

19 I didn't know if he was going to be going on vacation, or  
20 if he was going to be in the O.R. those first couple of days  
21 of the week. Essentially it was to make sure that I could  
22 safely send -- you know, have him as the referral physician  
23 for follow-up.

24 Q. Okay, and was this an agreement to see her in the  
25 future?

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1 A. Yes.

2 Q. And when you saw Kelly, you talked about the different  
3 times that you saw her in the off- -- I mean in the E.R., did  
4 she ever appear sweaty to you?

5 A. No.

6 Q. Did she ever look flushed?

7 A. No.

8 Q. Did she ever have shaking chills?

9 A. No.

10 Q. Did she ever complain to you that she was cold?

11 A. No.

12 Q. Did she ever complain that she was hot?

13 A. No.

14 Q. Did she ever say that I feel feverish?

15 A. No.

16 Q. And if a patient is having symptoms like that, would  
17 you expect a patient to tell you that they were having those  
18 problems?

19 A. Yes.

20 Q. And when you left Kelly and Sean and you talked about  
21 the information that you went over with them and the  
22 instructions that you gave them, and we are all familiar with  
23 that, was there any question in your mind that Kelly or Sean  
24 didn't understand what you were telling them?

25 A. No.

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JURY OUT

1 Q. Is there any question in your mind that they weren't  
2 competent to understand you?

3 A. No.

4 Q. And, in fact, do you believe that they understood that  
5 they were to return immediately if they had any of these  
6 problems?

7 A. That was my understanding, yes.

8 Q. Okay, and, in fact, did the Fays follow your  
9 instructions?

10 A. No.

11 **MS. SCALISE:** That's all I have. Thank you.

12 A. You're welcome.

13 **MR. FOSTER:** Briefly, Your Honor?

14 **MR. AIKEN:** No questions. There's no redirect.

15 **THE COURT:** Very good. Then that would conclude the  
16 questioning of the witness.

17 Sir, you are free to step down. Thank you.

18 All right, ladies and gentlemen, let's take our lunch  
19 break at this time. Let's break until two o'clock. I'll ask  
20 you to be back in the jury room at two and we will proceed  
21 still in the Defendants' cases at that time.

22 Let's all remain where we are while our jury departs the  
23 courtroom.

24 Have a nice lunch, ladies and gentlemen.

25 **(THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE**

JURY OUT/ON RECORD  
JURY IN

1 JURY.)

2 THE COURT: Do you intend to rest at this time or you  
3 have an expert witness as well?

4 MR. AIKEN: I have an expert witness.

5 THE COURT: Is he ready to go next?

6 MR. AIKEN: No sir. He's tomorrow.

7 THE COURT: Very good.

8 Are we going to take Dr. Young next?

9 MS. SCALISE: Actually, we have Dr. Maxted because he  
10 has a flight.

11 THE COURT: All right, very good. Then we'll be  
12 prepared to do that at two o'clock.

13 MR. TODD: Your Honor, for scheduling, we have a nurse  
14 here who's ready to go, and, of course, Dr. Young is here,  
15 so ...

16 THE COURT: All right. Well, we'll be back at two.  
17 Court is in recess until that time.

18 (THE FOLLOWING TAKES PLACE AFTER A LUNCH BREAK AND  
19 OUTSIDE THE PRESENCE OF THE JURY.)

20 THE COURT: All right, are we ready for the jury? (No  
21 response.) Then hearing no objection, please bring in the  
22 jury.

23 (THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE  
24 JURY.)

25 THE COURT: All right, welcome back. I trust you had a

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1 nice lunch, ladies and gentlemen, and you will recall we're in  
2 the Defendants' case.

3 And please call your next witness.

4 **MS. SCALISE:** Thank you, Your Honor.

5 We would call Dr. William Maxted.

6 **THE COURT:** Please come forward and take the oath of a  
7 witness.

8 **WILLIAM C. MAXTED, M.D.,** being first duly sworn,  
9 states as follows:

10 **DIRECT-EXAMINATION BY MS. SCALISE:**

11 Q. Dr. Maxted, you have a very soft voice, so if you will  
12 stay near the microphone, that will be great.

13 **MS. SCALISE:** And I guess if anybody can't hear him, if  
14 y'all will just kind of raise your hand and let him know,  
15 we'll make sure that they hear.

16 Q. Dr. Maxted, tell the jury a little bit about yourself.  
17 Where do you live?

18 A. I live in McLean, Virginia, which is a suburb of  
19 Washington, D.C.

20 Q. And are you married?

21 A. I am, but unfortunately my wife is deceased from  
22 malignancy.

23 Q. Okay; sorry about that. Tell us about children; do you  
24 have children or grandchildren?

25 A. I have three children, and I have five grandchildren.



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1 Q. Tell the jury about your education, starting, I guess,  
2 in college, where you went from there.

3 A. I received a Bachelor of Science degree from Georgetown  
4 University, went on to the School of Medicine at Georgetown  
5 and received my Doctor of Medicine degree from Georgetown in  
6 1954. Then I did my first post-graduate year up in Buffalo,  
7 New York, and following that, I had two years in the United  
8 States Air Force over in England. That was an era when all  
9 physicians had to go into the military for a two year period  
10 of time.

11 After I completed my military obligation, returned to  
12 Georgetown at Washington and began my urology residency. That  
13 was in 1957, and completed my residency in 1961 and was  
14 invited to stay on the faculty. I did. I'm still there and  
15 still active.

16 Q. Let's talk about that for a second. As far as  
17 Georgetown, for those who might not be familiar, where --  
18 where is Georgetown University located?

19 A. Sorry. Georgetown University is in Washington,  
20 Washington, D.C.

21 Q. All right, and I think you said that you're still at  
22 Georgetown, correct?

23 A. I am still at Georgetown.

24 Q. All right, so are you -- do you still actively  
25 practice?

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1 A. Yes, I am.

2 Q. And do you actively teach?

3 A. Yes, I am still teaching.

4 Q. Do you -- are you still operating?

5 A. And I am still operating, limited, none of the newest  
6 technology, but the technology that I grew up with and  
7 practiced for my lifetime, yes, still doing.

8 Q. And in your career, have you received any honors or  
9 awards?

10 A. I'll summarize that with awards in two areas. I  
11 received the Presidential Medal from the President of  
12 Georgetown University for my service to the university at the  
13 time that I stepped out -- which I didn't mention. I served  
14 as Dean of the School of Medicine for nine years, came out of  
15 that position in 1998, and prior to that, by the way, I had  
16 been Chairman of the Division of Urology from 1976 until 1998,  
17 and I think important to note, too, in that responsibility was  
18 Chairmanship and responsible for the urologic care of the  
19 Washington Veterans Administration Hospital.

20 And then I -- another award that I received was election  
21 to the Magis, that's M-A-G-I-S, Society, which is a society  
22 recognizing teachers outstanding over an extended period of  
23 time.

24 Q. Are you board certified?

25 A. I am.

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1 Q. Okay, in what area?

2 A. Urology.

3 Q. All right, and did you pass your boards the first time?

4 A. I did.

5 Q. And also, tell the jury have your privileges at any  
6 hospital ever been suspended, revoked, limited in any manner?

7 A. They have not been.

8 Q. And as far as your medical license to practice  
9 medicine, has that license ever been suspended, revoked,  
10 limited in any manner?

11 A. I have two and neither of them have.

12 Q. Okay, and by two, meaning they are from different  
13 states?

14 A. Yes. I'm sorry, uh huh.

15 Q. As far as your teaching responsibilities that you have,  
16 what type of physicians are you teaching?

17 A. I am teaching medical students at all levels, from  
18 first year through fourth year, and probably my major day-to-  
19 day teaching is those residents, that is people with their  
20 M.D. degree who are specializing in urology.

21 Q. Do you also have occasion to teach physicians about  
22 radiology?

23 A. I do. The Radiology Department has asked me to with  
24 their first year residents, that is the physicians just  
25 beginning their radiology residency, to introduce them to the

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1 fundamentals of the intravenous pyelogram. I'll -- I'll limit  
2 it to the intravenous pyelogram and the preliminary or flat  
3 plate, once in a while CAT scans.

4 Q. Okay. Do you teach other physicians in how to diagnose  
5 and read things off of CAT scans or KUBs?

6 A. Other physicians only in the context of resident  
7 physicians.

8 Q. Okay, because that would be who you were actually  
9 teaching would be residents, correct?

10 A. Yes.

11 Q. And explain to the jury as far as Georgetown University  
12 Medical School, how big -- when we are talking about  
13 physicians who are or people who are in medical school, how  
14 many students are there in medical school?

15 A. Don't hold me to a precise number. I think the current  
16 class -- average class enrollment is two hundred and five  
17 students per class.

18 Q. Okay, and then how many are in your residency program  
19 in the area of urology?

20 A. Fifteen.

21 Q. Okay, so that -- is it fair to say, then, that for a  
22 residency program, it's a very focused program with just a  
23 very few students?

24 A. Ms. Scalise, would you state that again, please?

25 Q. Sure. Is it fair to say, then, that for a residency

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1 program, there are a lot fewer students than there would be  
2 like in a big medical school?

3 A. Residency is one-on-one.

4 Q. As part of your work as a urologist, do you have to  
5 interact with emergency room physicians?

6 A. Yes, I do.

7 Q. And as part of your work as a urologist, do you also  
8 have occasion to deal with nurses in hospitals as far as  
9 discharge vital signs?

10 A. Yes.

11 Q. So are you familiar with the standard of care for a  
12 urologist?

13 A. Very much so.

14 Q. Okay. Are you familiar with the standard of care for  
15 an emergency room physician as it pertains to urologic  
16 conditions?

17 A. Yes, with that qualification, urologic conditions.

18 Q. Are you familiar with the standard of care as it  
19 pertains to hospitals and/or nursing -- nurses as it pertains  
20 to discharge vital signs?

21 A. Yes.

22 Q. All right.

23 **MS. SCALISE:** Your Honor, at this time I'd ask that he  
24 be qualified in those areas as an expert witness.

25 **THE COURT:** And that would be in the area of urology?

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1       **MS. SCALISE:** Yes sir, in the area of urology, emergency  
2 medicine as it pertains just to a urologic condition, and then  
3 for nursing as it pertains to discharge vitals.

4       **THE COURT:** All right. Are there questions, first of  
5 all, before we get to the issue of whether there's objections?  
6 Are there questions on the area of expertise from any party,  
7 Plaintiff or Defendants?

8       **MR. FOSTER:** No sir, Your Honor.

9       **MR. AIKEN:** No sir.

10       **THE COURT:** Is there objection?

11       **MR. AIKEN:** No sir.

12       **THE COURT:** Hearing none, then the witness is so  
13 qualified. You may proceed.

14       **MS. SCALISE:** Thank you, Your Honor.

15       Q. Doctor, how do you know Dr. Young?

16       A. I was introduced initially when Dr. Young was a student  
17 in the medical school at Georgetown, and then when he made the  
18 personal decision to pursue urology as his area of  
19 concentration or specialization, applied to the program at  
20 Georgetown, I was Chairman at that time. As a function of my  
21 experience with him as a student in all of this, the positive,  
22 personal qualities, he was someone that I was very anxious and  
23 happy to have join us in our resident staff.

24       Q. And prior to your coming to testify here at trial, when  
25 would be the last time that you would have seen or spoken to

1 Dr. Young?

2 A. It was either 1998 or 1999 at a conference in  
3 Washington.

4 Q. Okay. Now, your coming here to testify as an expert,  
5 are you doing that because of Dr. Young?

6 A. Not specifically, no.

7 Q. Okay, and when I asked you to render opinions, if you  
8 had rendered -- if you had told me that Dr. Young had deviated  
9 from the standard of care, or at least if you had found that,  
10 is that something you would have told me?

11 A. I certainly would have.

12 Q. Okay, and if -- I would assume if you had told me that,  
13 I wouldn't have had you down here, would I?

14 A. That's right.

15 Q. Let's talk about as far as the information in this  
16 case, do you recall that I sent you the medical records, and  
17 the depositions, the CAT scans, and the KUB to review?

18 **MR. FOSTER:** Your Honor, I'm going to have to object to  
19 the leading at this point. We're getting into substantive  
20 things.

21 **MS. SCALISE:** I can rephrase it, Your Honor.

22 **THE COURT:** Sustained.

23 Q. Doctor, what did you review in order to formulate your  
24 opinions in this case?

25 A. A very large number of depositions, and I will say

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1 maybe thirty, and the records from the initial -- Ms. Fay's  
2 initial emergency room visit of the 22nd of January of 19--  
3 of 2002; the emergency room record from February of 2000; the  
4 hospital records of her terminal admission and death,  
5 including the autopsy records; the flat plate of the abdomen  
6 that was taken at the time of her initial emergency room visit  
7 on January the 26th of 2002 -- of 2002, and then the abdominal  
8 CT done on that same date; and, of course, in the context --  
9 and laboratory work, the urinalysis, dipstick urinalysis, at  
10 the time of her initial emergency room visit on January the  
11 26th of 2002, but then also the laboratory work at the time of  
12 her emergent visit that resulted in her death. I think that  
13 covers.

14 Q. Doctor, after reviewing the medical records, and the  
15 depositions, and the radiologic studies, did you formulate any  
16 opinions in this case?

17 A. I have, yes.

18 Q. Okay, and just very generally, because we'll talk about  
19 specifics, but generally what were your opinions in this case?

20 A. That the standard of care was met in every aspect in  
21 Ms. Fay's evaluation at the time of her initial emergency room  
22 visit, that is the 26th of January of 2002.

23 Q. All right, and, Doctor, is that your opinion to a  
24 reasonable degree of medical certainty?

25 A. Yes, it is.



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1 Q. All right. Now, Doctor, in South Carolina the law  
2 requires that our experts give their opinions to a reasonable  
3 degree of medical certainty most probably, and so that I don't  
4 have to use all that fancy language every time I ask you a  
5 question, can you agree that every time that you answer a  
6 question, if it's your opinion, that it will be to a  
7 reasonable degree of medical certainty most probably?

8 A. Yes, it will be.

9 Q. Thank you, Doctor. What laboratory and radiologic  
10 testing does the standard of care require to determine if a  
11 patient has a kidney stone?

12 A. For the individual who comes in healthy, no co-morbid  
13 medical, that is other significant medical diseases, a young  
14 healthy person, just the dipstick urinalysis and an initial  
15 imaging screen, either the flat plate or KUB,  
16 anterior/posterior film of the abdomen. Those are all  
17 synonyms. Now they go by different names or goes by different  
18 names, or a stone protocol CT scan.

19 Q. Okay, and were those tests done in this case involving  
20 Kelly Fay?

21 A. Yes, they were all done.

22 Q. Okay, so does that meet the standard of care, that a  
23 dipstick urinalysis and a KUB and CAT scan were performed?

24 MR. FOSTER: Your Honor, she's leading ---

25 A. It does.

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1       **MR. FOSTER:**   --- again, and I object.

2       **THE COURT:**   Counsel, restate your question.   Just  
3 rephrase it if you would, please.

4       **MS. SCALISE:**   Thank you, Your Honor.

5       Q.       Was the standard of care met with regards to the  
6 laboratory testing and radiologic studies that were done in  
7 this case?

8       A.       Yes, it was.

9       Q.       Now, Doctor, if you want to come down and let's talk  
10 about -- if you would come right here.   I want to talk to you  
11 about the urinalysis.

12       All right, is this the dipstick urinalysis that you were  
13 referencing?

14       A.       Yes, it is.

15       Q.       And what does this urinalysis tell you?

16       A.       First, the color, it was yellow.   It was yellow-  
17 colored.   That is there was no gross blood in the ureter,  
18 which sometimes there can be with a stone.   The appearance was  
19 clear.   That is there was no turbidity, no cloudiness, which  
20 will often be the clue to urinary tract infection.   There was  
21 no sugar, and normally there's not any sugar in the urine.

22       Q.       And you reference there where it says glucose?

23       A.       That is glucose.   I'm sorry.

24       Bilirubin, that's a test for the specific abnormality  
25 of liver function, so it's a screening test with respect to

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1 certain problems with the liver. Urinary ketones, ketones are  
2 specific chemicals which appear in the urine when we are  
3 burning our fat tissue, so anybody who's on a diet is probably  
4 -- if they are religiously adhering to their diet, they are  
5 going to have ketones in their urine.

6 There are other situations as well. The urine specific  
7 gravity, that's the concentration or osmolality of the urine,  
8 it was ten-twenty. The normal is ten-ten. If it's -- if the  
9 specific gravity is lower than ten-ten, that means the  
10 individual has been taking very good fluids. They are taking  
11 more than their body really needs. The kidney is clearing  
12 that extra fluid. On the other hand if they are deficient in  
13 their fluid intake, the kidney is going to conserve water and  
14 that's going to be reflected in a specific gravity greater  
15 than ten-ten. Getting up to a ten-twenty, you need to come  
16 into a concentrated urine.

17 Q. What does that tell you, that it was one point zero two  
18 zero?

19 A. That Ms. Fay had been in relative deficit water, and  
20 I'm using water generically; it could be sodas, it could be  
21 fruit juices, but fluid intake probably in the preceding ten  
22 hours or so, and in the morning it usually is because most  
23 people don't drink fluids while they're sleeping at night, and  
24 this was -- this was taken probably somewhere between eight  
25 and eight-thirty A.M. on that January the 26th.

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1 Blood, there was no evidence of red blood cells, blood,  
2 in the urine. The urinary pH, that's the acidity or  
3 alkalinity of the urine. Ms. Fay's urine pH on her admission  
4 urine was five point zero. Now, that's about as acid as our  
5 kidney is normally capable of generating. It would be the  
6 rare individual who could get it down to four point five, but  
7 for most of us, five is as low as it would go, and it's just  
8 reflecting our -- our dietary intake, the acid versus basic  
9 types of food.

10 Urinary protein, negative. Normally, there's a minimal  
11 amount of protein in the urine, usually not enough to be  
12 detectible on the routine dipstick urinalysis, or by any other  
13 method really, unless a person is really very, very dehydrated  
14 and highly concentrated. It's a sign of kidney disease as a  
15 generalization.

16 Urobilinogen. In a way, that ties in with the bilirubin.  
17 It reflects liver function, but also the rate of red blood  
18 cell breakdown in the blood can raise the bilirubin.  
19 Urinary nitrite was negative. Now, all of us have nitrate in  
20 our urine, but normally we are not going to have nitrite. The  
21 only way in which we get nitrite into our urine is if we have  
22 gram negative bacteria, and any of the gram negative bacteria  
23 in distinction to the gram positives, like staph and strep,  
24 all of the gram negatives have an enzyme that will break down  
25 the nitrate in our urine to nitrite, so when we see the

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1 positive nitrite, we know we've got gram negative bacteria in  
2 the urine, and final, leukocytic esterase, the  
3 polymorphonuclear leukocyte, and we've been introduced to that  
4 repeatedly now, but that's the cell that our host response,  
5 host cellular response for acute inflammation, and the  
6 polymorphonuclear leukocyte contains an esterase within the  
7 cell -- I mean an enzyme within the cell, which is esterase,  
8 so when we have esterase in the urine, we know we have white  
9 blood cells in the urine.

10 Q. Okay. Thank you, Doctor. You can sit back down.

11 Now, what does this urinalysis, the result, what does  
12 that tell you?

13 A. In essence, this was an absolutely normal urinalysis.  
14 The only other point I would make is just to reiterate again  
15 Ms. Fay was somewhat dehydrated at that point based on  
16 specific gravity, but that represents good kidney function.

17 Q. All right, and as far as the pH, or I guess -- let me  
18 ask you this. Is there anything on this urinalysis that  
19 indicates she had an infection ongoing at the time this  
20 urinalysis was taken?

21 A. There are no findings that would have introduced  
22 concern for infection. Let me be specific. Her esterase was  
23 negative. Urinary tract infection in and of itself will  
24 usually cause some blood in the urine. There was no evidence  
25 of blood cells.

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1 Q. All right, and we've heard talk about, you know, with  
2 kidney stones, you normally would expect to see blood in the  
3 urine, so what does that mean when there is no blood found in  
4 the urine?

5 A. Well, when the clinical picture, as has been so well  
6 described, particularly by Law -- Dr. Law earlier this  
7 morning, when the clinical picture is that of an acute stone  
8 in the urinary tract, we're really going to expect to see  
9 blood. You will see about anywhere from ninety to ninety-five  
10 percent of the time there will be some red blood cells in the  
11 urine, so that when we have a urine in the context of a  
12 clinical picture consistent with a stone and we don't see  
13 blood, it just raises the question could it be something other  
14 than blood -- I mean other than a stone.

15 Q. But can you have a kidney stone and have a urinalysis  
16 that does not show blood?

17 A. Yes. Depending upon what series you want to look at,  
18 anywhere from five to ten percent of kidney stones at a given  
19 moment in time will not have blood in the urine.

20 Q. All right. Now, the jury has heard a lot about an  
21 organism called proteus mirabilis. How does proteus mirabilis  
22 affect the pH?

23 A. The proteus mirabilis contains an enzyme that will --  
24 let me back up. We have a tremendous amount of urea in our  
25 urine, all of us. It's really the end product of the protein

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1 component of our diet. When the proteus mirabilis is in the  
2 urine, because it has this enzyme, protease, that enzyme,  
3 protease, breaks down the urea and liberates ammonia, and the  
4 ammonia is alkaline and will raise the urinary pH to an  
5 alkaline level.

6 Q. Okay, and what is alkaline for people like me who  
7 aren't very good in chemistry? Is it acidic or basic?

8 A. It's basic. I'm sorry, yes. Basic would be an  
9 appropriate synonym.

10 Q. And so with a proteus infection, would you expect to  
11 see an acidic pH or a basic pH?

12 A. A basic or alkaline pH with a proteus infection.

13 Q. Okay, and so would that be closer to five or closer to  
14 the eight?

15 A. Would be much closer to a seven, in that range, and  
16 that sometimes is our first clue, to be honest, that there's a  
17 proteus infection, is a persistent alkaline pH.

18 Q. All right, so based on this urinalysis, can you say to  
19 a reasonable degree of medical certainty most probably whether  
20 or not she had proteus mirabilis in her urine at the time this  
21 urine was obtained for the urinalysis?

22 A. The answer is yes. There's absolutely no evidence here  
23 to suggest the presence of proteus mirabilis in her urine at  
24 the time this specimen was taken, a catheterized specimen.

25 Q. All right. Do you have an opinion as to where the

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1 urine came from that cau- -- I guess that was used for this  
2 urinalysis?

3 A. I have no reason other than to think there was at least  
4 some urine representing urinary output and flow from the right  
5 kidney, and that I can come into when we come to the imaging  
6 studies.

7 Q. Okay, and we will get to that, but let me ask you, if  
8 there was -- and I think I kind of jumped ahead. Well, let me  
9 ask you this. So because your opinion is that there was some  
10 urine coming from the right kidney, would that have been  
11 diluted by what was in the left kidney such that it would  
12 cause there to be a negative urinalysis?

13 A. In the sense it would be diluted inasmuch as it's not a  
14 fifty/fifty contribution, which is the normal, however I don't  
15 think that the magnitude of dilution would have been such that  
16 it would have neutralized and wiped out the findings that we  
17 would -- would have been generated by the right kidney or the  
18 upper urinary tract.

19 Q. Now, when physicians, such as you, when you have a  
20 negative dipstick urinalysis, does the standard of care  
21 require you to then do a microscopic urinalysis?

22 A. No, it does not.

23 Q. How about as far as when you have a negative dipstick  
24 urinalysis, does the standard of care require you to do a CBC  
25 or what's called a complete blood count?



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1 A. No, it doesn't.

2 Q. And do you have an opinion as to what, if this test had  
3 been done, what they most probably would have found or not  
4 found at -- I guess in this E.R. visit?

5 A. Of the CBC, normal, but specifically a normal count, as  
6 well as a normal distribution of the component white cells  
7 within the complete count, that is particularly the  
8 relationship of the numbers of the polymorphonuclearcyte, the  
9 lymphocyte, the -- and ...

10 Q. So in your opinion to a reasonable degree of medical  
11 certainty, if a CBC had been done, would it have indicated  
12 that there was an infection?

13 A. It would not. It would have been normal.

14 Q. All right. Now, if we can come talk about the KUB.  
15 And I think -- have you reviewed the KUB?

16 **THE COURT:** Counsel, we probably need to get nearer the  
17 microphone so in case we have to play some testimony back.  
18 Thank you.

19 A. What I want to do to both introduce my addressing the  
20 x-ray studies, but hopefully to clarify presumptively on my  
21 part now, clarify some questions that you have with respect to  
22 some of the concepts that have been introduced through the  
23 various testimonies. My first -- what I want to do in a very  
24 gross way is just go over the relevant anatomy.

25 Now, normally we're all going to have two kidneys, and

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1 normally each kidney is going to contribute fifty percent of  
2 the total demand of kidney function. The first point I want  
3 to make is that you will notice that the right kidney -- this  
4 is as though you were looking at me and looking through me.  
5 The right kidney is a little bit lower than the left kidney.  
6 That's because -- and it will become evident on the CT, but  
7 that's because of the bulk of the liver on the right side.

8 But where it's going to become important to keep in mind  
9 is when we come to look at the CT, we can't on a given frame  
10 look at the right kidney and the left kidney and compare them  
11 because they are at different -- different levels, and those  
12 cuts are taken probably at every five to six millimeters.

13 What I want to do next is focus on the left kidney. Now,  
14 let's say the front half has been cut off, folded back, and  
15 we're now looking into the kidney. Now, the reddish color is  
16 the kidney tissue itself. If one is to have a dish generated  
17 from kidney, this is the tissue that contributes to that  
18 delicacy.

19 Now, that's the functional portion. That's where urine  
20 is formed from the blood that comes into the kidney, and when  
21 the urine is formed, it's going to come out into the various  
22 tributaries for drainage. These are called calices, and the  
23 point I particularly want to bring to your clarification,  
24 you've heard repeatedly the term extravasation. How does  
25 extravasation occur? What are the implications of

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1    extravasation?

2           Well, if we look at this white line here that is  
3    outlining the kidney tissue, that's the lining of the  
4    collecting system, and that's kind of a fragile point of  
5    adherence where the tissue of the pelvis and the calix is  
6    attached to the true kidney tissue, so when there's a  
7    significant increase in pressure within the lumen of the  
8    collecting system, the potential exists to get a little tear,  
9    and when that tear occurs, and again if the pressure continues  
10   to be significant, that urine is now going to leak out into  
11   the -- into the surrounding tissue, and this will be a little  
12   more clear on the CT, but other consideration also is this.

13           When we have pressure within the collecting system  
14   sufficiently intense to cause a tear or rupture of the  
15   attachments, there's also going to be some back-up of urine  
16   into the veins draining the kidney, and that's how bacteria,  
17   when present in the area, one way in which they can get in --  
18   into the blood stream.

19           Now, the various branches of the collecting system  
20   ultimately come together and join, much as the major branches  
21   come to form the trunk of a tree and that in an analogous way,  
22   the trunk of the tree is the pelvis of the kidney, and that  
23   funnels down, tapers down like a funnel, why it's called  
24   funneling, to join or become contiguous with the tube that  
25   runs from the kidney to the urinary bladder. That is the

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1 ureter.

2 Well, when Ms. Fay had her -- when Ms. Fay had her  
3 abdominal flat plate probably about eight-fifteen, eight-  
4 twenty on Saturday morning, I take that time because there's a  
5 nurse's note in the emergency room record that stated the  
6 time, eight-twenty, that Ms. Fay is in x-ray, so -- and  
7 there's no special preparation for this. One just gets on the  
8 table; the x-ray is taken, and that's it.

9 At that time, and we'll see this on the CT, the stone was  
10 at the junction of the pelvis and the ureter, as it was  
11 reported to Dr. -- Dr. Law, but then when she had her CT done,  
12 and again that was probably about ten A.M. -- what's the basis  
13 for my postulating that? There's a nurse's note in the  
14 emergency room record, time, ten-twenty A.M., that Ms. Fay had  
15 returned from x-ray with the CT, so we had maybe about an hour  
16 and a half or hour and forty-five minute interval between the  
17 flat plate, the preliminary film, and this.

18 On her CT, as you will see, the stone has already moved  
19 down into the ureter itself, so in a very brief period of  
20 time, it had demonstrated not only the potential for being  
21 able to move down through the ureter, but there was actually  
22 some documented, demonstrated real movement, so it wasn't an  
23 impacted stone at that point. And those were the major points  
24 I wanted to bring out in preparation to move to the imaging  
25 studies.

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1 For orientation again, we're looking at -- so we're  
2 looking at the front. This is the left side. This is the  
3 right side, and here we can see the outline of her right  
4 kidney. Here we can see the outline of at least the lower  
5 half of the left kidney. We can't be confident about defining  
6 the upper half. Highlighted here -- as you can see, some  
7 purple lines here, which I think they detract a little bit --  
8 can you folks see this all right? Can you see this area of  
9 whiteness right here? That's the stone on this particular  
10 study, and there are two specific points I want you to look  
11 at.

12 Here are our ribs, vertebral bodies, pelvis. Look at the  
13 radiodensity of those structures. That radiodensity is due to  
14 calcium. I think you all know how important calcium is for  
15 bone health.

16 Q. Okay, let me ask you, when you say radiodensity, what  
17 does that mean?

18 A. The resistance that they generate to permitting the  
19 x-ray to go through. In other words, it's almost like a steel  
20 plate, total barrier, so the x-ray cannot get through to the  
21 film itself and thus we're left -- and again, I want you to  
22 notice the density relative to, say, the bone of the pelvis,  
23 pretty much the same -- same density, so it's a very dense  
24 calcium stone.

25 This is again the lower pole of the kidney. The stone is

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1 above the lower pole of the kidney. Now, on this stone we do  
2 not have the drainage system of a kidney defined, and  
3 everybody is different. We are all -- as our fingerprints are  
4 unique, so is our anatomy here, but the average would be at  
5 this point. This is probably the point where the renal pelvis  
6 -- where it has funneled down and ureter will begin.

7 Now if we can go to the ---

8 Q. Okay, and let me -- did you bring another KUB to show  
9 us something as to the size? I think I've got it over here.

10 A. Oh, yes. I brought this for one reason -- I brought  
11 this for one reason only. There's been a great deal of  
12 discussion with respect to stone size and what constitutes a  
13 large stone, but just to give you some concept of what by our  
14 criteria -- now these are stones. That's not dye sitting in  
15 the drainage system of the kidney. Those on each side are  
16 stones, and this is often referred to as a branched calculus,  
17 because of the configur- -- I show it just to give you some  
18 sense of when we talk about a large stone what we're -- what  
19 we're referring to.

20 Q. All right. Now, I want to go to the CAT scan, and I  
21 believe you were explaining to the jury that you can tell --  
22 will you explain to the jury if you can tell on these CAT  
23 scans that the stone had actually moved?

24 A. Yes, and that's why I wanted to point out the  
25 relationship on the flat plate, the relationship to the lower

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1 pole of the kidney, that it was above the lower pole of the  
2 kidney.

3 Q. And this has been marked as Defendant's Exhibit Number  
4 3, and on this does this show you, I guess, where the UPJ  
5 junction is?

6 A. This is -- this bulk here is the liver, and that's why  
7 the bulk on the right side is present. We don't see it here,  
8 and that keeps the right kidney a little bit lower, and I  
9 won't go into any details here.

10 Q. Just for the record, you're referencing Image Number  
11 21?

12 A. Uh huh (**indicating positive**). And possibly to help in  
13 some of Dr. Law's testimony, one of his differential  
14 diagnostic considerations was cholecystitis, and you see this  
15 structure, this spherical somewhat more black in structure,  
16 that's the gall bladder, so you can see the close anatomic  
17 relationship of the gall bladder and the kidney, how disease  
18 in either one sometimes can masquerade and be a little bit  
19 more difficult to sort out. Now, ---

20 Q. Now, let me ask you this. Can you compare, let's say  
21 like on this image, Number 28, can you look at the left and  
22 the right kidney in that one small image?

23 A. This is the left kidney. This is the right kidney, but  
24 for the reason that I pointed out by virtue of their different  
25 location, we can't look at them on a single film and really

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1 compare them.

2 Q. Okay, so for example, this one, Number 28, you can't  
3 say that in that image, the right kidney is much enlarged  
4 because -- am I understanding you right, because you can't  
5 compare that to the left kidney in that one image?

6 A. Correct; correct.

7 Q. And I think I was asking you for the UPJ junction.

8 A. Yes. Let's take this image right here, ---

9 Q. Which is Number 33.

10 A. Can you see this little projection coming out here?  
11 That's the pelvis, and again, we see it here. We see it here.  
12 It's not getting quite as obvious, a little bit less obvious,  
13 and as we move down, I'm going to come down to this image.  
14 This is ---

15 Q. Image Number 40?

16 A. Yeah. That little dash above the end of my pointer,  
17 that's the right ureter, so we've had the transition from the  
18 pelvis to the ureter, just so you get the sense of that  
19 gradual funneling.

20 Q. Let me make sure I'm understanding. Can you explain to  
21 them where you are on this representation?

22 A. Well, we're -- I'm trying to illustrate -- trying to  
23 illus. this -- this point here, that is the funneling of the  
24 renal pelvis down and ultimately becoming just a tubular  
25 structure, the ureter.



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1 Q. All right, so that that was Image Number 40, let's go  
2 to the next set, and what does this show you on that CAT scan?

3 A. Now, which -- what are we ---

4 Q. We just talked about Number 40, and so there's 41, 42,  
5 43.

6 A. 49.

7 Q. And 49 is this one.

8 A. Yes. This is the right kidney, the lower portion of  
9 the right kidney. Now, we're descending to the  
10 retroperitoneal space. By the way, we're no longer seeing the  
11 kidney on the left side because the left kidney is somewhat  
12 larger -- or somewhat higher than the right kidney, and as we  
13 follow the right kidney through the frames, we see it  
14 gradually decreasing in size, and here we have just a subtle  
15 residual image of the lower-most -- the lower-most portion of  
16 the kidney, and when we look at this film -- well, let's come  
17 up. It's a little more clear here.

18 Can you see this little whitish dot here at the end of my  
19 fingernail?

20 Q. And this is Exhibit 45?

21 A. Yes, and I totally know -- I have to stand in front of  
22 a film to read it. I could never read a film sitting where  
23 you are because you just can't get the definition.

24 The point I want to make is this is ureter. This is  
25 right ureter. This is right ureter, and as we follow the

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1. ureter down, look here. Can you see that more thin -- are you  
2 able to see that more dense, right nodule?

3 Q. Let's put it here. I think they can see it.

4 A. Again, this is the right kidney.

5 Q. You've got to speak really, really loud.

6 A. Sorry. This is the right kidney. This is the right  
7 ureter, and what I really want you to look at, this right  
8 here. That spherical structure is the left ureter. Now, the  
9 right ureter, and this is the right ureter between the kidney  
10 and the stone. It's not significantly increased in  
11 circumference or diameter relative to the normal left, taking  
12 the left ureter now as your normal reference to what a normal  
13 ureter looks like.

14 Now if we can go down to where the stone is. This is  
15 probably the clearest. You can appreciate that's much, much  
16 more easily seen, much more clearly defined than it was on  
17 that earlier -- where we just had the ureter. Now we have the  
18 stone within the ureter at this level.

19 Q. Okay, and you are referencing Image Number 52?

20 A. And what I'm circling, pointing to and circling now, is  
21 the ureter on the left side, and again hopefully you can see  
22 this well enough to appreciate that if we want to talk about  
23 circumference or diameter, they're essentially -- essentially  
24 equal.

25 Q. All right. Now, in your view of the CAT scan --

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1 actually, let me ask you this. I'll turn that off for a  
2 second while I'm looking at this picture.

3 A. Yes, I think you are at the other one, is the left  
4 kidney.

5 Q. Okay. I'll show you that in just a second. Let me  
6 first ask you this. With the transition, looking at the KUB  
7 to the CAT scan as far as the movement of the stone, where did  
8 that now move to?

9 A. The stone now is down in this area, and you saw on the  
10 flat plate, the preliminary film, it was probably up here. I  
11 point it out specifically the fact that you can see the lower  
12 portion of the kidney to appreciate that the stone was higher  
13 than the lower end of the kidney. Now we don't even have any  
14 right kidney on the film we were looking at. The stone is  
15 sitting about here.

16 Just to have some objective documentation for us in  
17 evaluating the patient, we know that it's a moveable stone.  
18 It was also a nice, smooth, balanced stone you will hopefully  
19 notice.

20 Q. And also -- if you want to stand right here because I  
21 have more questions -- as to the color consistency of the  
22 stone, does that indicate anything to you based on the CAT  
23 scans?

24 A. Well, it certainly -- it certainly is a stone  
25 containing a large amount of calcium.

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1 Q. Okay, and the struvite stones, do they have a large  
2 amount of calcium?

3 A. Or it could be uric acid. I'm sorry. It could be uric  
4 acid, too, but ---

5 Q. But does that type of stone that you are seeing in  
6 Image Number 52, is that a struvite stone?

7 A. It's not, for two reasons. It would not raise an index  
8 of suspicion. One point I should reiterate is this is the  
9 stone, but I want you to notice how nice and smooth and  
10 spherical it is. Keep that -- keep that image in your memory  
11 because that's not consistent with a struvite stone, and I'll  
12 show -- and I'll show you why on that.

13 Q. Okay, and also as far as the color -- I know we've got  
14 the lights on so it's difficult to tell on this, but looking  
15 at the actual image itself, could you tell anything as far as  
16 the translucency or radiodensity of that stone as to whether  
17 it was calcium versus something that would be consistent with  
18 struvite?

19 **MR. FOSTER:** I'm going to have to object to the leading.

20 A. I'm going to say yes to that. What I would ask you to  
21 do is look at the density of one the vertebral bodies, and  
22 that's what I will now point out. As you know, those are  
23 pretty much solid calcium salt, and this is essentially the  
24 density of bone on that film.

25 Q. All right, and struvite, what chemicals -- I guess it's

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1 chemicals that make up a struvite stone?

2 A. Magnesium, ammonium, phosphate is struvite.

3 Q. All right, and also on the CAT scan, were you able to  
4 see any evidence of obstruction on the CAT scan?

5 A. Yes. The frame that has the very minimal  
6 extravasation, and to be honest, folks, there's extravasation  
7 here, but it's so minimal, you may well not be able to see it,  
8 and I think other than a urologist or some radiologist, it  
9 probably would not be picked up.

10 Q. All right, and you were referencing Image Number 24?

11 A. Yes.

12 Q. Is that the image you wanted to look at?

13 A. Yes. Let's look at the -- let's look at the left  
14 kidney, and what I want you to focus on is this area right  
15 here. It's called the hilum, H-I-L-U-M. That's the space  
16 within the convex kidney where the drainage system exists, and  
17 that space is filled with fat tissue, and that's why there are  
18 blotches of darkness there. It's the fat tissue.

19 Now, if we look at the right kidney, we don't have -- we  
20 don't have quite the nice areas, definitive areas of blackness  
21 within the hilum of the right side that we have on the left  
22 side. That's the finding that results from urine leaking out,  
23 kind of saturating the fat tissue, somewhat analogous to the  
24 infant who has voided into their diaper and you go to change  
25 them, the diaper is pretty well saturated, or sometime you

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1 check to see if they need a change, they're nice and dry, in a  
2 gross analogous way, the distinction here, but it's very  
3 minimal. One almost has to look twice to see it.

4 Now, when extravasation is significant, the urine does  
5 not remain confined within the hilum of the kidney. It leaks  
6 out, oozes out, and this whole area -- that whole area around  
7 the kidney will become as cloudy as what we are seeing within  
8 the hilum. If you look at the area on the left and compare it  
9 with that comparable area on the right, there's no difference  
10 in the radiodensity. There's no evidence of any urinary  
11 leakage out into the tissue around the kidney. It's  
12 exclusively in the hilum, and the other important functional  
13 consideration to introduce is this film was taken, this study,  
14 around ten A.M. in the morning.

15 The basis for my saying that, there was a note at ten-  
16 twenty A.M. that she had returned to the emergency room from  
17 the CAT scan. Her pain started about seven-thirty based on  
18 Mr. Fay's history, so this was about three and a half hours  
19 after her pain started, and her pain would have started  
20 because that stone had dropped down and introduced some  
21 impediment or blockage resistance to urine flow. It was that  
22 sudden increase in pressure within the drainage system within  
23 the kidney that brought about the pain.

24 Now, in a three hour period of time, there's no more  
25 extravasation than what we see here, and my personal

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1 interpretation would be that at this time the obstruction had  
2 relieved itself and we're seeing some residual that occurred  
3 at the time that the stone initially dropped down there around  
4 seven-thirty or quarter of eight, in that period of time.

5 Q. All right. Please, Doctor, if you will -- actually,  
6 there's one more question I have. Did you find any evidence  
7 on the CAT scan of a stone in the left kidney?

8 A. Yes, and to be -- and to be honest, this is going to be  
9 hard for you to see. What I am -- what I am going to do is go  
10 up to the screen and I am going to put my pointer on an area  
11 of dense whiteness within the left kidney.

12 Q. For the record, this is admission number seventeen.

13 A. That -- that's a small stone forming in her left  
14 kidney, and you will recall from her past history, the episode  
15 of pain, acute stone she had in February of 2000, that was  
16 left-sided, and there was again radiologic imaging, an  
17 intravenous pyelogram, radiologic imaging that documented yes,  
18 she had a ureteral stone at the time of that particular  
19 emergency room visit.

20 Now, where this really becomes relevant is in this whole  
21 topic of proteus causation of a struvite stone. The postulate  
22 had or hypothesis had been put forth that there was a normal  
23 acid pH on the -- in the urine and that there was no blood and  
24 that there were no white cells in the urine because there was  
25 complete blockage of the right ureter. Let's -- let's take

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1 and accept that.

2 If the proteus was causing her stones, the urine from the  
3 left kidney which would have to -- to be consistent with  
4 pinking, the urine from the left kidney would have to show  
5 evidence of infection, and had it been cultured and it takes a  
6 minimum of forty-eight hours, and it's not a realistic thing  
7 to do, I mention it for completeness, had it been cultured  
8 would have documented proteus.

9 And I might just, while the thought is in my thinking at  
10 the moment, if you look at her urine pH at the time she was  
11 admitted to the emergency room at Grand Strand on Sunday --  
12 no, I'm sorry, on Monday, her urine pH now was six point five,  
13 which is getting up; it's up at the lowest alkaline range.

14 Q. All right. You can be seated, Doctor.

15 A. All right.

16 Q. Let's talk for a second, though, about that urine pH.  
17 When she returns on that Monday, you said it was a six point  
18 five, and we know, do we not, that at that time the records  
19 indicate that she had a proteus in her urine on Monday?

20 A. Yes, they -- they ultimately did. That is when the --  
21 when the urine culture is obtained at the time of her  
22 emergency room entrance, ultimately grew out a proteus  
23 mirabilis, as did her blood cultures also grow out proteus  
24 mirabilis.

25 Q. All right, and was she septic on that Monday?



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1 A. Extremely septic, as septic as you can get, and  
2 unfortunately that was the causation of her death.

3 Q. Okay. How does sepsis affect the pH in the urine?

4 A. I'm sorry?

5 Q. How does sepsis affect the pH in the urine?

6 A. Sepsis in and of itself wouldn't be likely to affect pH  
7 except the specific bacteria, and now if we have a proteus  
8 bacteria as the -- as the cause of the sepsis, then we're  
9 going to see pH toward the alkaline side.

10 Q. Okay, so if she had not been septic on that Monday, and  
11 we know that she had proteus in her urine on Monday, would you  
12 have expected her urine to be -- the pH to be higher ---

13 MR. FOSTER: Your Honor, I object to the leading.

14 THE COURT: I think an appropriate question of what  
15 would you have expected about the pH as opposed to would you  
16 expect it to be higher, so I would sustain on that basis.  
17 Please rephrase.

18 MR. FOSTER: Thank you.

19 MS. SCALISE: Thank you, Judge.

20 Q. If she did not have sepsis on that Monday, what would  
21 you have expected her pH of urine to be if she had proteus on  
22 Monday?

23 A. Again, it would probably have been six point five, no  
24 more than seven. Seven is about the -- even physiologically  
25 about the maximum pH that an unhealthy kidney can generate.

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1 Q. Let's go back just to talk for a minute about the CAT  
2 scan and the KUB that you -- you saw. Was there anything that  
3 you saw on the KUB or the CAT scan which the standard of care  
4 would have required Dr. Law to have admitted or -- and/or Dr.  
5 Young to have admitted Kelly Fay on that Saturday?

6 A. Nothing at all, and even in the context of my bringing  
7 out a little bit more than had been brought out by the  
8 radiology interpretations that there was nothing on that study  
9 that would have mandated admission.

10 Q. All right, and, Doctor, let's talk a minute. What is  
11 the largest stone that you've ever seen someone pass?

12 A. I had the experience once -- your unique experiences,  
13 you know, in life you just don't forget. The patient had a  
14 three centimeter stone. A three centimeter stone is about  
15 like that in the lower ureter and it had obviously been there  
16 a long time, and I just concluded there was no way she could  
17 pass that and scheduled her for surgery, and there was no  
18 urgency about the surgery.

19 And before we do anything interventionally in addressing  
20 stones we always get a flat plate of the abdomen before the  
21 patient has anesthesia because stone behavior is so  
22 unpredictable. She had passed that stone in the interim, and  
23 I -- there was no way I thought she could do that.

24 Q. All right. Now, and when you diagnosed that stone  
25 originally, and this is a three centimeter, which would be --

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1 is that like thirty millimeters?

2 A. That would be thirty millimeters, yes, but let me just  
3 pick up on that. There are -- there are ten millimeters to a  
4 centimeter, and there are two point five centimeters to an  
5 inch, for those of you who are not in detail familiar with the  
6 metric system. Looking at it another way, let's take the five  
7 millimeter stone in her ureter, what does that translate into  
8 in inches? It would be three-sixteenths of an inch.

9 Q. Okay. Now, for your lady that you had with the thirty  
10 millimeter stone, did you allow her to go home or did you  
11 admit her?

12 A. Allowed her to go -- oh, originally I allowed her to go  
13 home, and when I brought her in for surgery and the stone had  
14 passed, I allowed her to go home.

15 Q. The size and location of the stone, did those mandate  
16 admission?

17 A. I think it's evidenced by that experience. I'll say  
18 no. At the time that the patient presents to the emergency  
19 room, we may decide that in an elective way they need  
20 intervention for definitive resolution, but relatively  
21 electively.

22 Q. Okay. If a patient has moderate to severe obstruction,  
23 does that patient need to be admitted?

24 A. Let me try to answer that this way. If we have  
25 documented severe obstruction but we cannot get that insight

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1 on a -- on a CT, as Dr. Law brought out, we can only evaluate  
2 obstruction from a functional point of view. First of all,  
3 its presence at the moment, and secondly, the magnitude or the  
4 degree of obstruction by the use of contrast agents that are  
5 cleared by the kidney, so it measures kidney function and it  
6 also measures the transit of urine through the ureter beyond  
7 the stone, and then only with that study do we have any  
8 insight into this degree of or severity of magnitude of the  
9 obstruction.

10 Q. And, Doctor, do you agree with the statement that fever  
11 and kidney stone is a urologic emergency?

12 A. Yes.

13 Q. All right. Now, with that in mind at Georgetown  
14 Hospital when you have kidney stone patients there in the  
15 emergency room, are discharge -- is a discharge temperature  
16 taken?

17 MR. FOSTER: Your Honor, ---

18 A. Not necessar- ---

19 THE COURT: Excuse me.

20 MR. FOSTER: --- I am going to object to what happens at  
21 Georgetown.

22 THE COURT: Overruled.

23 MR. FOSTER: We are talking about the standard of care.

24 THE COURT: Very good. Overruled.

25 MR. FOSTER: Thank you, Your Honor.

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1           **THE COURT:**   Thank you.

2           Q.       I'm sorry, Doctor.  What -- what happens at Georgetown  
3           as far as discharge temperature?

4           A.       I was going to say not necessarily.  In other words, if  
5           they're having no nausea, vomiting, so they can retain fluids  
6           and stay hydrated, facilitate stone passage, if they have no  
7           earlier temperature, like they don't look sick, they state  
8           they're comfortable, they can go home.  The emergency room has  
9           to use some discretion in ---

10          Q.       All right.  Now, with regard to Kelly Fay, in your  
11          opinion was a discharge temperature required?

12          A.       Not based on the information that I could glean from  
13          reviewing the emergency room chart of January 26th.

14          Q.       Okay.  You've also heard some testimony about a  
15          conversation that Dr. Law and Dr. Young had, and what I wanted  
16          to ask you, all right, the Plaintiff's expert, a urologist,  
17          Dr. Siroky, when I was asking him questions, he had a list of  
18          some things he thought that Dr. Young needed to find out from  
19          Dr. Law.  Based on the testimony, do you believe that Dr.  
20          Young knew the size of the stone?

21          A.       Not that I am aware of.

22          Q.       Do you remember Dr. Law just testified, and he said  
23          that he told ---

24               **MR. FOSTER:**   Objection to leading, Your Honor.

25               **THE COURT:**   Sustained.

1 A. That's right, ---

2 **THE COURT:** Sustained, Counsel.

3 A. --- yes, yes, yes.

4 **THE COURT:** You cannot answer for your witness, Counsel.  
5 That was a leading question.

6 Q. Did -- let me ask you this: Did Dr. Law tell Dr. Young  
7 the size of the stone?

8 A. Yes.

9 Q. Did Dr. Law tell Dr. Young where the stone was located?

10 A. Yes.

11 **MR. FOSTER:** Judge, she's still -- the same objection,  
12 leading.

13 **THE COURT:** Counsel, a better series of questions, what  
14 did he tell him. You are asking a leading question because  
15 the answer is contained within it. Sustained.

16 A. Let me have the question again, then.

17 Q. What do you recall Dr. Law telling Dr. Young?

18 A. That he had a patient with a stone, no complications,  
19 that is it was afebrile, no evidence on urinalysis of any  
20 infection, pain well-controlled with -- well to be minimal  
21 medication, and he was planning to discharge her and wanted  
22 just to facilitate establishing contact with him Monday for a  
23 follow-up because of the concern that the stone was of size  
24 that it might not quickly pass and so she would be in touch  
25 with him for short-term management, short-term over the next

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1 two or three weeks.

2 Q. Was there any communication about where the stone was  
3 located?

4 A. Not that I recall.

5 Q. Do you recall whether or not there was any  
6 communication about whether it was obstructing or not?

7 MR. FOSTER: Your Honor, objection. We're getting back  
8 into the same line of questioning.

9 THE COURT: I'm going to sustain it again.

10 MS. SCALISE: I can -- I can ask Dr. Young.

11 THE COURT: Counsel, it is -- it is leading.

12 MS. SCALISE: All right.

13 Q. Let me ask you does the standard of care require when a  
14 urologist is called by an emergency room physician, does the  
15 standard of care -- just let me back up and say this: When an  
16 emergency room physician calls a urologist and says that the  
17 patient is afebrile, does the standard of care require the  
18 urologist to specifically find out what time the temperature  
19 was taken?

20 MR. FOSTER: Objection. We're still leading, Your  
21 Honor.

22 THE COURT: I'm going to -- to overrule. Go ahead.

23 MR. FOSTER: Thank you.

24 A. Can I answer it?

25 Q. Yes sir.

1 A. No.

2 Q. Did Kelly Fay have any indicators for admission?

3 A. None that were evident in the chart, the emergency room  
4 chart records of Saturday morning, January the 26th, 2002.

5 Q. Okay. Did the standard of care require Kelly Fay to be  
6 admitted on January 26th?

7 A. Definitely not.

8 Q. In your opinion, to a reasonable degree of medical  
9 certainty, was infection appropriately ruled out in the  
10 emergency room?

11 A. Yes.

12 Q. In your opinion, were antibiotics required?

13 A. No.

14 Q. Okay, and explain to the jury why it's your opinion  
15 antibiotics were not required.

16 A. Well, first and foremost, there was no evidence of  
17 infection to warrant the introduction of antibiotics.  
18 Secondly, if infection is there, there's no way we know what  
19 drug is going to be most likely to be effective, and to be  
20 consistent then in thinking, we have to give what we call  
21 broad coverage, and that often means two antibiotics to cover  
22 the gram-negative organisms and the gram-positive organisms  
23 that potentially could be infectious causes, and as Dr. Law  
24 pointed out in his testimony or cross-examination, there's a  
25 risk to antibiotics given. An individual doesn't always have



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1 a relatively minor reaction, the so-called skin rash that Mr.  
2 Foster described, or the redness of the skin. Sometimes it  
3 can be extremely violent.

4 I will give you one example. This was a patient of mine,  
5 a cardiologist who decided to treat himself without seeking  
6 help, took one dose of Ciproflaxin, and one of the potential  
7 side effects of Ciproflaxin, not too uncommon, is inflammation  
8 at the Achilles tendon. He ended up with bilateral Achilles  
9 tendon inflammation from a single dose of Ciproflaxin and had  
10 to wear boots for about six months before he could get into  
11 rehabilitation, so we are extremely cautious on the use of  
12 antibiotics. We see so many complications.

13 In addition to the potential for an atypical or allergic  
14 sensitivity type of reaction, one dose of antibiotic alone has  
15 the potential to introduce significant infection of the colon,  
16 clostridium difficile. You might have heard of that, and  
17 sometimes only one dose and then that's a significant  
18 complication for the patient, particularly somebody with a  
19 stone.

20 Q. All right. Doctor, I want to ask you a few questions  
21 again about that phone call. In your opinion, to a reasonable  
22 degree of medical certainty, did that phone call between Dr.  
23 Law and Dr. Young, did that establish ---

24 **MR. FOSTER:** Objection, Your Honor.

25 **THE COURT:** On what basis?

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1       **MR. FOSTER:** On the basis it's not a subject of expert  
2 testimony. It's for the jury to decide based on your charge.

3       **THE COURT:** Reply.

4       **MS. SCALISE:** I think, Your Honor, the only way for the  
5 jury to understand is it is so fact-specific that they've got  
6 to understand what experts have to say about this -- this  
7 topic.

8       **THE COURT:** All right. Counsel, you actually opened the  
9 door on the issue. I'm going to overrule because there was  
10 testimony elicited in the Plaintiff's case on that very point.  
11 This would be now responsive to that.

12       You may proceed.

13       **MS. SCALISE:** Thank you, Judge.

14       Q. In your opinion, to a reasonable degree of medical  
15 certainty, the phone call between Dr. Young and Dr. Law, did  
16 that establish a physician/patient relationship?

17       A. No.

18       Q. Okay, and, Doctor, would you want to practice medicine  
19 in South Carolina if the law was that every patient you  
20 discussed ---

21       **MR. FOSTER:** Objection, Your Honor. This is irrelevant.

22       **THE COURT:** Sustained, Counsel.

23       **MR. FOSTER:** Thank you.

24       Q. All right, Doctor, I'm going to kind of summarize some  
25 of your -- ask you some summary opinions. In your opinion, to

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1 a reasonable degree of medical certainty, was this a struvite  
2 stone?

3 A. It was not a struvite stone.

4 Q. Okay. In your opinion, to a reasonable degree of  
5 medical certainty, was Kelly Fay infected when she was in the  
6 emergency room?

7 A. There was no evidence that she was infected.

8 Q. In your opinion, to a reasonable degree of medical  
9 certainty, did Kelly Fay have any signs or symptoms in the  
10 emergency room that were consistent with infection?

11 A. She did not have any signs, symptoms, or laboratory  
12 evidence.

13 Q. In your opinion, to a reasonable degree of medical  
14 certainty, was Dr. Law's workup appropriate?

15 A. Yes, it was.

16 Q. In your opinion, to a reasonable degree of medical  
17 certainty, was Dr. Law's decision to discharge Kelly Fay, was  
18 that appropriate?

19 A. It was appropriate, yes, uh huh.

20 Q. Did you see any reason why Kelly should be admitted  
21 instead of discharged?

22 A. No reason whatever.

23 Q. Did the standard of care require antibiotics to be  
24 given if she was going to be discharged?

25 A. Certainly does not require antibiotics absent any

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1 evidence of infection.

2 Q. In your opinion, were the discharge instructions clear?

3 A. Yes.

4 Q. In your opinion, did the Fays understand that they  
5 needed to return if Kelly developed any ---

6 MR. FOSTER: Your Honor, this is just ---

7 THE COURT: Sustained, Counsel.

8 MR. FOSTER: Thank you, Your Honor.

9 Q. Okay. In your opinion, did Dr. Young meet the standard  
10 of care?

11 A. Yes, he did.

12 Q. In your opinion, did Dr. Law meet the standard of care?

13 A. Yes, he did.

14 Q. In your opinion, did the hospital meet the standard of  
15 care?

16 MR. FOSTER: Your Honor, it's the same thing. She's  
17 still -- object, Your Honor, leading and testifying.

18 THE COURT: Overruled, Counsel. This is in summary  
19 fashion.

20 You may proceed.

21 MR. FOSTER: Thank you.

22 MS. SCALISE: Thank you, Judge.

23 Q. Did the hos- -- in your opinion, did the hospital meet  
24 the standard of care?

25 A. Yes.

WILLIAM C. MAXTED, M.D. - DIRECT BY SCALISE  
JURY OUT

1 Q. In your opinion, is there anything that the Defendants  
2 did, and that's all the Defendants, is there anything that any  
3 of them did that proximately caused injury, damage, or death  
4 to Kelly Fay?

5 A. Not that I could identify.

6 Q. Okay, and have all your opinions been to a reasonable  
7 degree of medical certainty most probably?

8 A. I'm sorry; I had to cough.

9 Q. Have all of your opinions been to a reasonable degree  
10 of medical certainty most probably?

11 A. Yes.

12 Q. Okay.

13 MS. SCALISE: Thank you, Doctor. If you'll just answer  
14 any questions these other attorneys might have.

15 THE COURT: All right, let's take our afternoon break at  
16 this time, and, Doctor, I'm going to ask you not to speak to  
17 any of the lawyers during the break since you are a witness  
18 that's under testimony, but you are welcome to stand down and  
19 take a break, all right?

20 And let's all remain where we are while our jury departs  
21 the courtroom, and enjoy your break, ladies and gentlemen.

22 (THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE  
23 JURY.)

24 THE COURT: All right, Court is in recess now.

25 (THE FOLLOWING TAKES PLACE AFTER A BREAK AND OUTSIDE THE

1 STATE OF SOUTH CAROLINA ) COURT OF COMMON PLEAS  
2 )  
3 COUNTY OF HORRY ) (08-CP-26-9047)  
4 ) (08-CP-26-9368)  
5 SEAN D. FAY, as Personal )  
6 Representative of the )  
7 Estate of Kelly L. Fay, )  
8 deceased. ) TRANSCRIPT OF RECORD  
9 )  
10 )  
11 GRAND STRAND REGIONAL ) May 17, 18, 19, 20, 21, 2010  
12 MEDICAL CENTER, LLC, dba ) May 24, 25, 26, 27, 28, 2010  
13 SOUTH STRAND AMBULATORY ) Conway, South Carolina  
14 CARE CENTER, et al )  
15 )

10 B E F O R E:

11 HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.

12 A P P E A R A N C E S:

13 RUSKIN C. FOSTER, ESQ.  
14 BRADLEY HEWITT, ESQ.  
15 ATTORNEYS FOR PLAINTIFF

16 MONTEITH P. TODD, ESQ.  
17 RANDOLPH L. LEE, ESQ.  
18 ATTORNEYS FOR DEFENDANTS, GRAND STRAND

19 J. BOONE AIKEN, III, ESQ.  
20 ATTORNEY FOR DEFENDANTS, LAW AND CAROLINA HEALTH

21 MARIAN SCALISE, ESQ.  
22 LYDIA L. MAGEE, ESQ.  
23 ATTORNEYS FOR DEFENDANT, YOUNG

24 DIXIE COX EUBANK  
25 CIRCUIT COURT REPORTER  
FIFTEENTH JUDICIAL CIRCUIT

VOLUME 7 OF 8  
(SEE VOLUME 1 FOR INDEX)

RICHARD W. YOUNG, M.D. - DIRECT BY SCALISE

1 back to the courtroom. I trust you had a nice evening, and  
2 let me ask, since we were last together, is there any member  
3 of the jury panel who's had a discussion about the facts of  
4 this case with anyone or been contacted by anyone concerning  
5 this case? If you have, please raise your hand. (No  
6 response.) Let's let the record reflect that no one has  
7 raised their hand.

8 And you will recall we are in the Defendants' cases now,  
9 and Defense, please call your next witness.

10 **MS. SCALISE:** Thank you, Your Honor. May it please the  
11 Court. We call Dr. Richard Young.

12 **THE COURT:** Please come forward and take the oath of a  
13 witness.

14 **RICHARD WILLIAM YOUNG, M.D.,** being first duly sworn,  
15 states as follows:

16 **DIRECT-EXAMINATION BY MS. SCALISE:**

17 Q. Dr. Young, is this your first time ever on the witness  
18 stand?

19 A. It is. I have -- have been in the jury box before, but  
20 never in the witness stand.

21 Q. All right. Tell the jury a little bit about yourself.  
22 Where do you live?

23 A. I live in Myrtle Beach near Plantation Point.

24 Q. Are you married?

25 A. I'm married. I have three children, one nineteen, one

1 fifteen, and a girl who is thirteen.

2 Q. All right, and, in fact, is one of your family members  
3 here in the courtroom today?

4 A. My oldest son came today, yeah.

5 Q. Okay, and that's your son seated back here?

6 A. That's correct.

7 Q. All right, and is he home from college?

8 A. Just came home on Sunday. We picked him up.

9 Q. All right. Tell the jury a little bit about your  
10 education.

11 A. Well, I went to -- went to college at Washington & Lee  
12 University in Lexington, Virginia, where my son actually is  
13 now. When I finished there, I went to Georgetown University  
14 in Washington, D.C. You met Dr. Maxted yesterday from there.  
15 After I finished med school, I stayed on to do my two years of  
16 general surgery and then my four years of urology, which is  
17 pretty much what's required to become a urologist.

18 Q. All right, and what year did you finish all of your  
19 schooling?

20 A. Well, I finished med school in '87. I finished the  
21 urology residency in 1993.

22 Q. All right, and in 1993, what did you do at that point  
23 in time?

24 A. I moved to Myrtle Beach and joined Dr. Bill Greene and  
25 Dr. Kenneth Krzyzaniak in practice in urology.



1 Q. All right, and what's the name of your practice?

2 A. Grand Strand Urology.

3 Q. And what are the members of that practice?

4 A. There is currently five of us. Bill Greene retired a  
5 couple of years ago, but it's myself, Bill Bogache, Ken  
6 Krzyzaniak, Brian Roberts, Neal Shore.

7 Q. Okay. Tell the jury are there any activities that you  
8 do here in our community?

9 A. Yeah. I'm a -- I'm a -- I'm a member of the Grand  
10 Strand Sertoma Club. I run the scholarship committee for  
11 them. I am actually sitting on a board at St. Andrews Church.  
12 We're trying to get the Diocese of Charleston to build a high  
13 school in this area.

14 Q. All right, and in your career as a urologist, have you  
15 received any honors or award?

16 A. Yeah. I -- I -- in 2008-2009, I was president of the  
17 South Carolina Urological Society. It's just a statewide  
18 association that virtually all the urologists belong to.

19 Q. Let me ask you about that. With that, is this an  
20 elected position?

21 A. Yes. Yeah, I was elected to that position. I still  
22 serve on the executive committee for the state society.

23 Q. Okay. Anything, any awards or honors there at the  
24 hospital?

25 A. Yeah. I am currently on the medical executive

1 committee. I served as chief of staff actually 2009-2010. In  
2 April actually I just finished my term as chief of staff.

3 Q. All right. Are you board certified?

4 A. Yes.

5 Q. In what area?

6 A. Urology.

7 Q. And when you took your boards, did you pass them the  
8 first time?

9 A. Yes.

10 Q. Okay. Have you been recertified?

11 A. Yes. I was recertified in 2003.

12 Q. And did you pass those boards the first time?

13 A. Yes.

14 Q. Now, as far as your medical license, what states have  
15 you held medical licenses?

16 A. Well, I currently hold a medical license in South  
17 Carolina. I had a North Carolina license at the time of the  
18 deposition, and that's inactive right now. We closed our  
19 office in North Carolina a couple of years ago.

20 Q. Your medical licenses either in South Carolina or North  
21 Carolina, have they ever been limited, suspended, revoked?

22 A. No.

23 Q. And as far as hospital privileges, where do you hold  
24 hospital privileges?

25 A. I'm on active staff at Grand Strand Regional Medical

1 Center and Waccamaw Hospital. I have courtesy privileges at  
2 Conway Hospital and also Seacoast Medical Center.

3 Q. All right, and those privileges at all those four  
4 hospitals, have those privileges ever been suspended, revoked,  
5 limited in any manner?

6 A. No.

7 **MS. SCALISE:** At this time, Judge, I would ask that he  
8 be qualified as an expert in the field of urology.

9 **THE COURT:** And are there questions on expertise from  
10 any party?

11 **MR. FOSTER:** None from the Plaintiff, Your Honor.

12 **THE COURT:** And is there objection from any party? (No  
13 response.) Hearing none, then the witness is so qualified.

14 Q. Dr. Young, tell the jury did you have a  
15 physician/patient relationship with Kelly Fay?

16 A. No.

17 Q. All right, and explain to the jury what -- how do you  
18 define a physician/patient relationship?

19 A. I think it begins when you actually sit down, meet the  
20 patient, examine them, and arrive at a diagnosis.

21 Q. All right, and did you -- during the course of your  
22 career, do you get calls from emergency room physicians as  
23 well as other specialists about patients who have urologic  
24 issues?

25 A. Every day.

1 Q. Okay, and what are some of the reasons why you get  
2 these phone calls?

3 A. Well, oftentimes it's to -- they're sending me a  
4 patient that they think, you know, would benefit from my  
5 urologic care for them. That's probably the most common.  
6 Sometimes they just have a question about what they should do  
7 or whether or not the patient might even need to see me, so  
8 those are probably the two most common reasons they would call  
9 me, either for advice or to send me a patient.

10 Q. All right, and in those patients that you were --  
11 physicians, I guess, call you as far as referring those  
12 patients to you for you to see in follow-up. Do you have a  
13 physician/patient relationship with those patients that you  
14 were -- have agreed to see in follow-up?

15 A. No, not ---

16 **MR. FOSTER:** Objection; relevance.

17 A. --- until I actually see them.

18 **THE COURT:** All right, just a moment. Overruled.

19 And you may proceed.

20 Q. You said no, that you do not?

21 A. No.

22 Q. Okay, and why is that? Why do you not have a  
23 physician/patient relationship with a patient who you are  
24 going to -- I guess that you've agreed to see in the future?

25 A. Well, one, you don't really know if the patient is

1 going to come in until they actually come in. They may find a  
2 different urologist, you know. They may -- a friend may send  
3 them to somebody else. They may change their mind. They  
4 might get better before they come in, and even -- and even  
5 when they come in, we may not hit it off. I mean, they may  
6 decide they don't want to see me or even I may decide I can't  
7 take care of them.

8 Q. All right. Now, tell the jury, do -- you know, these  
9 phone calls that you get from emergency room physicians, from  
10 other specialists, how frequently are you called?

11 A. Oh, at least daily, and then if I'm on call, several  
12 times a day, yeah.

13 Q. But now the phone call in question, the call with Dr.  
14 Law back on January 26, 2002, do you remember that phone call?

15 A. I remember it, yeah.

16 Q. Okay. Tell the jury why you remember that phone call  
17 as compared to all the other phone calls that you receive.

18 A. Because Kelly Fay died.

19 Q. Tell the jury, I guess, why is it that because Kelly  
20 Fay died that you specifically remember this conversation.

21 A. Well, it was -- it was just a real shock to learn that  
22 she had died. It's just not something that commonly happens  
23 with a kidney stone.

24 Q. All right. Tell the jury what does it mean to be on  
25 call.

1 A. We have a urology practice. I have a few, you know,  
2 other physicians I mentioned that -- that work with me, and we  
3 take turns being available twenty-four hours a day, seven days  
4 a week, so that whenever somebody, you know, a patient of our  
5 practice has a problem, they can call and you have that  
6 problem, you know, addressed.

7 That's one aspect, the call is just taking care of the  
8 patients in our practice, and the other aspect is covering the  
9 hospital for any patients that may need urologic care there,  
10 so that's basically the purpose of having somebody available  
11 twenty-four hours a day.

12 Q. Did the fact that you were on -- let me ask you this.  
13 Were you on call at the time that Dr. Law called you?

14 A. Yes; yes.

15 Q. Did the fact that you were on call, did that in and of  
16 itself establish a physician/patient relationship?

17 **MR. FOSTER:** Your Honor, I'm going to object to the  
18 leading.

19 **THE COURT:** Counsel, overruled. That's not leading.  
20 Go ahead. You may restate your question if you wish.

21 **MS. SCALISE:** Okay.

22 Q. Doctor, the fact that you were on call, does that fact  
23 alone, does that establish a physician/patient relationship?

24 A. No.

25 Q. Can the hospital create a physician/patient

1 relationship for you with patients?

2 A. No.

3 Q. Can an emergency room physician create a  
4 physician/patient relationship for you with a patient?

5 A. Absolutely not.

6 Q. All right. Now, prior to January 26, 2002, did you  
7 know Dr. Law?

8 A. Oh, yes; yeah.

9 Q. Had you spoken to him before?

10 A. Yes.

11 Q. Had you worked with him before?

12 A. Yes. He's been at that hospital for at least a few  
13 years and we had a lot of interactions over patients.

14 Q. All right. Did you have any questions or concerns  
15 about Dr. Law's ability to diagnose and treat kidney stones in  
16 an emergency setting?

17 A. Not at all. We'd had previous kidney stone patients  
18 that we had discussed and treated together.

19 Q. Did you have any questions or concerns that Dr. --  
20 about Dr. Law's ability to diagnose and treat infection in an  
21 emergency setting?

22 A. No, not at all.

23 Q. Did you have any questions or concerns about Dr. Law's  
24 ability to determine if a patient needed to be admitted versus  
25 whether or not he could send a patient home?

1 A. Not at all, no.

2 Q. Based on your prior dealings with Dr. Law, do you  
3 believe that he would ask you for help or advice if he needed  
4 it?

5 A. Yes.

6 **MR. FOSTER:** Objection, Your Honor; speculation.

7 **THE COURT:** Overruled.

8 **MR. FOSTER:** Thank you, Your Honor.

9 Q. You said ---

10 A. Yes, he certainly would ask me for advice if he needed  
11 it.

12 Q. Based on your prior dealings with Dr. Law, do you  
13 believe that he would ask you to come in and see a patient if,  
14 in fact, Dr. Law thought you needed to see the patient?

15 A. Absolutely. I'm -- I'm sure he had, yes.

16 Q. And based on your prior dealings with Dr. Law, if he  
17 thought a patient needed to be admitted for a urologic  
18 condition, do you believe he would have called you and told  
19 you that?

20 A. Absolutely, yeah.

21 Q. Is there any reason at all for you to question Dr.  
22 Law's medical judgment or decision-making skills?

23 A. No.

24 Q. Now, in this instance when Dr. Law called you, did he  
25 ask you for advice concerning Kelly Fay?



1 A. No.

2 Q. Did Dr. Law ask you to come in to see the patient?

3 A. No.

4 **THE COURT:** Counsel, you are leading at this point.  
5 Just please ask him what -- a better question is what did he  
6 ask.

7 Q. Well, let me ask you that, then. What did Dr. Law tell  
8 you when he called you on January 26, 2002?

9 A. Again, I remember the phone call, but it's difficult to  
10 recall specifics. We -- especially since I went back and read  
11 through her chart when I learned she had died, so it's hard  
12 for me to tell you exactly what I learned on the phone call  
13 and what I learned from going through the medical record.

14 It's been a while, but he told me -- I remember him  
15 saying he had a patient with a stone, that he was getting  
16 ready to send her home, he thought that stone would need  
17 further care. It was five or six millimeters in size, was in  
18 the -- at the UPJ or the upper ureter, and I remember telling  
19 him that, yeah, if, you know, as long as she's afebrile and  
20 feeling better, she's fine to go home, but if it's, you know,  
21 a stone that big and that approximate to the ureter, there's a  
22 good chance she will need care. I agreed with him there, and  
23 I had him -- and I had him call the office to get an  
24 appointment Monday morning.

25 Q. All right. Now, in your phone call -- phone calls that

RICHARD W. YOUNG, M.D. - DIRECT BY SCALISE

1 you might have with, you know, doctors who are calling about a  
2 patient with a urologic condition, are there certain things  
3 that you normally find out about these patients?

4 A. Yeah. You do want to know in general, you know, why  
5 the -- why the emergency room doctor is calling you. They  
6 don't call about every stone that they see. You know, the  
7 typical stone is a smaller stone than what Kelly Fay had.  
8 It's usually more distal by the time it starts to cause a  
9 problem, and it's usually pretty likely that those stones will  
10 pass relatively uneventfully, but if you have a more proximal  
11 stone, if you have a larger stone, and larger probably  
12 starting to mean somewhere around five millimeters, those are  
13 the ones that the emergency room doctor is more likely to call  
14 you about. They are less likely to pass on their own, or if  
15 they do pass, they're going to take a much longer time.

16 The patient probably is going to need further care during  
17 that time. They may not be able to pass a stone. If they  
18 have a lot of pain, they develop a fever, they're going to  
19 need some sort of urologic intervention. They may need to  
20 have the stone treated in that case, so those are the patients  
21 they're more likely to call you about, patients like Kelly  
22 Fay.

23 Q. Did y'all have any conversation about whether or not she  
24 had any infection?

25 A. Yes. That's something that we usually want to clarify

1 whenever we're called about a stone, whether or not the  
2 patient is febrile, first of all, whether or not there's any  
3 other signs of infection.

4 Q. And what did Dr. Law tell you in that phone call about  
5 what you just told me?

6 A. We discussed the lab results, normally a urinalysis,  
7 the -- the CT scan, again where the stone was, how big it is,  
8 it's obstructing, and the fact that, yes, she probably would  
9 need further follow-up urologic care.

10 Q. Did y'all discuss anything related to her temperature?

11 A. He told me she was afebrile.

12 Q. Okay. Tell the jury what does that mean when an E.R.  
13 doctor tells you that a patient is afebrile?

14 A. Simply the patient doesn't have a temperature  
15 elevation, that she doesn't have a fever.

16 Q. Okay, and what -- is that significant?

17 A. Yeah. We've talked about it here the last couple of  
18 weeks. I think it's pretty clear to everybody that if you  
19 have a stone and a fever, that's an extremely serious  
20 situation.

21 Q. Did you ask Dr. Law what time the temperature was  
22 taken?

23 A. No; no.

24 Q. Have you ever asked any physician what time the  
25 temperature was taken when a physician tells you the patient

1 is afebrile?

2 A. No.

3 Q. Okay. In your opinion, to a reasonable degree of  
4 medical certainty, does the standard of care require you to  
5 specifically ask what time the temperature was taken?

6 A. No.

7 Q. All right. Now, based on what your testimony that you  
8 have given, I believe -- did you find out the size of the  
9 stone?

10 A. Yes.

11 Q. Did you find out the location of the stone?

12 A. Yes.

13 Q. Did you find out whether there was obstruction?

14 A. Yes.

15 Q. And what do you remember as to the amount of  
16 obstruction?

17 A. I vaguely recall him discussing the CT scan with me,  
18 and again I know I read through it a couple of days later, but  
19 it was a moderately to severely obstructing stone.

20 Q. Okay, and what did you learn about an infection?

21 A. That she had a normal urinalysis; she was afebrile.

22 Q. Did you ask him about whether there were any white  
23 blood cells in the urinalysis or in a complete blood count?

24 A. No. I didn't ask him about a complete blood count, no.

25 Q. Okay. In your opinion, to a reasonable degree of

1 medical certainty, is a complete blood count required in  
2 an ---

3 **MR. FOSTER:** Your Honor, this is still leading and I  
4 object.

5 **THE COURT:** Well, let me first of all hear the question.  
6 Let's pose the question, please.

7 Q. In your opinion, to a reasonable degree of medical  
8 certainty, is a complete blood count required in a patient  
9 such as Kelly Fay?

10 A. No.

11 **THE COURT:** Overruled as to that question.

12 **MR. FOSTER:** Thank you, Your Honor.

13 Q. Okay.

14 A. Thank you. No.

15 Q. Do you have an opinion if a complete blood count had  
16 been done on Kelly Fay what it would have shown?

17 A. Yeah. What -- I expect it would have been either  
18 normal or possibly marginally elevated, and pain can cause  
19 your white blood cell count to go up, so it's not uncommon for  
20 patients with an acutely obstructing stone to have an elevated  
21 white blood cell count.

22 Q. Do you feel that Dr. Law gave you the information you  
23 needed to know?

24 A. Yes; yes.

25 Q. Based on the information that Dr. Law gave you, was

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1     there any reason why this patient needed to be admitted?

2     A.     No.

3     Q.     Based on the information that Dr. Law gave you, was  
4     there any reason why Kelly Fay needed to receive an  
5     antibiotic?

6     A.     No.

7     Q.     And explain to the jury why that you're saying no to  
8     that.

9     A.     Yeah. Again, I think Dr. Maxted made it pretty clear  
10    yesterday, as well. You really don't give antibiotics to  
11    people who don't have a reason to be on antibiotics. They  
12    don't have the -- in -- in -- in dealing with stones, you  
13    would put somebody on antibiotics only if you thought they had  
14    an infection, but you wouldn't just put them on antibiotics.  
15    Usually you're going to admit that patient to the hospital to  
16    be certain they're not going to get a fever if you think they  
17    have an infection.

18    Q.     Did you rely on Dr. Law to give you accurate  
19    information as best he knew it?

20    A.     Yes.

21    Q.     All right. Let me ask you, so after Dr. Law told you  
22    this information, tell the jury again what you told him in  
23    response.

24    A.     Well, I basically told him to make sure that they had  
25    my phone number so they could get in to -- so they could call

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1 the office on Monday to get them in so if they -- she did need  
2 follow-up care, we could do it in an expeditious manner.

3 Q. Okay, and on these discharge instructions that were  
4 given to Kelly Fay, it has a phone number on that. Is that  
5 your phone number?

6 A. That's the office phone number, yeah.

7 Q. Okay, and what happens if a patient were to call this  
8 phone number on Saturday or Sunday?

9 A. They -- the answering service answers the phone on the  
10 weekends and the pager operator pages me with a message.

11 Q. Okay. Did you receive a message or a page on Saturday  
12 after you had the phone call with Dr. Law about Kelly Fay?

13 A. No, not about Kelly Fay, no.

14 Q. Did you receive any pages on Sunday about Kelly Fay?

15 A. No.

16 Q. Did you receive any pages on Monday about Kelly Fay?

17 A. No.

18 Q. Now, there's been some testimony that Sean Fay called  
19 your office on Monday morning. What is your understanding  
20 about what occurred on that Monday morning with regard to the  
21 phone call?

22 A. Well, he -- he actually talked to one of the nurses in  
23 our office that morning, did not say his wife was acutely ill,  
24 said she'd been to the E.R. with a kidney stone, and the nurse  
25 gave her an appointment, worked them into the schedule for

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1 that afternoon so I could see them then.

2 Q. Okay. Do you know if Mr. Fay had told your nurse that  
3 his wife had had fevers or chills what would have happened at  
4 that point?

5 A. She would have either -- well, she would have told them  
6 to go -- mostly likely she would have told them to go to the  
7 emergency room immediately. She might have told them to come  
8 to the office immediately.

9 Q. And is that something that you would have wanted to  
10 know if your patient had developed or if Kelly Fay had  
11 developed a fever or chills?

12 A. Absolutely.

13 Q. Okay, and why is that important?

14 A. Well, again, we've talked about it for the last week  
15 and a half, but that's a very serious situation.

16 Q. Did you ever bill Kelly Fay or Sean Fay?

17 A. No.

18 Q. Okay, and why not?

19 A. It didn't -- we didn't provide any service for them,  
20 so, no, they wouldn't get a bill.

21 Q. Did you ever receive any medical records from the  
22 hospital on Kelly Fay?

23 A. No.

24 Q. All right. Now, the jury has been shown -- here it is,  
25 Dr. Law's dictation that says cc: Dr. Richard Young.



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1 A. Right, and I expect that even did come to the office,  
2 and again, when a patient has been seen in the emergency room  
3 and the patient is asked to follow up, oftentimes the  
4 emergency room will send the record over so that we have it  
5 available so that when the patient makes the appointment we've  
6 already got that information on the chart when they come in.  
7 In Kelly's -- in Kelly Fay's case, unfortunately, she never  
8 came in, so we never made a chart.

9 Q. Now, tell the jury how you learned that Kelly Fay had  
10 passed away.

11 A. I learned on Tuesday morning. One of my nurses -- she  
12 hadn't -- she had missed her appointment Monday afternoon, and  
13 one of my nurses called and actually spoke to Mr. Fay Tuesday  
14 morning, and Mr. Fay told the nurse that Kelly had expired at  
15 the hospital Monday night, and she was shocked, I was shocked,  
16 to learn that, yeah.

17 Q. Okay, and so what did you do when you learned that?

18 A. I was in the middle of seeing patients that morning in  
19 the office, Tuesday, and at noontime I went over to the  
20 hospital, pulled up her records and talked to Dr. Molnar.  
21 Actually I would have talked to Dr. Law as well, but he was  
22 not -- he wasn't working that day, so I talked to Dr. Molnar,  
23 who was typically there during the day. He's the head of the  
24 emergency room, and we went through her chart, went through  
25 Dr. Law's note, the CT report, trying to figure out what had

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1 happened, you know, and there was really absolutely no sign  
2 that she had an infection while she was in the emergency room.

3 Q. When you went through that -- that note, you are  
4 referencing this E.R. report?

5 A. Yes; yeah. Dr. Law's dictated note is the first thing  
6 we looked at.

7 Q. Okay, and this would be something that you looked at on  
8 that Tuesday?

9 A. Yes.

10 Q. Now, if the doctor had not electronically signed it, is  
11 this document still available for you to look at?

12 A. Oh, yeah. We -- we even -- yeah, as soon as it has  
13 been typed, it's available on the hospital system, yeah.

14 Q. Okay. Was this wording, I did explain to the patient,  
15 however, that if her pain becomes out of control or if she has  
16 increasing nausea, vomiting, any fevers or chills, that she is  
17 to return to the emergency room immediately, Doctor, was that  
18 language in the report you looked at?

19 A. Absolutely. I specifically remember reading that.

20 Q. So based on your review of these records, looking back  
21 retrospectively, was there anything that you found that  
22 indicated Kelly Fay needed to be admitted on that day?

23 A. No, and we -- I mean, that's really what we were  
24 looking for, yeah.

25 Q. Dr. Young, to kind of summarize everything, did you at

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1 any point in time ever have a physician/patient relationship  
2 with Kelly Fay?

3 A. No.

4 Q. Was there any affirmative act that you performed that  
5 created a doctor/patient relationship with Kelly Fay?

6 A. No, there was not.

7 Q. Did the fact that you were the on-call urologist, did  
8 that establish a physician/patient relationship with Kelly  
9 Fay?

10 A. No.

11 Q. Did the standard of care require Kelly Fay to be  
12 admitted on that Saturday morning?

13 A. No.

14 Q. Did you meet the standard of care?

15 A. Insofar as I didn't give any care, but I certainly met  
16 the standard in returning the phone call and discussing the  
17 case with Dr. Law and arranged for follow-up, yeah.

18 Q. Did you do what a reasonably prudent urologist would  
19 have done under the same or similar circumstances with regard  
20 to Kelly Fay?

21 A. Yes. It's -- yes.

22 Q. Is there anything that you did that breached any  
23 standard of care or anything that a reasonably prudent  
24 urologist would not have done?

25 A. No, nothing.

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1 Q. Okay, now have your opinions that you've told to the  
2 jury, have they been to a reasonable degree of medical  
3 certainty most probably?

4 A. Yes.

5 MS. SCALISE: Thank you, Doctor. If you will answer any  
6 questions these other attorneys might have.

7 A. Thank you.

8 THE COURT: And cross-examination, Plaintiff.

9 MR. FOSTER: Thank you, Your Honor.

10 CROSS-EXAMINATION BY MR. FOSTER:

11 Q. Just to start off with, every question that Ms. Scalise  
12 just stood up and told you, those are your opinions, correct?

13 A. I'm not sure what you're driving at.

14 Q. Those are your opinions about whether you did this  
15 correctly, or whether you did that correctly, or whether  
16 you ---

17 A. Well, we discussed some facts of the case as well. We  
18 didn't just discuss opinions.

19 Q. A physician/patient relationship is not a fact, though,  
20 is it? That's your opinion, correct?

21 A. I'm not sure how to -- how to answer that.

22 Q. Let me ask it to you this way. Isn't it true, Dr. Law,  
23 and ---

24 A. I'm Dr. Young.

25 Q. Dr. Young, I'm sorry. Isn't it true that you've been

1 Q. Now, is it your testimony under oath, Dr. Young, that  
2 he specifically told you that she was afebrile or is that  
3 something that you think normally y'all might talk about?

4 A. No, that's something we always talk about.

5 Q. And if you knew the results of the CT scan, obviously  
6 your phone call was after ten-thirty in the morning, correct?

7 A. Correct, yes.

8 Q. And you would agree with me, as we've stated several  
9 times, if he told you that, there was no way for him to know  
10 that she was afebrile that time of the morning, correct, or  
11 any time after eight o'clock in the morning?

12 A. Well, again, this is something we've been through  
13 several times this week, but although a temperature was not  
14 taken after somewhere around eight o'clock in the morning when  
15 she came in, he did have other ways of knowing that she was  
16 afebrile, yes.

17 Q. Was there any way for him to tell you her temperature?

18 A. He told me her temperature, yeah. I mean, he told me  
19 she was afebrile, yes.

20 Q. Is there any way for him to have known what her  
21 temperature was after eight o'clock in the morning?

22 A. Absolutely.

23 Q. Sir?

24 A. Absolutely there was ways for him to know, yes.

25 Q. To know what her temperature was?

1 A. Well, there was ways for him to know if she was  
2 developing a fever, yes.

3 Q. I'm asking you about temperature, Dr. Young.

4 A. From reviewing the chart, I know that no temperature  
5 was taken after eight o'clock in the morning.

6 Q. So there was no way for him or anybody else to know  
7 what her temperature was after eight o'clock in the morning,  
8 isn't that true?

9 A. Again, we've been through it several times this week.  
10 If somebody else had -- if somebody had taken her temperature  
11 we would know for certain, but yeah.

12 Q. Now, you mentioned several times when Ms. Scalise was  
13 asking you questions that if she had a kidney stone and a  
14 fever or a kidney stone and an infection, either one, that it  
15 was a very serious condition, correct?

16 A. That's correct.

17 Q. But -- but the truth is what you testified to  
18 previously and what everybody else has -- you've been in here  
19 all -- for the last week and a half, correct?

20 A. Yes.

21 Q. Is a kidney and a fever stone (sic), in your own words,  
22 is a true urologic emergency, correct?

23 A. That's correct.

24 Q. All right, and if -- you agree with me there was  
25 obstruction there, correct?

1 A. There must have been obstruction there for her to -- I  
2 mean, patients don't develop pain from kidney stones unless  
3 there's obstruction.

4 Q. Okay, and if Dr. Law relayed information to you about  
5 her condition, then you knew that it was his impression that  
6 she had severe hydroureter, correct?

7 A. I don't know if he used those terms precisely when I  
8 talked to him, but yes, I knew she had an obstructing stone in  
9 the ureter.

10 Q. But that would be important for you to know, would it  
11 not, whether or not she had severe hydroureter with urine  
12 backed up behind the stone?

13 A. No.

14 Q. That wouldn't be important?

15 A. Again, the -- the -- the degree of obstruction, the  
16 degree of hydronephrosis, are some factors that may give you a  
17 guess as where a patient may or may not pass a stone, but I  
18 don't think it's important in deciding whether or not a  
19 patient can go home or how acutely you're going to intervene  
20 in that patient.

21 Q. Dr. Law (sic), if, in fact, Kelly Stone -- Kelly Fay  
22 had a fever and kidney stone that day and if Dr. Law would  
23 have called you and told you that she's got a kidney stone and  
24 a fever with severe hydroureter, the reason it's an emergency,  
25 and what you would have done is you would have rushed to the

1 hospital, put her in the O.R. and drained that urine, correct?

2 A. Again, if a patient has a stone in the ureter and they  
3 have a fever, they're almost certainly going to be admitted to  
4 the hospital, and the -- the purpose is, one, if you ascertain  
5 that, yes, that fever is due to that obstructing stone, I mean  
6 if there's infection in the urine behind the stone, yes,  
7 you're going to take that patient promptly to the emergency  
8 room. They're going to be on IV fluids. They're going to be  
9 given antibiotics. You're going to observe those patients  
10 very closely for any signs of sepsis developing. Yeah, that's  
11 an emergency, yeah; yeah.

12 Q. And didn't you previously testify under oath that what  
13 you would have done was you would have gone in immediately and  
14 put a stent up there to drain that ur- -- that static urine  
15 that was back behind the stone?

16 A. Yeah. That's what I was just talking about, yeah.

17 Q. That would be your course of action, wouldn't it?

18 A. Yes. If you have a -- if you're certain you have an  
19 infected stone in the ureter and an infection proximal to it,  
20 you have to put a stent in to get that urine draining.

21 Q. Okay, and both you and Dr. Law knew she -- knew she was  
22 going to need further urologic care, did you not, from you?

23 A. Well, we didn't know, but, I mean, when you have a  
24 patient with a proximal stone that's more than five or six --  
25 five or six millimeters in size, there's a good chance they're



1 going to need some urologic care. They'll need it, or more  
2 pain medicine, or if the pain gets bad enough, you'll  
3 intervene and maybe treat the stone with lithotripsy or  
4 ureteroscopy, and again, certainly if they develop an  
5 infection, you'll -- you'll bring them into the hospital,  
6 yeah.

7 Q. Okay, and had you so chosen, there was nothing  
8 preventing you from going on Saturday and draining Kelly ---

9 A. Well, there was no reason -- there was no reason to go  
10 in on Saturday and do that.

11 Q. I understand that's your opinion, but what I'm asking  
12 you is there was nothing preventing you from going in and  
13 doing that on Saturday, was there?

14 A. No, there was.

15 Q. Okay. What prevented you from doing it on Saturday  
16 other than your opinion she didn't need it?

17 A. From what Dr. Law told me, she was not a candidate for  
18 surgery, no.

19 Q. Okay. If you had so chosen, if he had given you  
20 information to make you believe that perhaps this was a close  
21 call here, there was nothing preventing you from going into  
22 the hospital and draining that urine on Saturday, was there?

23 A. If she had a fever, I most certainly would have done  
24 that, yes.

25 Q. And isn't it also true, Dr. Young, you're talking about

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1 A. Yeah. He -- he -- he called. He actually spoke to one  
2 of the nurses and never mentioned how ill Kelly was, and made  
3 an appointment, yeah.

4 Q. And you learned exactly what he said to the nurse how?

5 A. I've spoken to the nurse who -- who made the  
6 appointment, yeah.

7 Q. Okay, and no nurse called that day to say, hey, it's  
8 three o'clock, why aren't you here, did they, three-thirty,  
9 four o'clock? Nobody called Monday to say, hey, ---

10 A. No, no. We -- we -- I don't know exactly when we  
11 picked it up, but Tuesday morning we called. She hadn't come  
12 in and wanted to know if she was doing fine or if she was  
13 still going to have me -- to see a urologist, yeah.

14 Q. All right, and your practice obviously, Dr. Young, is a  
15 for-profit practice, correct?

16 A. Yes; yeah.

17 Q. And Grand Strand is a for-profit hospital, correct?

18 A. Yes.

19 Q. Now, Dr. Young, another point, this being another --  
20 and I want to make sure you agree, is that the only one that  
21 could have admitted Kelly on Saturday was you, correct? That  
22 was between you and Dr. Law?

23 A. Yeah. Technically emergency room physicians don't have  
24 admitting privileges, so if they have a patient who needs to  
25 be admitted, they have to call a consultant or specialist to

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1 admit them, yeah.

2 Q. And you recall previously testifying under oath, and  
3 you've heard Dr. Law's testimony yesterday wherein you both  
4 agreed that she could wait until Monday, did you not?

5 A. Yeah. I agreed with Dr. Law's assessment that ---

6 Q. So that was a joint decision that she could be made --  
7 that she could wait until Monday to see you, correct?

8 A. Well, I don't want to parse words, Mr. Foster, but he  
9 decided to send her home. He presented the case to me, and I  
10 agreed with him it sound like she was okay to go home, yeah.

11 Q. You agreed that the patient could be discharged, which  
12 was potentially a life or death decision, correct?

13 A. Usually we don't do -- view discharge from the  
14 emergency room as a life or death decision, no. This patient  
15 appeared to be like many patients we have with kidney stones.  
16 There was no sign of infection when she was in the emergency  
17 room. She didn't have a fever. Her pain was well-controlled,  
18 and, yeah, those patients are sent home. They are not  
19 admitted.

20 Q. And the second-most reason, other -- other than -- the  
21 second-most common reason that an E.R. doctor will call you  
22 with a kidney stone patient, other than pain, is a kidney  
23 stone and a fever, correct?

24 A. I'm not sure that's the second-most common reason. It  
25 is certainly one of the common reasons to get called, yeah.

1 Q. Do you recall tes- -- turn to page thirty, if you  
2 would, please sir. Are you there?

3 A. Yes.

4 Q. All right. My question on line two was, my question  
5 then would be why do you get phone calls? Why do you get an  
6 emergency room physician consulting with you in regard to  
7 kidney stones, and your answer was if they have a patient  
8 whose pain they can't control, then they'll call me so that we  
9 can admit the patient to the hospital for better pain control.  
10 That's the most common thing. The next most common reason is  
11 that they have a patient with a kidney stone and a fever.  
12 Isn't that what you said?

13 A. That's exactly what I said, yeah.

14 Q. And isn't it also true, Dr. Young, if an E.R. physician  
15 is unsure about a patient, they have complicating factors that  
16 they're unsure about, they're going to call you and consult  
17 with you, too, correct?

18 A. Correct.

19 Q. And you would -- well, I've asked you -- I know we've  
20 talked about this and we've talked about it in a roundabout  
21 way, but I want to be specific. The standard of care does  
22 require you to admit a patient with a kidney stone and a fever  
23 that you can't attribute to another source, correct?

24 A. Yes, that's correct.

25 Q. And it's -- your personal practice is to admit those

1 patients, correct?

2 A. Yes.

3 Q. And the reason for that, Dr. Young, is just what we've  
4 talked about? If you -- if you've got a kidney stone, if they  
5 really don't admit them and drain that urine, then that leads  
6 to urine sepsis and death, does it not, if it's not treated?

7 A. In patients who come to the emergency room with a  
8 kidney stone and a fever, they are absolutely going to be  
9 admitted, yeah.

10 Q. Now, do you recall previously testifying under oath  
11 that when you talked to Dr. Law that he said he didn't think  
12 there was any sign of fever?

13 A. No, I don't remember that specifically.

14 Q. All right. Would you turn to page thirty-nine, please  
15 sir. All right, I asked you the question on line three, tell  
16 me what Dr. -- tell me what Dr. Law told you, and your answer  
17 on line four was, again, I don't remember the specifics of the  
18 conversation, but I remember him saying that he had a patient  
19 in the emergency room with a stone that he saw on CT scan and  
20 that he thought the pain was well-controlled, and he was going  
21 to send them home, and that he didn't think there was any sign  
22 of fever and he thought she'd be okay to go home, but he said  
23 the stone was about five or six millimeters in size and he  
24 thought that she would probably need follow-up, correct?

25 A. That's what it says.

1 Q. All right, so you -- he didn't think there was any  
2 fever, correct?

3 A. Correct.

4 Q. And at that point in time did you say, Dr. Law, you  
5 can't think about that. You've got to know whether she's got  
6 -- you send home a patient with a kidney stone and a fever or  
7 not?

8 A. I just have to remind you, Mr. Foster, that again I  
9 don't remember the specifics of the conversation, and that's  
10 what it says right there in the deposition you just read.

11 Q. And you never asked him whether or not she had a fever,  
12 did you?

13 A. I -- I -- when we talk to patients in the -- when we  
14 talk to emergency room physicians about kidney stones, that is  
15 one of the details we invariably discuss, yes.

16 Q. You didn't ask him whether she had -- you don't think  
17 you asked him whether she had a fever, did you?

18 A. I think ---

19 **MR. AIKEN:** Your Honor, I would object to the  
20 redundancy. We've been over this time and time again.

21 **MS. SCALISE:** I agree, Your Honor.

22 **THE COURT:** Counsel, no -- no speaking objections.  
23 Sustained. This has been asked and answered.

24 Q. You didn't -- you didn't ask him whether or not it was  
25 an obstructing stone, did you?

1 tract infection?

2 A. Well, I'm not sure exactly what you're driving at.  
3 Again, you don't -- there's no one thing that you do when you  
4 think someone has a -- that makes you think someone has an  
5 infection. That's a clinical scenario.

6 Q. You think a urine culture is better at diagnosing an  
7 infection than a urinalysis?

8 A. If you think a patient has an infection, you may or may  
9 not do a culture. Certainly if you think a patient has a  
10 kidney stone -- if a patient has a kidney stone and you think  
11 they have an infection, you're going to do a culture.

12 Q. Okay. If you do a culture and it grows bacteria, you  
13 can see the infection, can you not?

14 A. Well, that's -- yeah, the bacteria growing on the  
15 culture plate, and you can see the bacteria.

16 Q. Okay, and isn't it true that you believe, Dr. Young,  
17 that the key finding is a fever in a patient with a kidney  
18 stone?

19 A. Well, that's the -- that's what prompts the decision if  
20 someone is going to have to have a -- is going to have to be  
21 admitted to the hospital, certainly, that's what -- one of the  
22 things that prompts the decision, yeah.

23 Q. And you agree with everybody else's simple proposition  
24 that the best way to determine whether somebody has a fever is  
25 take their temperature, correct?

RICHARD W. YOUNG, M.D. - CROSS BY FOSTER

1 A. Yes.

2 Q. And would you agree with me, Dr. Young, and the truth  
3 of the matter is if a patient with a kidney stone has a fever,  
4 they're not stable, are they? They're not stable for  
5 discharge?

6 A. No, we don't discharge patients in that situation.

7 Q. And you wouldn't consider that patient stable, would  
8 you?

9 A. Well, they're usually stable. I mean, they're ---

10 Q. Stable for discharge?

11 A. No. I said we don't discharge a patient in that  
12 situation. They're usually -- by stable I mean  
13 hemodynamically stable. Their blood pressure is stable; their  
14 pulse is stable usually.

15 Q. All right. Dr. Young, you agree that the standard of  
16 care in evaluating a patient with a kidney stone, whether it's  
17 obstructed or not, requires the examining physician to rule  
18 out infection, true?

19 A. Yes. When someone has a kidney stone, we want to be  
20 certain they do not have an infection.

21 Q. All right, and you -- isn't it also true, Dr. Young,  
22 that temperature is what drives the decision-making process as  
23 to whether or not a person needs emergency treatment?

24 A. Yes. When someone has a kidney stone, we always check  
25 their temperature.



1 suspicion for whether or not there's white blood cells in the  
2 urine. If it's positive, you then actually examine the  
3 urinary sediment to confirm that there is no contaminants  
4 causing a false-positive.

5 Q. All right, and that was the only thing done with Kelly  
6 Fay to rule out infection, was a dipstick, correct?

7 A. She had a negative urine dipstick.

8 Q. That was the only thing done to rule out infection in  
9 Kelly Fay was a dipstick, correct?

10 A. The dipstick has all those tests on it that we talked  
11 about before, but that was -- that was the -- the main  
12 laboratory test that was done to rule out infection, yes.

13 Q. All right. Her temperature wasn't even taken after  
14 eight o'clock in the morning, was it?

15 A. Her temperature was taken at eight o'clock in the  
16 morning, yes.

17 Q. It wasn't taken after eight o'clock, was it?

18 A. No, it was not taken after eight o'clock, no.

19 And, in fact, you know, -- well, talking about temperature,  
20 I'll just give you a scenario. Patients often come into our  
21 office with kidney stones, particularly patients who've had  
22 them before, but sometimes new patients call up knowing that  
23 it would be easier to get seen there quickly than go to the  
24 emergency room, and typically what we do is -- is when we see  
25 those patients, what we do is a urinalysis to make sure they

1 crannies, does it not?

2 A. If a stone has been there for a very long time, it can  
3 start to fill them in, but even then oftentimes doesn't  
4 completely obstruct, yeah. I've seen stones that have sat in  
5 the ureter for weeks and weeks, even months, rarely even  
6 years, that were not obstructing, were fairly large sometimes,  
7 yeah.

8 Q. And you've seen them -- you've seen them kill somebody  
9 within a little over forty-eight hours, hadn't you?

10 A. Unfortunately, yes.

11 **THE COURT:** Counsel, it's been twenty minutes. Anything  
12 further?

13 **MR. FOSTER:** Yes sir. I'm getting ready to sit down,  
14 Your Honor.

15 Q. And again, just to make sure as far as discharging her,  
16 that's what you -- in your own words is that's what we  
17 decided, correct?

18 A. That's -- that's what it says in the deposition, yeah.

19 Q. And lastly, Dr. Young, everything you said about that  
20 urinalysis assumes that she was getting urine down that  
21 ureter, that right ureter, correct?

22 A. No, that's not really true. Again, when -- when  
23 someone comes in with acute kidney stone pain, we do a  
24 urinalysis and if there's no sign of infection on the  
25 urinalysis, we have no reason to think there's infection

JURY OUT/ON RECORD

1       **THE COURT:**   We'll be in recess now.

2       **(THE FOLLOWING TAKES PLACE AFTER A LUNCH BREAK AND**  
3       **OUTSIDE THE PRESENCE OF THE JURY.)**

4       **THE COURT:**   All right, while our jury is out, let's just  
5       -- let's go on the record and memorialize what happened in a  
6       conversation earlier this morning at the bench that was not on  
7       the record.

8       I am aware that the parties in this case, I expect,  
9       probably are going to have Two Hundred Thousand Dollars in  
10      costs. We are in our eighth day of trial. This upcoming  
11      weekend is Memorial Day Weekend. The Court is, of course,  
12      concerned about judicial economy, as well as alleviating  
13      expenses, but more particularly if we can avoid calling  
14      particular witnesses and specifically experts on the area of  
15      urology, I felt I needed to tell the parties if that was a  
16      possibility.

17      I called the lawyers up. I asked them if -- what motions  
18      would be made at the end of the trial most likely, and all of  
19      the Defense Counsel told me they would be making the same  
20      motions, which were motions for a directed verdict at the end  
21      of the case.

22      At that point, I advised Counsel for Dr. Young that it  
23      was the Court's most likely intention to dismiss this case  
24      against Dr. Young at the conclusion of all the evidence upon  
25      the appropriate motion. I did that, again, because if that

JURY OUT/ON RECORD

1 could avoid calling Dr. Albala, who is an expert on the issue  
2 of urology, who cannot be here until Thursday, and thus speed  
3 the trial, I felt that that would be a better course rather  
4 than have a witness here who may not be necessary.

5 Now, I'll be glad to hear from the parties. I simply  
6 start by memorializing what was said. If there are  
7 discussions that you wish or responses you wish to put on the  
8 record at this time, I'll be glad to hear from you.

9 Plaintiff, you are the one who is aggrieved by this. You  
10 may have a response. If so, please go ahead.

11 **MR. FOSTER:** Thank you, Your Honor.

12 Your Honor, we believe that the standard of care at the  
13 directed verdict motion would -- first of all, we think it's a  
14 jury question as far as -- as far as Dr. Young is concerned.  
15 We believe that the directed verdict standard is not the  
16 weight of evidence by the Court, but the existence of  
17 evidence, and if it -- if it there exists and all reasonable  
18 inferences, still even at the end of the case, are to be drawn  
19 in the light most favorable to the non-moving party.

20 We believe, in that case again, this is a jury question  
21 based on the fact that we had not only Dr. Siroky who gave his  
22 opinion that he (sic) should have been admitted, that Dr.  
23 Young should have had him (sic) admitted to the hospital that  
24 weekend because he was the only one that -- had Kelly admitted  
25 to the hospital that weekend because he was the only one that

JURY OUT/ON RECORD

1 could admit her, but he said he deviated from the standard of  
2 care by not determining either through information obtained by  
3 Dr. Law or direct examination that the patient did not need  
4 admission to the hospital or did not need admission to the  
5 hospital for treatment of a urinary stone, and I'm not going  
6 to get into every detail for the record that Dr. Siroky -- but  
7 certainly Dr. Siroky testified that in his expert opinion that  
8 Dr. Young deviated from the standard of care and that that  
9 proximately -- that it proximately caused Mrs. -- proximately  
10 caused Kelly's death.

11 Now, in addition to that, we've got -- we've got evidence  
12 in the case by Dr. Young and Dr. Law, but specifically by Dr.  
13 Young, that he met with Dr. Molnar to see if, quote, we missed  
14 anything, being him and Dr. Law. We've got evi- -- Dr.  
15 Siroky's testimony, his -- Dr. Young's testimony that he was  
16 the only physician that could admit her, Dr. Young's testimony  
17 that he did not ask about blood in the urine, he did not ask  
18 about the time or degree of temperature, did not ask about a  
19 CBC, did not ask about a urine culture, did not ask about  
20 obstruction, did not ask about infection, which he knew if  
21 there was infection there it would be an emergency.

22 Dr. Maxted even said that the urologist should read his  
23 own CT results and not rely on the radiologist, which, of  
24 course, Dr. Young never did.

25 We think it's an issue for the jury, Your Honor, and also

## JURY OUT/ON RECORD

1 it is in the record, Your Honor, and I didn't want to argue  
2 with you in front of the jury about that, and I don't want to  
3 argue with you to start with, ---

4 **THE COURT:** No, go ahead.

5 **MR. FOSTER:** --- but I want to say this for the record.  
6 It is in the record that Dr. Young had to be paged more than  
7 once, and that was from Dr. Law. That is in the record.

8 **THE COURT:** All right. Well, anyway, you go ahead.  
9 Excuse me.

10 **MR. FOSTER:** Okay. He knew she would need further  
11 urological care. He said it was a joint agreement to  
12 discharge the patient and that that was -- and Dr. Young  
13 agreed with me that that was a life or death decision. He  
14 agreed it was a joint agreement, and he agreed that the  
15 standard of care required admission of a patient with a kidney  
16 stone and a fever, and there's no question by anybody in this  
17 case in a week and a half that they did not take her fever  
18 after eight o'clock in the morning and that it could certainly  
19 spike within four hours.

20 Your Honor, based on that, we think that it's really up  
21 to the jury to weigh -- the law says it's up to the jury to  
22 weigh the expert testimony and the testimony of Dr. Young in  
23 this case and determine whether he has any liability in this  
24 case or not and not for the Court to weigh it at this point in  
25 the trial and determine.

JURY OUT/ON RECORD

1       **THE COURT:** Let me -- let me respond to you, Counsel,  
2 and I've given this substantial thought. I have followed this  
3 issue closely once it was crystalized at the summary judgment  
4 motion that was made prior to us drawing the jury and  
5 beginning the trial, and thus I've listened closely throughout  
6 this testimony for evidence of Dr. Young's involvement or  
7 culpability, if you wish to state it that way, but before we  
8 talk about that, let's look at the big picture.

9       Every weekend, there are hundreds of physicians who are  
10 on call for various specialties throughout this state, and  
11 what the evidence shows here is that Dr. Young took a  
12 telephone call. He had a telephone conversation, and then he  
13 made an appointment or at least allow- -- suggested that the  
14 person, now deceased, make an appointment for -- or call  
15 Monday morning to have an appointment with him. That was, I  
16 think, ostensibly, just looking at the big picture, that was  
17 the involvement that Dr. Young had, without getting into  
18 specifics.

19       I can tell you again, still looking at the big picture,  
20 that this Court cannot enact judicially or support a public  
21 policy that would require a physician that every time that  
22 specialist or physician takes a phone call with regard to a  
23 patient, that he is automatically locked in for responsibility  
24 for whatever the outcome may be. This is -- thus it's not the  
25 way medicine is practiced in South Carolina and it cannot be

JURY OUT/ON RECORD

1 that our courts would set up a system where the doctor would  
2 have liability for what simply occurs in the course of a  
3 telephone call when a physician is on call when the phy- --  
4 when the on-call physician is really not the one who is making  
5 the decisions here.

6 You complain -- now, getting down to the little picture  
7 of this specific case, you complain that the hospital didn't  
8 take a discharge temperature. You theorize from that, and  
9 there is testimony to the effect that she must have had  
10 temperature, although there's evidence to the contrary, but  
11 that because there was no discharge temperature, she was  
12 febrile at the time she left, she had an infection, she went  
13 home, and she died from that. This is the Plaintiff's theory.  
14 Well, if there was a mistake that was made, the mistake was  
15 made by the hospital or by Dr. Law and, of course, that's  
16 hotly disputed, but not by Dr. Young.

17 South Carolina's public policy has to be that an on-call  
18 specialist must be able to rely on the information given to  
19 him by a competent, capable, and certified emergency room  
20 physician. Otherwise, again, there'd be no end to the duty on  
21 the physicians, that is those who are on call, the  
22 specialists, to verify every piece of information that they  
23 are given in a telephone conversation, and the practice of law  
24 -- well, the practice of medicine, nor does the practice of  
25 law for that matter, although I misstated it, just simply



1 can't permit that and, therefore, the Court's ruling -- and  
2 again, I don't have all the evidence in.

3 I just tipped, if you want to put it that way, the  
4 lawyers to the point that it appeared to me that Dr. Young was  
5 going to be released from this case at the end of all the  
6 evidence so that he would not feel it necessary to call  
7 additional witnesses in his favor, but it just seems to me  
8 that we cannot support a policy that would put that kind of  
9 burden on a specialist or on a physician who is on call, and  
10 now, of course, the decision -- this issue about whether or  
11 not there was a mistake made by Dr. Law, well, the hospital,  
12 again, that -- this is where the battleground in this case is,  
13 not what Dr. Young did.

14 The only evidence in the record that would tend to make  
15 it appear that Dr. Young had something to do with this  
16 decision and what came from Dr. Law on a leading question from  
17 you, which was appropriate on cross-examination, you said  
18 wasn't this really a joint decision between the two of you  
19 that she could go home, and the response of that was yes.

20 Now, when I have -- have these issues, before I take the  
21 evidence I have to give every inference to the non-moving  
22 party. However, when I've heard the evidence, there's not a  
23 lot of inferences to simply be given because I've heard what  
24 the evidence is, and the evidence on that point is that -- and  
25 perhaps -- and this is consistent with construing what Dr.

1 Law's testimony was when he called it a joint decision.

2 I think what he probably was saying was that Dr. Young  
3 might have -- he might have given Dr. Young the credence to  
4 reverse the decision to release her, but it was his decision  
5 to release her. Dr. Law testified to that, and Dr. Young has  
6 testified to that. There's no evidence to the contrary, and  
7 thus for that reason, Dr. Young has no responsibility here.

8 And then finally, just like Dr. Law cannot discharge --  
9 excuse me, cannot admit someone to the hospital, well, Dr.  
10 Young can't discharge someone from the emergency room when  
11 they're being treated by Dr. Law. Obviously the decision to  
12 discharge was Dr. Law's, and thus therein is where your  
13 complaint lies, not with Dr. Young.

14 These are the reasons that the Court would intend at the  
15 appropriate time to release Dr. Young from the case upon  
16 appropriate motion.

17 I just simply have that discussion with you now so that  
18 the record would be clear and in the event of appellate review  
19 of that decision, your position, as well as the Court's  
20 position, would be stated.

21 If you have something further either side wishes to add  
22 so -- for completeness of the record, we'll be glad to hear  
23 from you at this time before we call the jury back in.

24 **MR. FOSTER:** Your Honor, could I just make one more  
25 statement and one question, Your Honor?

1       **THE COURT:**   Go ahead.

2       **MR. FOSTER:**   Thank you, Your Honor.  Your Honor, I would  
3       just like to read from Roberts v. Hunter, which is -- I  
4       believe we all agree is the current law in South Carolina, and  
5       what we were going to request the Court to charge was -- was  
6       this out of **Roberts**:  The establishment of a doctor/patient  
7       relationship is prerequisite to a claim of medical  
8       malpractice.  The relation is a consensual one wherein the  
9       patient knowingly seeks the assistance of a physician and the  
10      physician knowingly accepts him as a patient, and we believe  
11      that that was fully established through the records, and the  
12      signing, and the phone conversation between Dr. Law and Dr.  
13      Young.

14           Now, my question to you is this, Your Honor -- I  
15      understand your ruling.  I just wanted to put that on the  
16      record.

17       **THE COURT:**   Very good, and, Counsel, I should reply to  
18      that.  I probably didn't say this, but the decision is not  
19      based on the patient/physician issue.  The Court does not  
20      reach that issue.  It's not necessary to determination here.  
21      I find as a matter of law there's no negligence on the part of  
22      Dr. Young and don't even reach the patient/physician issue ---

23       **MR. FOSTER:**   Okay.

24       **THE COURT:**   --- simply because there's no underlying  
25      negligence on which a recovery could be grounded.

1       **MR. FOSTER:** I understand, Your Honor. We're all  
2 getting tired.

3       Can I ask this, Your Honor, and this is what would --  
4 what concerns me probably more at this moment than anything,  
5 is the way that Dr. Young is going to be released and the way  
6 the jury is going to perceive that. I mean, does Your Honor  
7 have any idea how you intend to handle that or ---

8       **THE COURT:** Well, what I would intend to do, and again,  
9 this is going to happen at the end of all the evidence, which  
10 is when their motion would be appropriate, and again, we're  
11 still taking evidence here and it's possible something could  
12 come out, I suppose, that would reverse that. I doubt it  
13 because the two people involved in that conversation, which is  
14 pivotal, that telephone conversation, now have both testified,  
15 which is Dr. Law and Dr. Young, but I would intend at the  
16 close of the evidence, if the motion is made, to grant that  
17 motion, and then prior to charging the jury would tell them  
18 that Dr. Young has been released from the Court -- by the  
19 Court as a matter of law and your case against him has been  
20 dismissed, he is no longer a party. That's the way I  
21 generally tell it.

22       **MR. FOSTER:** Any chance, Your Honor, we can just say  
23 that Dr. Young is no longer in the case and it's not -- and it  
24 is not for their consideration one way or the other?

25       **THE COURT:** Well, let me just simply say that I'll let

1 you talk to the other parties. If y'all reach some consensus,  
2 I will abide by the consensus you reach, but it would be my  
3 position, absent consensus and agreement, that I would simply  
4 tell them the way it's happened. They've sat here and  
5 listened. They've invested eight days of their lives thus  
6 far, and they would have the right to know that it was a  
7 decision by the Court, and I would tell them that.

8 **MR. FOSTER:** All right. Thank you, Your Honor.

9 **THE COURT:** One other thing I did not say in my -- in my  
10 soliloquy was Dr. Siroky's testimony about Dr. Young having  
11 the necessity of going beyond what he's told by Dr. Law in  
12 checking about what time was the temperature given and  
13 checking behind the other facts establishes a standard that is  
14 simply not the law of South Carolina, and thus the Court  
15 rejects Dr. Siroky's testimony on that point as against being  
16 inappropriate under South Carolina law and thus not a grounds  
17 to hold Dr. Young in the suit.

18 Anything further now before we close this discussion and  
19 bring the jury in?

20 **MS. SCALISE:** Nothing, Your Honor. I think that you  
21 said it very well, so all of our motions we'll make at the  
22 end. Is that what you're asking us to do?

23 **THE COURT:** Right; right.

24 **MS. SCALISE:** Thank you, Your Honor.

25 **THE COURT:** And I realize, you know, Dr. Young is

1 STATE OF SOUTH CAROLINA ) COURT OF COMMON PLEAS  
 2 COUNTY OF HORRY ) (08-CP-26-9047)  
 3 ) (08-CP-26-9368)  
 4 SEAN D. FAY, as Personal )  
 5 Representative of the )  
 6 Estate of Kelly L. Fay, )  
 7 deceased. ) TRANSCRIPT OF RECORD  
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 B E F O R E:  
 HONORABLE J. MICHAEL BAXLEY, Judge; and a jury.  
 A P P E A R A N C E S:  
 RUSKIN C. FOSTER, ESQ.  
 BRADLEY HEWITT, ESQ.  
 ATTORNEYS FOR PLAINTIFF  
 MONTEITH P. TODD, ESQ.  
 RANDOLPH L. LEE, ESQ.  
 ATTORNEYS FOR DEFENDANTS, GRAND STRAND  
 J. BOONE AIKEN, III, ESQ.  
 ATTORNEY FOR DEFENDANTS, LAW AND CAROLINA HEALTH  
 MARIAN SCALISE, ESQ.  
 LYDIA L. MAGEE, ESQ.  
 ATTORNEYS FOR DEFENDANT, YOUNG  
 DIXIE COX EUBANK  
 CIRCUIT COURT REPORTER  
 FIFTEENTH JUDICIAL CIRCUIT  
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 (SEE VOLUME 1 FOR INDEX)

1 We did the best we could.

2 **THE COURT:** Very good.

3 All right, anything else now before we go into motions?

4 (No response.)

5 All right, let's take up our motions at the close of the  
6 case. We'll go first to Dr. Young.

7 **MS. SCALISE:** Thank you, Your Honor. May it please the  
8 Court.

9 First, I'd like to incorporate by reference all of the  
10 arguments that were made in relation for summary judgment  
11 memorandum, the arguments made at the hearing on the motion  
12 for summary judgment, and arguments made at the close of  
13 Plaintiff's evidence. In addition, Your Honor, as a matter of  
14 law, the only reasonable inference that the jury could  
15 determine based on the evidence and testimony is that Dr.  
16 Young was not negligent or culpable, first, as it pertains to  
17 the physician/patient relationship. We believe that there is  
18 no evidence of a physician/patient relationship on the  
19 testimony that has been heard by this jury is that Dr. Law  
20 called to arrange follow-up because Dr. Law had already  
21 determined that the patient was capable of being discharged  
22 because the stone was not going to pass.

23 The agreement was for Dr. Young to see the patient in the  
24 future. In looking at the Roberts v. Hunter case, 426 S.E.2d  
25 797, that case found that there was no physician/patient

1 relationship when the doctor agreed to see the patient, but  
2 the patient was never examined, so absent contact with the  
3 patient, we believe that there is no physician/patient  
4 relationship.

5 Additionally, Your Honor, the issue of the on-call status  
6 does not establish a physician/patient relationship. There's  
7 no testimony that the hospital or the emergency room physician  
8 can create a physician/patient relationship for Dr. Young.  
9 Additionally for public policy reasons, the on-call status  
10 cannot create a doctor/patient relationship. Otherwise, no  
11 physician would ever take calls, so, Your Honor, based on the  
12 testimony and the evidence in this case, the only inference  
13 from this is that Dr. Young did not have a physician/patient  
14 relationship with Kelly Fay.

15 Secondly, Your Honor, we believe that there's no evidence  
16 as a matter of law that Dr. Young was negligent or culpable.  
17 Dr. Siroky's testimony was that the standard of care require  
18 that Dr. Young find out (a) the size of the stone, (b) the  
19 location of the stone, (c) obstruction, and (d) if there was  
20 an infection.

21 Based -- Dr. Young has testified that he found out that  
22 information. That's why specifically when he was testifying I  
23 checked on the board everything that he said, went through all  
24 those different issues, so based on Dr. Young's testimony, he  
25 has met the standard of care as required by Dr. Siroky, so



## MOTIONS

1 that's the only reasonable inference that a jury could make is  
2 that Dr. Young did comply with the standard of care.

3 Specifically, there is no testimony that Dr. Young did  
4 not have the right to rely on the information Dr. Law gave.  
5 The information that Dr. Law gave was accurate. There was no  
6 reason for Dr. Young to not believe he was receiving accurate  
7 information, so, in fact, the only and consistent evidence is  
8 that Dr. Young had this right to rely on Dr. Law.

9 Dr. Law told him that she was afebrile, or told Dr. Young  
10 that the patient was afebrile. If Dr. Law was incorrect and  
11 the patient was febrile, Dr. Law would not have any -- Dr.  
12 Young would not have any evidence of this or reason to dispute  
13 the same, and thus he has a right to rely on the information  
14 given.

15 As a matter of public policy, there's no requirement to  
16 quiz another physician as to the time a temperature was taken,  
17 and I would incorporate into this the comments that Your Honor  
18 made earlier on these same topics.

19 And, in fact, if truly there was a requirement for a  
20 specialist to quiz a doctor, then doctors would never get  
21 anything done because they would have to be questioning the  
22 accuracy of the information given, so as a matter of public  
23 policy, they must be able to rely on the information that they  
24 are given, so the only reasonable inference is that Dr. Young  
25 was not negligent or culpable in Kelly Fay's death.

1           Thirdly, we move for directed verdict just simply on  
2 public policy grounds, that the law in South Carolina cannot  
3 be that every time a specialist takes a phone call, the  
4 specialist is automatically responsible for what happens. The  
5 on-call urologist must be able to rely on the information  
6 given to him by competent, capable, and board certified  
7 emergency room physicians. Otherwise, there's no end to the  
8 specialist's duty to verify every piece of information and for  
9 public policy reasons the law cannot require that a specialist  
10 be -- I can't read my writing -- Dr. Law could not -- I mean,  
11 Dr. Young cannot be responsible for that. Otherwise, it would  
12 impose a tremendous burden on the specialist, which is against  
13 public policy.

14           Next, Your Honor, as a matter of law, the only reasonable  
15 inference that a jury could determine was that the failure to  
16 take a discharge temperature, if that is a deviation by the  
17 hospital and/or Dr. Law, that that broke any causal chain of  
18 alleged negligence on the part of Dr. Young, so the hospital  
19 and/or Dr. Law's alleged negligence was a superseding  
20 intervening act of negligence, and for that reason we believe  
21 that a directed verdict is appropriate.

22           Additionally, as it pertains to the Sunday phone call, if  
23 the jury finds that the patient should have been told to come  
24 back, or if they have any questions about that issue of the  
25 phone call, as a matter of law the only reasonable inference

## MOTIONS

1 that a jury could determine is that Dr. Young had no  
2 involvement or responsibility with that phone call, and  
3 there's no testimony whatsoever to the contrary of that, so if  
4 the jury finds any negligence associated with the phone call,  
5 that again breaks this causal chain as well, so the hospital's  
6 alleged negligence is a superseding intervening act of  
7 negligence, and for that reason again, we believe a directed  
8 verdict is appropriate.

9 And last, Your Honor, I'd have to refer to my Answer, but  
10 in my Answer I've listed various specifications of negligence  
11 as to Sean Fay ---

12 **THE COURT:** All right.

13 **MS. SCALISE:** --- and/or Kelly Fay, so I would  
14 incorporate what those specifications were into this argument,  
15 and I believe that the only reasonable inference that a jury  
16 could -- could determine was that the Plaintiff's negligence  
17 far outweighed any alleged negligence on the part of Dr. Young  
18 and so because of that, based on the comparative negligence  
19 law, a jury would have to find that he was -- his negligence  
20 was greater and exceeded in far excess any alleged negligence  
21 on the part of Dr. Young, so accordingly, a directed verdict  
22 would be appropriate on a comparative ground as well. Thank  
23 you, Your Honor.

24 **THE COURT:** Very good. Thank you, and Mr. Foster, you,  
25 in our earlier colloquy, placed your reasons on the record for

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1 which you believe this was not appropriate. Do you wish to be  
2 heard further at this time?

3 **MR. FOSTER:** Your Honor, I would just like to add a few  
4 points to that.

5 **THE COURT:** Go ahead.

6 **MR. FOSTER:** Will everybody stipulate that we can  
7 reincorporate what I stated on the record earlier as my  
8 response to the directed verdict motion?

9 **THE COURT:** So stipulated by the Court and the parties,  
10 I'm certain. Go ahead.

11 **MR. FOSTER:** We would just like to add a few things,  
12 Your Honor. Number one, I don't think there was -- as far as  
13 no reasonable inference that reasonable minds can't differ on  
14 the issue of Dr. Law's liability, I vehemently disagree with  
15 that. I think that there's plenty of evidence in this case,  
16 not only by our expert, but by Dr. Young and Dr. Law  
17 themselves that would say that if he -- that if he  
18 participates with the law being the establishment of a  
19 doctor/patient relationship, and she argued that again, which  
20 you didn't -- you didn't rule on before, is a prerequisite to  
21 claim the relationship a consensual one with a patient,  
22 knowingly seeks the assistance of a physician, and a physician  
23 knowingly accepts him as a patient. I think we have more than  
24 adequately proved that, Your Honor.

25 The portion they want to cite for **Roberts** is totally

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1 inapplicable to the facts of this case where the physician  
2 didn't see the patient because the patient -- the physician  
3 was going down to the emergency room to see the patient in  
4 **Roberts** and the patient left against medical advice and gave  
5 the physician no opportunity to see the patient. That has  
6 nothing to do with the facts of this case.

7 The other thing I wanted to say, Your Honor, is I don't  
8 believe they've pleaded -- I don't believe they've pled  
9 intervening negligence.

10 **THE COURT:** Well, they amended their -- they amended  
11 their -- by motion amended their pleadings -- well, time runs  
12 together, but I believe it was two days ago.

13 **MR. FOSTER:** Well, I heard that motion, but I didn't  
14 hear your ruling on it, Your Honor.

15 **THE COURT:** All right. Go ahead.

16 **MR. FOSTER:** And obviously we would object to an  
17 amendment at that stage of the game as to -- as to add  
18 intervening negligence. We would oppose that motion to amend.

19 However, on her public policy argument, Your Honor, we're  
20 not trying to set forth, Judge, that everybody that picks up -  
21 - everybody that's on call and picks up the telephone call is  
22 automatically -- has a physician/patient relationship, but  
23 when you get on the stand and you admit that you jointly  
24 agreed to make a life or death decision with a patient, we do  
25 think that's an affirmative act, along with the fact that he

1 accepted -- he asked to see her, he accepted her as a patient,  
2 she agreed to see him, we think the combination of those three  
3 things definitely establishes a physician/patient  
4 relationship.

5 On the -- on the liability part of it, Your Honor, I  
6 believe you ruled on. I believe you didn't rule on  
7 physician/patient relationship if I understood you correctly.

8 **THE COURT:** That's correct. The Court did not reach the  
9 issue and still does not reach the issue. It is not necessary  
10 to reach it, physician/patient relationship.

11 **MR. FOSTER:** But we would certainly argue that that's a  
12 question for the jury, Your Honor, for them to weigh, that  
13 reasonable minds could differ, based on our expert testimony  
14 and everything I put in before, and on the law, Your Honor.

15 Beg the Court's indulgence for one moment.

16 Oh, and they had mentioned as far as a break in the  
17 causal chain, Your Honor, and I feel like I need to respond to  
18 that for the record. As far as the break in the causal chain,  
19 when Dr. Young agreed with Dr. Law on Saturday to -- that she  
20 -- that she could be discharged and wait until Monday to be  
21 seen, I think the law is that on foreseeability, that you  
22 don't have to anticipate the particular type of harm that came  
23 about, only that some harm could come about from your  
24 negligent act, and I believe they both testified that she was  
25 -- and their experts, I believe there was abundant testimony

1 that they were concerned about -- that they were concerned  
2 about infection, Dr. Law was concerned about infection, that  
3 he relayed all the pertinent information to Dr. Young.

4 Their expert said that they should have been concerned  
5 with infection, and ultimately that's what came to pass, so  
6 whether there was a break in the causal chain -- there never  
7 should have been a break. If there was a break in the causal  
8 chain, it was still foreseeable that that would happen, and we  
9 oppose it on those grounds. Thank you, Your Honor.

10 **THE COURT:** All right. It's not necessary for a  
11 response. If you wish to make one, however, for the record,  
12 you may briefly.

13 **MS. SCALISE:** Just for the record, thank you, Your  
14 Honor, that I believe that the amendment should be allowed so  
15 that the pleadings conform to evidence. First, the issue he  
16 just raised about foreseeable risk, I don't believe it's  
17 foreseeable that a patient who was told to return to the  
18 emergency room is not going to return, but also it's not  
19 foreseeable that if truly the conversation took place with the  
20 emergency room, that the emergency room is not going to tell  
21 them to come back in, or that the temperature would not be  
22 accurate. Thank you, Your Honor.

23 **THE COURT:** Very good. The Court is prepared to rule,  
24 and my ruling is the same from our discussion that we had  
25 earlier today. First of all, it's not necessary to reach,

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1 and, therefore, I do not reach the issue of whether or not  
2 there was a physician/patient relationship established between  
3 Dr. Young and Ms. Fay.

4 The Court just finds as a matter of law that there is,  
5 first of all, there is no negligence on the part of Dr. Young  
6 who has a right to rely on any information given to him by a  
7 competent, capable, and board certified emergency physician.  
8 To hold otherwise would turn the practice of medicine on its  
9 head in South Carolina, but furthermore, I am going to permit  
10 the parties, Dr. Young specifically, to amend his pleadings to  
11 allege superseding or intervening negligence.

12 There's really no surprise here because this came before  
13 the testimony, the motion did, before the testimony of Dr.  
14 Young and Dr. Law and thus could have been explored during the  
15 time they were on the stand, but furthermore, it cannot --  
16 does not seem to the Court that that could be a shock or  
17 surprise because that issue sort of permeates the factual  
18 scenario from which arose this unfortunate event, and thus for  
19 all these reasons, the Court is going to grant dismissal to  
20 Dr. Young at this time, and it is so ordered.

21 Dr. Young, you are free to leave if you wish. You are  
22 free to remain for the day if you wish, but I'm going to  
23 dismiss Dr. Young at this time from the case.

24 All right, very good. All right, now, other motions at  
25 the close of the Plaintiff's case. I have one motion under



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1       **THE COURT:** All right, what I was starting to say, one  
2 of the good things about this -- this level of what we're  
3 doing here is I've got good, experienced lawyers. You've been  
4 on both sides of this case, Mr. Foster. You are -- you are  
5 embroiled in a tremendous battle over whether or not the  
6 failure to take her temperature was negligence to begin with,  
7 and you're asking the Court to let you go to the jury on  
8 punitive damages. I mean, really, just lawyer to lawyer, do  
9 you believe that's in the best interest of the Plaintiff at  
10 this point based on the way that the evidence has broken? I  
11 mean, I'm looking at the big picture.

12       I start with just -- with that rhetorical question, but I  
13 conclude with this ruling. This is not a case for punitive  
14 damages. There's no conscious disregard or wilful failure to  
15 comply. I mean, there may be a failure to comply, but it's  
16 certainly not some conscious, wilful, knowing, reckless  
17 disregard of the rights of others.

18       It's a very unfortunate incident, but nevertheless, the  
19 Court finds that this clearly is not a punitive damages case.  
20 And again, we had this discussion, although as Judge Anderson,  
21 Judge Joe Anderson says, it's not the sine qua non of punitive  
22 damages, there's no evidence of financial worth or capability.  
23 That's yet another flaw as to punitives. The Court is going  
24 to strike punitives as well because simply this -- this is not  
25 a punitive damages case, and for these reasons, the Court is

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1 going to grant the motion globally to remove punitive damages  
2 from the case.

3 **MR. FOSTER:** Thank you, Your Honor.

4 **THE COURT:** Yes sir. Thank you.

5 Now, anything further from the Defense side?

6 **MR. TODD:** We move for a directed verdict on the same  
7 grounds as I earlier -- lack of reliability concerning  
8 causation testimony, regarding causation, and also the only  
9 reasonable inference from the evidence is that the cause of  
10 this death is Sean Fay's failure to bring his wife back to  
11 the ---

12 **THE COURT:** Well, this is the battleground of the case  
13 and that is the issue for the jury, and I decline -- deny your  
14 motion, would decline to grant you any further relief at this  
15 time.

16 Anything further on behalf of Dr. Law?

17 **MR. AIKEN:** Yes sir, Your Honor, somewhat reluctantly,  
18 and you can argue alternative theories. I would also move to  
19 -- move to amend Dr. Law's Answer to assert intervening  
20 negligence or superseding negligence of the hospital if the  
21 Court finds the only reasonable inference is that call was  
22 made, those conversations took place as alleged by Mr. Fay.  
23 I'm not saying it happened. I'm just moving to amend to  
24 assert that.

25 I had this much to look at tonight on intervening

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1 negligence. I didn't know we would get to the arguments  
2 today, ---

3 **THE COURT:** All right.

4 **MR. AIKEN:** --- but just two bullet points, the  
5 negligence of a third party intervening between the negligence  
6 of the Defendant and the Plaintiff's injury will insulate the  
7 Defendant from liability only where the third party's  
8 negligence was unforeseeable.

9 **THE COURT:** All right. Let me stop you. Are you saying  
10 that -- are you referring to the hospital's failure to take a  
11 discharge temp?

12 **MR. AIKEN:** No sir, I'm not mentioning discharge. I'm  
13 talking about the phone call on Sunday, if that conversation  
14 took place, clearly he should have been -- he should have been  
15 told to come in, if that conversation took place. Quite  
16 frankly, I'm not going to argue that to the jury.

17 **THE COURT:** I hear you.

18 **MR. AIKEN:** I'm just making the motion at this time.

19 **THE COURT:** I follow. Counsel, well let me -- what says  
20 the -- well, who wants to be the first to be heard on that?

21 **MR. TODD:** We're going to oppose it, Your Honor.

22 **MR. FOSTER:** We oppose it as well.

23 **THE COURT:** All right. Well, Mr. Aiken, your motion is  
24 different, because first of all, all the testimony has closed.  
25 There's no one able now to respond to what you raise and what

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1 could be a cognizable argument in front of the jury. I do  
2 find that the parties are surprised by the late date of this  
3 motion, and I simply deny the motion for you to assert that  
4 claim at this eleventh plus hour.

5 **MR. AIKEN:** I did not argue with my usual fervor.

6 **THE COURT:** All right, very good. Anything further?

7 **MR. AIKEN:** Yes sir. I would also just move for a  
8 directed verdict on liability for Dr. Law and adopt my  
9 arguments that I made earlier at the directed verdict motion  
10 stage after the Plaintiff's case. Number one, the only  
11 reasonable inference to be drawn from this evidence in every  
12 light favorable to the Plaintiff is the sole negligence --  
13 correction. The death of Kelly Fay was the sole negligence of  
14 Sean Fay by not following clear discharge instructions from  
15 Dr. Law.

16 Even Mr. Foster's experts have no reason to challenge the  
17 credibility of the dictated note. They were both told to come  
18 back if her condition worsened, if you have fever, chills,  
19 nausea. According to Mr. Fay, that's what she developed.  
20 According to their expert, Dr. Stratton, if they had -- if  
21 Sean had taken her back -- excuse me, Mr. Fay, had taken her  
22 back Sunday, she would be alive today. If he had taken her  
23 back Monday, if she had gotten to the hospital by ten o'clock  
24 Monday, she would be alive today. That's the sole negligence.  
25 That's the sole ---

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1       **THE COURT:** Counsel, the jury has left.

2       **MR. AIKEN:** I understand, but I certainly, if I may,  
3 alternatively, the only reasonable inference to be drawn from  
4 the evidence is that if Mr. Fay was not solely negligent, he  
5 was at least comparatively negligent, greater than fifty-one  
6 percent.

7       **THE COURT:** All right. Again, without taking argument  
8 from the other side, this is the battleground of what -- one  
9 of the battlegrounds of the case. There is ample evidence for  
10 these issues to go to the jury. The Court denies any further  
11 relief at this time.

12       All right, now, anything further from the Defense side?  
13 Hearing nothing, anything from the Plaintiff's side now with  
14 regard to motions before we close the record for today?

15       **MR. FOSTER:** Just for the record, Your Honor, we would  
16 put on the record that we would move for a directed verdict  
17 for the same -- on the same grounds that Mr. Aiken did, that  
18 the only reasonable inference to be drawn from the evidence is  
19 that the conscious disregard of Dr. Law and the nurses at the  
20 hospital was the sole cause of Kelly Fay's death and based on  
21 all the testimony, we think there is adequate testimony to  
22 support that, and we would move for a directed verdict on  
23 liability as to that.

24       **THE COURT:** All right. For the same reasons,  
25 denied, ---

1           **(THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE**  
2           **JURY.)**

3           **THE COURT:** All right, is the Plaintiff ready?

4           **MR. FOSTER:** Not quite, Your Honor. Just one more  
5 minute if you would, please.

6           **THE COURT:** Mr. Todd, do you have a copy of your 22 that  
7 you wanted added to the charge? All right, thank you.

8           And I'll ask the Defendants this while Mr. Foster is  
9 getting ready. Was there some agreement of the language for  
10 which the Court would instruct the jury that there's a  
11 dismissed party here?

12           **MR. TODD:** Your Honor, we're okay with you just telling  
13 them that Dr. Young has been released.

14           **THE COURT:** You simply say that Dr. Young has been  
15 released from the case?

16           **MR. TODD:** I think that's what the Plaintiff asked.

17           **THE COURT:** Well, I -- I -- I don't mean to throw a kink  
18 in your works here, but I decline to do that because to me,  
19 there may be an inference in that there was a payment made for  
20 him to leave. That may affect the Plaintiff's damages. I  
21 don't know how it may be taken.

22           I think the best course is simply to tell them that at  
23 the end of the case the Court takes motions from all the  
24 parties and upon motion of Dr. Young's Counsel, the Court  
25 dismissed Dr. Young from the lawsuit because as a matter of

1 law there was no liability under South Carolina law, and thus  
2 leave it there. That's what I always do.

3 Now, are you wounded by that?

4 **MR. FOSTER:** Yes sir. I think I'd rather you say  
5 something like you said yesterday, that Dr. Young is -- I  
6 have, rather than motions or anything like that, that I have  
7 released Dr. Young from this case as a matter of law and his  
8 involvement in the case is not for your consideration any  
9 more, or something to that effect.

10 **THE COURT:** Doctor, y'all's Counsel is here. I'll be  
11 glad to -- I think this affects you. I'll be glad to hear  
12 from you if you have a position.

13 **MS. SCALISE:** If I have a position?

14 **THE COURT:** Yes. Your client is behind you, as well. I  
15 mean, their professional reputation is at stake and other  
16 issues here do go far beyond what is happening in the  
17 courtroom, so what say you?

18 **MS. SCALISE:** I think, Your Honor, your wording that you  
19 have just -- that ultimately and that you did yesterday -- as  
20 far as this morning what you said, that is a fair statement to  
21 the jury.

22 **THE COURT:** Counsel, I would decline to tell them  
23 anything other than what I've just said this morning that I'm  
24 going to do because some other indication to them would first  
25 of all make it appear that Dr. Young -- may appear to create

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JURY IN

1 an inference that he's paid to be -- has made a payment in  
2 settlement to be released. Again, that would -- that language  
3 may enure to the Plaintiff's detriment as well, so I decline  
4 to accept the recommendation and the Court will explain as the  
5 Court foresees it best.

6 All right, are you ready for the jury, Mr. Foster?

7 **MR. FOSTER:** Yes. I'm ready as I'm going to be.

8 **THE COURT:** Okay. That's a thick book.

9 **MR. FOSTER:** Well, of course, all this is just -- I tell  
10 you what I can do.

11 **THE COURT:** I was just going to say, you're going to  
12 scare the jury when they see all that.

13 **MR. FOSTER:** No, I don't want them to think we're going  
14 back through the whole case. Let me just pull some pages out,  
15 Your Honor.

16 **THE COURT:** While you're doing that, please bring in the  
17 jury.

18 All right, the jury is coming in, ladies and gentlemen.  
19 Please be aware.

20 **(THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE**  
21 **JURY.)**

22 **THE COURT:** All right, welcome back, ladies and  
23 gentlemen. Did you think we had forgotten you this morning?  
24 I apologize for the delay. I always -- one of the things  
25 that's important to me is that the jury believe that the Court



1 perceives that your time is important, and it is. It is  
2 critically important, but sometimes things happen that just  
3 require -- we are about some fairly important business in the  
4 Court, and sometimes things happen that we have to stop,  
5 resolve what we have in front of us, and then move forward.

6 I had set a settlement conference in another case this  
7 morning, not related to this case. It took longer than  
8 anticipated, and thank you for your understanding of that, but  
9 let me ask you, ladies and gentlemen, since we were last  
10 together, is there any member of this jury panel who has had a  
11 discussion about the facts of this case with any party or been  
12 contacted by any party? If so, please raise your hand, and  
13 let's let the record reflect no one has raised their hand, and  
14 thank you again, as I've thanked you throughout this trial,  
15 for complying with the Court's request and instructions.

16 Let me say to you that at the end of the day yesterday  
17 there were -- and this always happens at the end of the  
18 testimonial phase of the case, the parties make certain  
19 motions, and yesterday upon the -- you notice there's a change  
20 in the seating in the courtroom here.

21 Dr. Young is not seated here with Counsel at the  
22 Defendant's table, and that is because at the close of all the  
23 evidence, Dr. Young's attorneys made a motion yesterday to  
24 dismiss him from the lawsuit, and the Court granted that  
25 motion on the basis that for the facts that were put forth in

1 this trial, as a matter of law South Carolina law does not  
2 permit recovery against Dr. Young under those circumstances.  
3 He is now dismissed from this case by the Court. I tell you  
4 that so that obviously you will realize his lawyers are not  
5 participating in the trial today.

6 Now, the way we proceed in the final arguments is,  
7 although both sides of the case have the same amount of time,  
8 the Plaintiff is allowed to open and close final argument, and  
9 the reason they are given that benefit is they bear the burden  
10 of proof in the main claim which they've asserted, so they  
11 will -- you will hear from them first and then you will hear  
12 from them last. Again, all parties have the same amount of  
13 time.

14 There's one other thing I really meant to mention to you  
15 earlier in this trial. You probably heard a little bit of  
16 spill-over noise that's coming from that secure door right  
17 there. What that door is, that leads to an internal elevator  
18 that is secure for which people on the criminal side of this  
19 Court, the General Sessions Court, are brought in and out of  
20 the courthouse from the detention center. That's why you will  
21 hear chains and other things, unfortunately, that may sort of  
22 -- quite often when it's quiet in the courtroom, you can hear  
23 it.

24 We try to keep that room as quiet as we can because  
25 what's -- but what's actually happening is on the other side

## PLAINTIFF'S SUMMATION (FOSTER)

1 But we get back to the general premise, here's Kelly.  
2 This is all I can do to introduce you to Kelly. It is all I  
3 can do, to show you her picture again. That's all -- that's  
4 all we have left, okay? And again, this is why we're here.  
5 This girl was twenty-five years old. She was healthy.  
6 Everybody admits that. She went in to the hospital to the  
7 emergency room seeking help for a kidney stone, and then two  
8 days later, she dies because of that kidney stone. Why? Why?

9 Everybody -- and I told you during opening, too, that we  
10 would prove our case to you, not only through our experts, but  
11 through the Defendants, through the Defendants, and a little  
12 bit through some of their experts, which was true.

13 Both -- all the Defendants admitted a fever and a kidney  
14 stone is an emergency. That is the foundation of this case.  
15 That -- that is the foundation upon which this whole case  
16 started. A fever, or an infection and a kidney stone is a  
17 true urologic emergency, and the patient should be taken to  
18 the O.R. and emergently treated. You heard that from both  
19 sides, not just one side, both sides.

20 The other thing is there were a lot of arguments about --  
21 let me put it to you this way. Once you figured that out, I  
22 mean, common sense tells you that you don't take a temperature  
23 on somebody when they come into the hospital when you know a  
24 fever and a kidney stone is an emergency, and then send them  
25 home without ever taking their temperature again. How in the

## PLAINTIFF'S SUMMATION (FOSTER)

1 world can they sit up there and say she was stable to go home  
2 when they didn't bother to take her temperature? This is all  
3 it took.

4 In every room, you heard the testimony, in every room of  
5 the case -- in every room of the hospital there was a  
6 thermometer. All they had to do was stick this thermometer in  
7 her mouth before she left, put this thermometer in there and  
8 one of two things would have happened.

9 It would have absolutely proven -- I mean, there would  
10 have been written documentary proof of what we're saying or we  
11 wouldn't be here at all. I mean, this is one you buy in the  
12 drugstore, Seven to Ten Dollars. In the hospital, on the  
13 other hand, all it is is just a little tip, you know, because  
14 they use the same one over and over. They just take off a  
15 little plastic tip and put it on there and put it in your  
16 mouth, so that's what it would have taken to take her  
17 temperature.

18 Everybody admits they did not take her temperature. Now,  
19 so we've had experts come in and say, okay, what do you think  
20 happened? What do you think happened with the temperature?  
21 We had all this argument, though, she had a temperature while  
22 she was at the hospital and what her temperature was before  
23 she left -- after she left. But we know for a fact that she  
24 had a temperature after she left the hospital because when  
25 they got home Sean took her temperature.

1 taken, so, I mean, you know, how do we know?

2 But let me ask you this, ladies and gentlemen. Mr.  
3 Foreman, and ladies and gentlemen of the jury, let me ask you  
4 this. How in the world can they come in here and say because  
5 we didn't do our job, you can't prove your case? That's kind  
6 of crazy. We didn't do our job, so you can't prove -- so you  
7 can't prove it. That makes -- that makes no sense, so then we  
8 have to go to experts and see what their opinions are based on  
9 the facts that we do have, okay, and the facts that we do have  
10 is that nobody ever took her temperature again.

11 It didn't cost anything. It wasn't hard. It was a  
12 simple thing to do. Nobody ever took her temperature again,  
13 except for Sean when he got her home, and when he got her  
14 home, it was a hundred and one point two, three, to somewhere  
15 up to one-o-one point six. He doesn't remember exactly, but  
16 it didn't vary all weekend when he was taking her temperature  
17 to the point it worried him.

18 Based on -- but I was trying to tell you that when that  
19 pain started, all the -- most of the doctors told you the pain  
20 starts when a kidney stone drops from the kidney into the  
21 ureter. That's what hurts. That's what -- that's what makes  
22 the pain hurt.

23 Now, I wrote this down, and I circled it when Dr. Young  
24 was testifying about what he said, and he said in his -- even  
25 Dr. Young said in his opinion when she got to the hospital,

## PLAINTIFF'S SUMMATION (FOSTER)

1 to that, too.

2 Let me tell you a few things that I wrote down that Nurse  
3 New admitted to. Nurse New -- Nurse New told us that she  
4 takes vital signs every hour. Nurse New admitted that  
5 temperature is a vital sign. Everybody admitted temperature  
6 is a vital sign, I think, except one or two reluctant  
7 witnesses maybe, but everybody admits that temperature is a  
8 vital sign.

9 Nurse New admitted that she didn't remember a phone call.  
10 Nobody remembers a phone call, but if there had been -- but if  
11 Sean called back on Sunday, like he's testified he's done,  
12 that she doesn't suggest them to come in or not come in.

13 She admitted, and so did Dr. Law, that flank pain is  
14 abdominal pain. I mean, they want -- they even want to argue  
15 about what the flank pain -- whether kidney stone pain is  
16 abdominal pain or not, because they -- because maybe it's a  
17 technically new word on an anatomical model or something like  
18 that, and that gets down to -- it sounds like somebody is  
19 saying, well, it depends on what your definition of is, is.  
20 Okay, I mean, it's abdominal pain. It's -- flank pain, it's  
21 abdominal pain. It's still abdominal pain.

22 She admitted -- and this is very important, ladies and  
23 gentlemen. I hate to put another -- I hate to put this back  
24 up. You've seen this thing too many times already, but this  
25 is very important. Not only was what they did a breach of the

## PLAINTIFF'S SUMMATION (FOSTER)

1 standard of care, what a normally prudent nurse or physician  
2 would do, but it was also a breach of their own internal  
3 policy, their own internal policy.

4 Abdominal patients will have a minimum of two vital signs  
5 recorded, and there's a good reason for that, because  
6 abdominal patients have all sorts of infectious processes that  
7 may be going on in their body and you need to know.

8 You can't take one temperature and say, well, that  
9 temperature is good forever, anymore than you can take in a  
10 diabetic one blood sugar and say, okay, well, the blood sugar  
11 is going to stay the same. You've got to take it again to see  
12 where it is now, not at eight o'clock in the morning.

13 All the doctors admitted that these -- that this  
14 infection can -- that she -- that this infection, as soon as  
15 that stone drops down into the ureter if it's got bacteria in  
16 it, that static urine behind the ureter, that you can spike a  
17 tenth in fifteen minutes, thirty minutes, an hour, two hours,  
18 so how can you let somebody sit in the emergency room for four  
19 hours when you know a fever and a kidney stone is an emergency  
20 and not take their temperature again.

21 Dr. Law admitted the most important vital sign with her  
22 presentation, Dr. Law admitted this, was her temperature.  
23 Pain isn't going to kill her. It might make her think she was  
24 going to die, but pain is not going to kill you, but this  
25 infectious process will, especially urosepsis.

## PLAINTIFF'S SUMMATION (FOSTER)

1        They told you -- I mean, that goes -- those -- those  
2        veins from the kidney, once it gets up into the kidney, that  
3        goes straight into your abdominal aorta. Somebody talked  
4        about that. See how it spread. I'm not sure -- these have  
5        got some -- that's your abdominal aorta that goes up to your  
6        heart, so once it gets in there, it's going all over your  
7        body.

8        So they keep her in the hospital four hours. They give  
9        her pain medication. They don't do anything to rule out  
10       infection. Dr. Law's note says he's taken a CAT scan because  
11       there's no blood in the urine. He's taken that CAT scan to  
12       see -- the CT, to see if there's obstruction, because he knows  
13       if there's obstruction, there's a problem.

14       He admits to you he doesn't call a urologist on every  
15       patient. There's a reason he called on Kelly Fay, not just  
16       for follow-up, and not in one or two weeks. He wanted her to  
17       -- he wanted her to follow up sooner than later, like right --  
18       as soon as the next business day, he wanted Sean to phone at  
19       eight-thirty Monday morning to see Dr. Young, and Sean did  
20       call at eight-thirty. Everybody admitted that. They admit  
21       that phone call.

22       He called at eight-thirty, made an appointment. They  
23       said the soonest they could work her in was three because he  
24       was in surgery that had been planned for two or three weeks,  
25       so he got her in as soon as he could get her in.



1 I tell you what else, is they had on these discharge --  
2 these, quote, discharge instructions that were typewritten by  
3 law -- that were transcribed, typewritten before she left,  
4 transcribed within, say, twenty-five minutes when you heard  
5 Nurse Farrelly, I believe, says it takes on the low end  
6 seventy-two hours, and on the high end maybe a week to get  
7 transcription back, that he told her to come back immediately  
8 if she had further pain, or vomiting, or nausea, or all that.

9 Well, that isn't what they took home. They took home the  
10 written discharge instructions which say call or go to the  
11 emergency room if you experience this. She woke up with  
12 chills, but before that, let me tell you this. Let me get  
13 back to this thermometer for just a second.

14 They wanted to tell you, ladies and gentlemen, that --  
15 what Grace New ended up saying, and I didn't finish with Grace  
16 New, but let me finish with her, she also said that the policy  
17 and procedure, is what she said, was every hour -- was every  
18 hour, but if you were there for less than one hour, then they  
19 didn't have to repeat them. She said to comply with the  
20 standard of care, discharge -- I'm sorry. Let me start that  
21 over.

22 With the policy and procedure, she said, Nurse New said,  
23 every hour, but if you're there less than an hour, they don't  
24 have to repeat them, and on discharge, you need to take  
25 discharge vitals to comply with the standard of care, not just

1 their own internal policy, but with the standard of care, what  
2 the reasonably prudent nurse would do.

3 She admitted that you can't tell by looking at a patient  
4 whether they have a fever or not, and you've heard all -- how  
5 they can look at them, and their heart rate, and their  
6 respiration, and all the ways that you can tell if somebody  
7 has a fever without taking their temperature.

8 She also admitted that the most accurate way -- and most  
9 everybody admitted the most accurate way to tell if somebody  
10 has got a fever is to take their temperature. Back to the  
11 thermometer; all they had to do before she left -- I mean,  
12 even if it was eleven-thirty, even if it was a little bit  
13 before eleven-thirty, you know, just make sure when you send  
14 her home, when you send her home that she's not in an emergent  
15 situation. You can't say she's stable when you know a kidney  
16 stone and a fever is an emergency and you don't take her  
17 temperature before she leaves. That's just insane.

18 So they send her home -- but they want to tell you all  
19 the ways they could tell that she didn't have a fever, and her  
20 nurse, Doolittle, is now a Schustek, that came in here last  
21 and said, well, we touched her on the wrist, you know, we had  
22 to take her pulse, and we had to -- I had to disconnect her  
23 IV. Mr. Todd rolled his sleeves up, let her do all that.

24 Now, anybody that's been to the doctor or anybody that's  
25 been to the hospital, as far as this touching goes, knows when

1 those nurses come in there, what have they got on their hands?  
2 Gloves; they have gloves on their hands. How good can you  
3 feel through that glove, a temperature?

4 Then they want to start talking about moms. Moms know  
5 when their children have fevers. The first thing I would  
6 submit to you, ladies and gentlemen, is that Kelly's mom  
7 wasn't there. I would submit to you also that it's common  
8 sense a mom knows her child like the back of her hand. Ain't  
9 a mom in the world who doesn't know when something is wrong  
10 with their child. They know when they're lying. They know  
11 when they're telling the truth.

12 Your mom seems -- when you're little, your mom seems like  
13 a wonder woman because you can't figure out how she knows what  
14 you're doing when you hadn't told her, but I'll submit to you  
15 this, too, I had a mom. Moms, when they think their child has  
16 a fever, what do they do? Most of them put their cheek up to  
17 their cheek, put their hand on their head, and then they're  
18 still not sure, so then they go grab a thermometer and take  
19 it.

20 But you know what, there wasn't anybody that knew Kelly  
21 that well, what she normally looked like, what she normally  
22 felt like. She's in there, sick with a kidney stone. They've  
23 got her on narcotics, but they want to tell you, they didn't  
24 even take a fever because they looked at her and could tell  
25 she didn't have one.

1        So at that point, the only common sense conclusion I  
2        think you can come to is they're rolling the dice with her  
3        life. That's exactly what they did by not taking her  
4        temperature. They rolled the dice and they lost. You know  
5        what, most of the time they would have gotten away with it  
6        probably.

7        If that had been -- Dr. Law admitted -- I said, Dr. Law,  
8        isn't it true if she had gone to the doctor on any day but  
9        Saturday, she -- if she had come to the emergency room on any  
10       day but Saturday, and I told y'all this in opening, and sure  
11       enough, he admitted it, she'd still -- any day but Saturday,  
12       she'd still be alive, isn't that true? He said, yep, it is,  
13       and that's a shame. That's a real shame, that because she  
14       came in on a Saturday and they decided -- he decided to roll  
15       the dice, thinking that she -- since her pain was under  
16       control, that she'd be okay until Monday. Well, she wasn't,  
17       okay, and now they want to -- again, they want to go back to  
18       blaming it on Sean. It's not Sean's fault. It's not Sean's  
19       fault.

20       Now, our experts testified to you that she should never  
21       have been sent home on Saturday. She should have been  
22       admitted to the hospital on Saturday. If they had checked her  
23       temperature or she would have had it more likely than not, she  
24       would have had it -- we can't prove it to a hundred percent  
25       certainty, and we're not bound to that in this Court, that she

1 from an accepted standard of care, then it's -- you don't  
2 honor your oath if you talk about money. It's not --  
3 shouldn't even be discussed. You've got to find he did  
4 something wrong.

5 So we go back to speaking the truth. Does Kelly's mom  
6 know the truth? They were called by the Defense. Does  
7 Kelly's step-dad, Tom Meier, know the truth? Does Kelly's  
8 brother know the truth? You'll have to tell them. Thank you.

9 **MR. FOSTER:** Briefly, Your Honor.

10 **THE COURT:** Yes sir.

11 Plaintiff now in rebuttal for closing.

12 **MR. FOSTER:** Ladies and gentlemen, this is it. You're  
13 not going to have to listen to anybody else, but I do have  
14 five or ten -- between five and ten minutes to respond to some  
15 of the things they said, and I wrote some notes down here, and  
16 I would submit to you that you have just heard some of the  
17 biggest mischaracterization of testimony that you probably  
18 ever will, and you've got notes, and you can go back and look.

19 Mr. Lee told you -- the first thing that hit my mind was  
20 that Dr. Siroky -- Dr. Siroky, our expert from Boston, a  
21 urologist, got up there and said that Dr. Law and nobody  
22 deviated from the standard of care. He testified as to every  
23 deviation that he thought that was committed, basically  
24 starting off with the deviations by not doing the tests that  
25 Dr. Law said he did in his deposition that he didn't do, and

1 said that she should never have been let go from the hospital  
2 on Saturday and then we wouldn't even be having all these  
3 other discussions about Sunday.

4 So that's up to y'all; that's for y'all to decide. You  
5 heard the evidence. You heard the witnesses. You took notes,  
6 so you know what was said, and between -- between the twelve  
7 of you, you're going to have notes as to what was said from  
8 that witness stand and what wasn't.

9 They talk about screaming, Sean talking about her  
10 screaming. He said that was a bad choice of words. She  
11 wasn't screaming at the top of her lungs, and I understand how  
12 they're arguing now that she was screaming, and he should have  
13 known something, but again, it should have never been -- she  
14 wasn't screaming.

15 She was -- had major chills, and they did break, and then  
16 she did what they were told to do on the telephone. She  
17 didn't think she needed to go in, which is what she was told  
18 to do. If you think you need to, come in. If you don't,  
19 don't. And so then she didn't think she needed to, so she  
20 didn't. If they'd have told her it was an emergency or she  
21 could die, they'd have been there. They'd be here today.

22 They are also trying to fool you. They keep telling you  
23 three sets of vitals were taken. Three sets -- go look at the  
24 records when you go back there. Three -- three -- they might  
25 have taken her heart rate or blood pressure three times, but

1 Dr. Law even said the most important vital in her presentation  
2 was her temperature; once when she walked in the door at eight  
3 o'clock.

4 Dr. Proia, they talked about, saying it was twenty-four  
5 hours old, he admitted to me and I wrote it up here on this  
6 board, that acute to him, as long as this thing was acute was  
7 up to two days, and then I had to make him admit chronic,  
8 remember, out of his article, and I won't look for it, but you  
9 probably remember he admitted that acute was way back there at  
10 the beginning, so acute was up to two days after I read him  
11 his own article, okay?

12 Then Dr. Stratton said his own article said up to four  
13 days, and as long -- and by the way, Dr. Stratton doesn't do  
14 autopsies. He is a pathologist, but he takes care of -- he  
15 takes care of and consults on live patients, not dead  
16 patients, and he's the infectious disease specialist, and he's  
17 the one that told you when the infection started, so y'all --  
18 y'all make your mind up on that.

19 Mr. Miliano that sat down here yesterday, the only reason  
20 I didn't ask him but a few questions is he admitted -- he  
21 admitted that temperature is not paid enough attention to and  
22 just sloughed over, and if they paid more attention to taking  
23 somebody's temperature, that it would help the patients, that  
24 it's a -- it's a vital sign that is ignored, and they should  
25 do serial vital signs even in the patient that's only got an

1 ankle injury, sitting up looking fine, because they can tell  
2 you a lot about what's going on with a patient, is their  
3 temperature.

4 Chris Knight, they want to disrespect Chris Knight,  
5 because after we hired her -- she was nursing when we hired  
6 her. After we hired her, she made a career change. She went  
7 to work for a law firm and she's a nurse consultant for the  
8 law firm, which, by the way, is nursing. Chris Knight was the  
9 only nurse that took this stand that was a certified emergency  
10 nursing association nurse. The other ones were not. She's a  
11 certified ENA nurse and the only one that took that stand and  
12 told you what the standard of nursing care was and that they  
13 had deviated from it by not taking her temperature, and the  
14 phone calls.

15 Now, they also keep talking about the family members.  
16 Sean Fay is not a family member? Sean Fay was her husband.  
17 The family members are also her mother, and her step-father,  
18 and her brother, but under South Carolina law, this lawsuit is  
19 Sean's fight, not their fight. He's the -- he's the one that  
20 has to bring this -- this argument to court and have it  
21 resolved, not them, so why didn't we call them? Well, you  
22 can't call them but once, so ...

23 It talks about Kevin saying she had a fever of a hundred  
24 and three on a phone call that night. Did we question them as  
25 to whether they made phone calls or not because they didn't



1 bring phone records or it wasn't documented? No, I didn't.  
2 We don't have any reason to just -- does a hundred and one  
3 point three and a hundred and three sound a lot like the same  
4 thing?

5 Apparently after they talked to her, none of them were  
6 concerned over the silence when he said is Sean taking care of  
7 you? Well, then, why didn't somebody call 911 if they  
8 believed that, if there was some belief. They didn't believe  
9 that or they would have said it.

10 I told you that Mr. Aiken would stand up and start  
11 screaming about money before this was over with. Like I said,  
12 this is the only -- only chance she's going to have to get any  
13 justice. It's the only chance that Sean is going to have to  
14 get any justice. It's the only thing that's going to get  
15 anybody's attention. You've heard them all say they don't do  
16 anything differently anymore.

17 You've got good -- this is the last thing I want to tell  
18 you. You've got good medical care here in Horry County.  
19 We've got good medical care over most of South Carolina. If  
20 you want that medical care to stay good, then when people do  
21 sloppy work, or they are careless, or they are negligent on  
22 one day, regardless of how good they are on the other days,  
23 then you've got to bring back a verdict that renders justice  
24 and a verdict that speaks the truth because that's the only  
25 thing that's going to get their attention.

1       You want your level of care in this county to stay the  
2 same, you need to let them know this is not acceptable, we're  
3 not going to have healthy twenty-five year old girls coming  
4 into the emergency room and dying with a kidney stone forty-  
5 eight hours later because somebody won't pick up a thermometer  
6 for one -- among other reasons and take their temperature,  
7 just for that, a Seven or Ten Dollar thermometer.

8       Thank you, Your Honor.

9       **THE COURT:** All right, Counsel, what I propose to do at  
10 this time is I'm going to go ahead and give my charge to the  
11 jury, and then we'll take a break and come back and explain  
12 the verdict form after the break, and make sure the evidence  
13 is in order, and then they can retire to deliberate.

14       Any objection to that from any of the remaining parties?  
15 All right, hearing none.

16       Ladies and gentlemen, let me just have your attention for  
17 a few minutes here if I may. My microphone is off to the  
18 side, but let me ask, can you hear me? Are you able to hear  
19 me in the courtroom? All right, well, if for some reason you  
20 cannot during the course of my charge, please let me know.

21       You may recall I told you at the beginning of the case  
22 that most likely the last person you would hear from at the  
23 end of the case before you retire to deliberate would be the  
24 Court giving you the charge on the law, and this is where we  
25 find ourselves now.

1       Before I give you the specifics of the law in this case,  
2       I want to make a comment, if I may, about your service. You  
3       may recall we talked about it, it seems like a long time ago  
4       now, when you first came in that I knew there wasn't one of  
5       you sitting out there among your other colleagues in the jury  
6       pool before you were chosen to sit on this jury who had come  
7       down to the Courthouse just to see what was going on here in  
8       Horry County and that you had been summoned here and that you  
9       had busy lives, even before you got your jury summons, and I  
10      am well aware that throughout these last nine days now, you've  
11      put aside your busy lives and you've given this case your  
12      close focus.

13       And as I sit here in the courtroom, I just sit  
14      logistically where I can look beyond a lawyer or beyond a  
15      witness and observe the jury, and I try to do that throughout  
16      the trial. I'm trying to observe you for comfort level and  
17      for other things, and I don't want you to feel like I'm  
18      staring at you, so I try to be somewhat cautious about it, but  
19      every time I've looked, just as I'm looking now, you've sat  
20      there with close focus and what I call rapt attention, giving  
21      this case your very best.

22       That's important to me and to the parties, and really to  
23      this justice system, because in a few minutes when you retire  
24      to determine the facts of this case and to deliberate, you'll  
25      be in a position to do that simply because you've set aside

1 your busy lives, given of your best to this case, and promoted  
2 the cause of justice in South Carolina, so I thank you for  
3 that level of commitment.

4 Now, at this juncture, at this point, you've heard the  
5 arguments, you've heard the evidence. Now I want to charge  
6 you the law that applies to this action. As you know, the  
7 Plaintiff's estate claims that the Plaintiff's decedent, Ms.  
8 Fay, was injured by the actions of the Defendants, and in  
9 bringing this lawsuit, which is a claim that's authorized  
10 under South Carolina law, the Plaintiff claims that the  
11 Defendant should compensate Plaintiff's estate and her husband  
12 for those injuries and damages.

13 Now, in this case as you are aware, there are two  
14 Defendants. There's a physician and a hospital, and under  
15 South Carolina law, a hospital, as a corporation, is liable  
16 for the actions of its agents, servants, or employees while  
17 those agents, servants, or employees are acting within the  
18 scope of their authority.

19 I further charge you that one of the most sacred  
20 principles of law in this country is that all persons are  
21 entitled to equal justice under the law. This applies to  
22 corporations, as well as individuals. Corporations, whether  
23 they be large or whether they be small, are legally persons,  
24 and as such are entitled to equal treatment under the law.

25 I instruct you that the parties in this case are entitled

1 to careful deliberation without regard to the fact whether the  
2 Defendant is a corporation or whether the Plaintiff is an  
3 individual. I charge you that the parties are equal under the  
4 law, and it would be wrong and a violation of your oath to  
5 hold against a party or in any way consider their status as  
6 either an individual or a corporation.

7 Now, I also want to tell you, as will be discussed more  
8 fully in this charge, your decision as to any particular  
9 Defendant -- remember, we have two Defense here in the case,  
10 does not control your decision to the other Defendant. In  
11 other words, each of the two Defendants must be considered  
12 separate in your deliberations.

13 Now, as I said when we began this case -- and I'm going  
14 to go over this again briefly. I don't want to be  
15 duplicative, but I think it may be important. You're the  
16 finders of facts. You are the judges of the facts in this  
17 case. Only you make the decision of what the facts are, and  
18 throughout the trial I've intended and attempted to be fair  
19 and impartial and not give you some perception of how I may  
20 feel about the facts, because I'm going to tell you again, I  
21 don't have a position on the facts. If I did, I'm invading  
22 your territory because you are the judges of the facts.

23 But I will say to you that one of the things you've got  
24 to do in determining the facts, if you hear testimony that  
25 seems inconsistent, and I think you may find that you have

1 heard testimony that may seem inconsistent or mutually  
2 exclusive here in the courtroom, then you must decide the  
3 believability or credibility of those witnesses offering this  
4 testimony in order to decide the facts of the case.

5 Some of the things you may want to look to, and before I  
6 tell you those, I'm going to say to you again, just as I said  
7 when we started, remember this is something you do every day,  
8 out on the street, in the room, in your house, at your work,  
9 wherever it may be, you gauge those to whom you're speaking  
10 for credibility and believability.

11 You should employ those same factors you use every day,  
12 but some of the things you may want to look to here in the  
13 courtroom in addition are what's the manner and appearance of  
14 a witness when they testify. Are they hesitant? Are they  
15 straightforward? Do they appear to know what they're talking  
16 about? How did they come to know what they're talking about,  
17 and in the event it's an expert opinion, what is the basis  
18 given for that expert opinion?

19 Is the testimony of the witness consistent even with  
20 itself, and is it weakened or strengthened by the other  
21 evidence in the case, and further in light of the global  
22 evidence in the case as you find the evidence to be, how  
23 reasonable is what that witness is saying, and then finally,  
24 might a witness want to help or hurt one side or another  
25 because might that witness have a bias or a prejudice?

1        Now, I will tell you that when you decide the facts of  
2        the case, you, the jury, can believe as much or as little of  
3        any witness's testimony you think proper. You can believe one  
4        witness against a whole bunch of witnesses, or you can do just  
5        the opposite. You can believe part of what a witness says and  
6        completely disbelieve the rest.

7        I'll just say to you that throughout this process you  
8        have one objective, and that is to search for and seek and  
9        find the truth regardless, again, from which side of the case  
10       or from which witness or exhibit it may come.

11       Now, of course, during the course of this trial we've had  
12       some objections from Counsel. I will tell you that you must  
13       not consider as evidence any statement that Counsel has made  
14       during the trial which includes opening and closing, and any  
15       statement or opinion that may be contained within a question  
16       that was directed to a witness.

17       Now, I will say to you that if the parties have  
18       stipulated to any particular facts and you've been told that,  
19       or any fact been admitted by Counsel, you should regard that  
20       fact as being conclusively proved as to the party or parties  
21       that make that stipulation or that admission.

22       Now, as to any questions to which there was an objection  
23       sustained during the course of the trial, and you saw that  
24       happen on some occasions, you must not speculate if the answer  
25       wasn't given as to what the answer might have been or what the

1 reason was for the objection. You must not consider for any  
2 purpose any offer of evidence that was rejected or any  
3 evidence that was stricken by the Court. Such a matter should  
4 be treated as though you didn't know of it, or don't know of  
5 it, never did know of it.

6 You must never speculate to be true any insinuation  
7 suggested by a question that's asked a witness. A question is  
8 not evidence and may be considered only as it supplies the  
9 meaning of whatever answer was given.

10 Now, during the course of the trial you also heard  
11 testimony of witnesses who had special knowledge, skill, or  
12 experience, training, or education in a particular field. In  
13 fact, we heard several, and that witness came in and gave  
14 their opinion as an expert witness about matters in which they  
15 were skilled.

16 Now, in determining the weight to be given those  
17 opinions, again, you should consider the qualifications given  
18 by that witness and the credibility of the expert and the  
19 reason given, the basis given, for their opinion. You're  
20 not bound by any opinion that was given in here. You give  
21 those opinions what weight, if any, you deem they're entitled  
22 to.

23 Now, in this case if you find there's been a conflict in  
24 the testimony of expert witnesses, then you must weigh one  
25 expert opinion against the other and you must consider the



1 reason given by the one as compared with those given by the  
2 other. You should consider the relative credibility and  
3 knowledge of the experts who testified and thereupon you  
4 should find in favor of that expert testimony that in your  
5 opinion is entitled to the greater weight.

6 When a Plaintiff relies upon expert medical testimony to  
7 show a causal connection between an incident of alleged  
8 medical negligence and a subsequent result, the medical expert  
9 must testify that it is his or her professional opinion based  
10 upon a reasonable degree of certainty within his or her  
11 profession that the result in question most probably or most  
12 likely came from the cause alleged. In other words, just  
13 stated in regular language, the experts don't come in here and  
14 testify and say, well, I think this or I think that.

15 They must give their opinion in order for it to be  
16 appropriate evidence to a reasonable degree of certainty  
17 within their profession most probably or most likely. It's  
18 not necessary that the medical expert, though, testify to  
19 exact cause of the ultimate result. It's sufficient if the  
20 ultimate outcome most probably or most likely resulted from  
21 medical negligence.

22 A Plaintiff carries the burden of proof when the  
23 Plaintiff shows that the Defendant's negligence most probably  
24 or most likely caused the injuries and damages complained of.  
25 However, proof of causation cannot rest in conjecture and the

1 mere possibility of such causation is not enough to sustain  
2 the Plaintiff's burden of proof.

3 Now, while we're talking about experts, let's go a little  
4 further and I want to explain to you and charge you that in a  
5 medical negligence claim expert testimony is necessary, is  
6 required, on the following issues. Number one, to establish  
7 the generally recognized and accepted practices and procedures  
8 that would be followed by average competent practitioners in  
9 the Defendant's field of medicine under the same or similar  
10 circumstances.

11 And number two, to establish that the Defendant departed  
12 from that recognized and generally accepted standard, and  
13 number three, to establish that the Defendant's departure from  
14 such generally recognized practices and procedures, if any,  
15 were the proximate cause of the Plaintiff's injuries and  
16 damages, and that word again was proximate. We'll talk about  
17 that in a moment further. Anyway, those three things must be  
18 proved by expert testimony in the Plaintiff's case.

19 Now, certain testimony in this case has been presented in  
20 evidence by deposition. A deposition, as we said during the  
21 course of the trial, is testimony taken under oath that's  
22 before trial and it's preserved in writing or by mechanical  
23 means, such as a video or an audio tape recording, and you  
24 should consider that testimony as if the witness had given it  
25 here in Court because it is given under the same conditions

1 and requirements as if it had been given in the courtroom.

2 Now, there are two types of evidence in cases such as  
3 these. There is direct evidence and there is circumstantial  
4 evidence. Direct evidence is the testimony by a witness about  
5 what that witness personally saw, or heard, or did, such as  
6 eye witness testimony. Circumstantial evidence, on the other  
7 hand, is indirect evidence. Circumstantial evidence is proof  
8 of a set or chain of facts that indicate over here the  
9 existence of yet another fact.

10 Now, you should consider both direct and circumstantial  
11 evidence in your deliberations. The law permits you to give  
12 equal weight to both, but it is for you to decide how much  
13 weight you give any of it. There's not some greater certainty  
14 required of one than the other between direct and  
15 circumstantial evidence.

16 I will tell you that it is a well-recognized rule that an  
17 issue may be proved by circumstantial evidence, but for  
18 circumstantial evidence to be sufficient to warrant the  
19 finding of a fact, the circumstances must lead to the  
20 conclusion with reasonable certainty and must have sufficient  
21 probative value to constitute the basis for a legal inference,  
22 not mere speculation. The facts and circumstances shown  
23 should be reckoned within the light of ordinary experience and  
24 such conclusions deduced therefrom as common sense would  
25 indicate.

1        Now, let's talk a little bit about my role. The same  
2        Constitution that makes you the judge of the law makes me the  
3        -- excuse me, makes you the judge of the facts makes me the  
4        judge of the law here in the courtroom, and I will tell you  
5        that as the judge of the law, it is my responsibility to give  
6        you this charge on the law.

7        But I also tell you, as I said earlier, I live in a small  
8        town. I'm out on the street a good bit, down at the cafe, or  
9        wherever I may happen to be. I hear a lot of people talking  
10       about the law, and I'll tell you right now, there's a lot of  
11       bad information out on the street about what the law is on any  
12       particular given topic, whatever it may be, so I'm telling you  
13       that you must, in order to perform under your oath, you must  
14       set aside what you believe the law was before you came in and  
15       accept the law as I give it to you here in this charge and  
16       apply it to the facts that you find and in doing that, you're  
17       going to reach a verdict which is just and true.

18       Now, I'm giving you the law that is correct in South  
19       Carolina, but let's just think about this for a moment. If I  
20       don't, if somehow I make a mistake in giving you the law,  
21       well, that error would be preserved by our court reporter,  
22       taken down, it would be saved, and there would be another day  
23       and time when that could be considered and corrected if  
24       necessary, but I'm telling you that I'm giving you the law  
25       correctly, and you must accept the law as I give it and apply

1 it to the facts as you find them.

2 Now, let's talk a little about the law. The Plaintiff  
3 claims that the Defendants here committed medical malpractice  
4 or professional negligence, and malpractice is the failure to  
5 treat a patient following a good and accepted medical  
6 practices resulting in harm to the patient as a form of  
7 carelessness or negligence.

8 Now, in order to recover for medical malpractice, the  
9 Plaintiff must first prove by a preponderance or greater  
10 weight of the evidence what was the standard of care the  
11 Defendants owed to the Plaintiff in treating the Plaintiff, n  
12 other words, what was the standard of care.

13 When a doctor, nurse, or hospital employee, and I'm going  
14 to refer to them in this charge, I'm going to use the term  
15 provider, which would encompass all those, when a provider  
16 treats a patient, the law does not require absolute accuracy  
17 either in practice or in decision-making. The law does not  
18 hold the provider to a standard of perfection. It does not  
19 even require the highest degree of care and skill of which the  
20 human mind is capable.

21 The law does require that the provider use that degree of  
22 knowledge, care, and skill as ordinarily used by providers in  
23 good standing under the same or similar circumstances and that  
24 the provider follow the generally accepted practices and  
25 procedures in the profession.

1       The degree of skill and care a provider must use is that  
2       which would be used by a competent provider in the Defendant's  
3       field of medicine and not that which would be exercised by the  
4       profession generally.

5       A provider must use reasonable care and diligence in  
6       using skill and applying knowledge. What is reasonable care,  
7       skill, and diligence depends largely on the circumstances of  
8       each particular case as you -- which is obvious, taking into  
9       account the risk and dangers to be apprehended and guarded  
10      against in that particular case and, therefore, such care and  
11      attention must be given as are required by the circumstances  
12      of the particular case.

13      A physician that holds himself out to be a specialist is  
14      bound to bring to the discharge of his professional duties as  
15      a specialist that degree of skill, care, and learning  
16      ordinarily possessed by specialists of a similar class under  
17      the same or similar circumstances. Accordingly, one who holds  
18      himself out as a specialist or who undertakes a service in a  
19      special branch of medicine, or actually of medical science,  
20      owes his patient the duty of possessing that degree of  
21      learning and skill ordinarily possessed by a specialist of  
22      good standing.

23      A physician who has undertaken the treatment of a patient  
24      whose condition known to the physician or should be known is  
25      such that without continuous or frequent expert attention the

1 patient is likely to suffer injurious consequences must either  
2 render such attention himself or herself or see that some  
3 other competent provider does so.

4 Now, so first the Plaintiff must prove what was the  
5 standard of care. Second, the Plaintiff must prove that the  
6 Defendant or Defendants negligently departed from the standard  
7 of care in treating the Plaintiff. Negligence is the failure  
8 to do what an ordinarily careful provider would have done  
9 under the same or similar circumstances, or it's the doing of  
10 something that an ordinarily careful provider would not have  
11 done under similar circumstances, or perhaps both.

12 A provider's duty in treating a patient is to be measured  
13 by both the provider's skill and diligence. If by the lack of  
14 required skill you find that the Defendants failed to properly  
15 treat the patient so that the patient is injured or damaged as  
16 a result, then the Defendants would be responsible for any  
17 injury proximately caused to the patient.

18 The Defendant would also be responsible if having the  
19 required skill the Defendant negligently fails to use that  
20 required skill or is not as careful and diligent in the  
21 treatment of the patient as the provider should be. A  
22 provider, though, is not an insurer of a cure or even of a  
23 positive result. Therefore, the mere fact that a treatment  
24 does not benefit a patient or that it even harms a patient  
25 does not in and of itself mean that the Defendant was

1 negligent. A bad result, injury, or failure to cure is not by  
2 itself enough to show that the provider was negligent.

3 If you find that the Defendant used due care and skill in  
4 treating the patient and followed generally recognized  
5 practices and procedures and despite this the patient suffered  
6 damage, injuries, or death, you should return a verdict for  
7 the Defendant.

8 Now, similarly, a provider's mistake or error in making a  
9 decision alone doesn't constitute negligence either. If,  
10 however, a provider fails to gather information reasonably  
11 available that a reasonable provider would have gathered  
12 before making a decision, the provider fails to comply with  
13 the recognized standard of medical care that would be  
14 exercised by a similar provider under similar circumstances.

15 The difficulties and uncertainties in the practice of  
16 medicine and the unpredictable variations in the response to  
17 treatment are such that no provider can guarantee a result.  
18 Where there is more than one recognized diagnosis or treatment  
19 and no one of them is used exclusively and uniformly by all  
20 providers in good standing is not negligence for a provider in  
21 making the decision to choose one of the approved methods even  
22 when the choice later turns out to be a wrong selection.

23 Qualified providers and experts may differ as to what  
24 constitutes the best course of treatment, and these  
25 differences don't amount to malpractice. Where providers in



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1 good standing disagree or when medical authorities are divided  
2 with regard to a specific course of treatment or care, then  
3 the provider is bound only to exercise his best judgment in  
4 determining which course on the whole is best for the patient.

5 Just because another provider might have used a different  
6 course of treatment doesn't make the Defendant negligent.

7 However, if a provider does not have the degree of learning  
8 and skill that's required or if the provider doesn't use the  
9 care required, it's no defense to a charge of negligence that  
10 the provider just did the best that he or she could.

11 In considering whether the Defendant made a reasonable  
12 decision you must consider the decision in relation to the  
13 facts as they existed at the time and not in light of what  
14 hindsight might reveal.

15 All right, now let's talk about proximate cause. I've  
16 used that term a couple of times, and the third thing the  
17 Plaintiff has to prove in a medical negligence claim is that  
18 the Defendant's negligence proximately caused the Plaintiff's  
19 damages. Again, that word is not approximate. It is  
20 proximate, and proximate cause is something that produces a  
21 natural chain of events that in the end brings about the  
22 injury or the death. It is the direct cause of the injury.

23 To prove that the Defendant's negligence proximately  
24 cause the Plaintiff's injury, the Plaintiff must first prove  
25 what we call causation in fact, and this is proven by showing

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1 that the injury would not have occurred but for the  
2 Defendant's negligence.

3 The Plaintiff must also prove legal cause. Legal cause  
4 is proven by showing that the injury was foreseeable. Now,  
5 this means that the injury occurred as a natural and probable  
6 consequence of the Defendant's negligence. The Plaintiff must  
7 prove that some injury from the Defendant's negligence was  
8 foreseeable, but doesn't have to prove that the particular  
9 injury that occurred, that that specific injury, was  
10 foreseeable. However, the Defendant cannot be held  
11 responsible for something which could not have been expected  
12 to happen.

13 Now, sometimes the Defendant's negligence will combine  
14 what other forces such as acts of nature, something like that,  
15 to bring about a result. The law does not require the  
16 Defendant's negligence be the only cause or the sole cause of  
17 an injury. A Defendant must compensate the Plaintiff if one  
18 or more of his negligent acts or omissions was an efficient  
19 cause of the injury and combined with other efficient causes  
20 in such a way that had there been no negligent acts or  
21 omissions the injury either would not have resulted or would  
22 not have been as severe.

23 Proximate cause doesn't mean it has to be the only cause  
24 or the sole cause of the condition. A Defendant's act can be  
25 a proximate cause of the Plaintiff's injury if it was at least

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1 one of the direct concurring causes of that injury.

2 If the concurrent or successive negligent acts or  
3 omissions of two or more persons or entities, although acting  
4 independently of each other or in combination, the direct and  
5 proximate cause of a single injury to a Plaintiff and it's  
6 impossible to determine in what proportion each contributed to  
7 the injury, all are said to be responsible for the whole  
8 injury even though one person's act alone might not have  
9 caused the entire injury or the same damage might have  
10 resulted from the act of other wrongdoers.

11 If you should find from the evidence that two of the  
12 Defendant -- that two or more Defendants were negligent and  
13 that the negligence of such Defendant was a proximate cause of  
14 the injury complained of by the Plaintiff, then you should  
15 return a verdict in a single sum for such damages as you to be  
16 deter- -- as you determine to be due against all Defendants  
17 whom you find liable for such damages.

18 I further charge you under South Carolina law that a  
19 hospital has an absolute duty to provide competent medical  
20 care in its emergency room and this duty cannot be delegated  
21 to someone else.

22 I further charge you under South Carolina law that a  
23 physician is negligent in failing to administer a test or  
24 examination in aid of diagnosis if the recognized professional  
25 standards of skill and care, existing state of medical

1 knowledge and the like require the making of that test or  
2 examination which are generally accepted by the profession.

3 I further charge you under South Carolina law that South  
4 Carolina has adopted a national standard of care for  
5 physicians and nurses. The record in this case shows that the  
6 Defendants were nationally certified specialists in a  
7 particular area of medicine or nursing. The standard of skill  
8 and care required of such a physician is determined by  
9 reference to the practice within these fields of medicine  
10 rather than by practice among physicians in some specific  
11 locality. All right, now, that's -- that's about the  
12 Plaintiff's case.

13 Let's talk about the Defense's now. In their Answer to  
14 the Plaintiff's Complaint, the Defendants set forth what are  
15 called defenses. Now, the Defendants jointly first defense  
16 which these -- both Defendants asserted, this first defense,  
17 which is what we call a qualified general denial and by that  
18 defense, the Defendants admitted the truthfulness of the fact  
19 that the Defendant's hospital and Dr. Law treated the  
20 Plaintiff, Kelly Fay, but deny all the claims that would make  
21 them responsible for the Plaintiff's injuries or damages. In  
22 other words, they admit that they treated her, but deny any  
23 negligence.

24 The Defendants have also pled what we call an affirmative  
25 defense, and that is of comparative negligence, and I'll

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1 discuss that in a moment, but I just simply say comparative  
2 negligence means the Defendants have pled that the Plaintiff  
3 was negligent in causing the Plaintiff's own injuries.

4 All right, now, as you know, there's more than one  
5 Defendant in this case, and I charge you that there are two  
6 Defendants in the case, and you're aware of that, both of whom  
7 are alleged to have committed medical negligence. The case of  
8 each Defendant and the evidence and the law concerning that  
9 Defendant should be considered separately by you and  
10 individually, and the verdict form will set this out for you.  
11 In other words, it's not all lumped together.

12 Your verdict doesn't have to be the same for both  
13 Defendants. The fact that you may find for or against one  
14 Defendant does not control and should not control your verdict  
15 as to the other. Where more than one person is alleged to  
16 have committed medical negligence, if the evidence warrants  
17 it, you may find in favor of one Defendant and not the other,  
18 or you may find for the Plaintiff against both Defendants, or  
19 you may find that neither Defendant is liable to the  
20 Plaintiff.

21 It will depend upon your view of the testimony and the  
22 evidence. You must take each Defendant and consider the  
23 evidence as to that Defendant and my instructions to you on  
24 the law separately and then write a separate verdict form, and  
25 we will discuss that further when we talk about the verdict

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1 form.

2 Now, let's talk about comparative negligence. I  
3 mentioned that the Defendants had filed that affirmative  
4 defense back against the Plaintiffs, and in doing so, the  
5 Defendants claim that it was the Plaintiff's own negligence  
6 that proximately caused the Plaintiff's own damages. If you  
7 find that either of the Defendants were negligent, then you  
8 must decide whether the Plaintiffs were negligent.

9 Negligence, as I said earlier, means that a person didn't  
10 use the same amount of care that a person of ordinary reason  
11 and prudence would have exercised under the same or similar  
12 circumstances. Carelessness or careless means the same thing,  
13 and as I said earlier with regard to medical negligence, it  
14 can be said that a negligent person has done something that a  
15 reasonable person would not have done if faced with the same  
16 situation or failed to do something that a reasonable person  
17 would have done, or both.

18 Now, because the Defendants have raised this issue as an  
19 affirmative defense, again which we call comparative  
20 negligence, the Defendants bear the burden on that -- on  
21 asserting that affirmative defense. Now, when I say bear the  
22 burden, I mean they bear the burden of proof on the defense  
23 that they've asserted, all right?

24 Now, what that means is that the Defendants must prove by  
25 a preponderance or a greater weight of the evidence that the

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1 Plaintiff's own negligence, by either the Plaintiff or the  
2 Plaintiff's deceased spouse, proximately caused the  
3 Plaintiff's own injuries.

4 Now, if you find that the negligence of both the  
5 Plaintiffs and the Defendants combined and proximately caused  
6 the Plaintiff's loss, well, then you're going to have to  
7 decide how much of the negligence should be attributed to the  
8 Plaintiffs and how much should be attributed to the  
9 Defendants, and in deciding the percentages of negligence of  
10 the Plaintiffs and the Defendants, you may consider the  
11 following factors, among other things if you find them  
12 applicable.

13 Number one, and I'll tell you there's seven of these,  
14 whether each party's conduct was only inadvertent or whether  
15 it was engaged in with an awareness of the danger involved.  
16 Number two, the magnitude of the risk created by each party's  
17 conduct including the number of persons endangered and the  
18 possible severity of the loss. Number three, the significance  
19 of the goal that each party was trying to reach at the time  
20 and the need to achieve that goal in that particular way.

21 Number four, each party's capabilities and abilities to  
22 realize and eliminate the risks involved. Number five, the  
23 particular circumstances confronting each party at the time  
24 the conduct occurred, such as the existence of an emergency  
25 that may require a quick decision. Number six, the relative

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1 closeness of the causal relationship of the negative conduct  
2 of the Defendant and the harm to the Plaintiff, and finally,  
3 number seven, whether the conduct of either party involved a  
4 violation of the safety statute or regulation, or a company  
5 policy.

6 Now, I will give you written questions on a special  
7 verdict form, and what we're going to do is in a few moments  
8 when you retire to take your break, then we'll come back and  
9 discuss the verdict form, but the verdict form is going to  
10 have spaces to sort of help you, I guess, organize your  
11 discussions about whether there is negligence on the part of  
12 the Defendants, and whether there's comparative negligence on  
13 the part of the Plaintiffs, and we set it out in a progression  
14 for you to answer these questions for us.

15 Now, let's talk about the burden of proof. The mere fact  
16 that some bad result here occurs standing alone doesn't permit  
17 the jury to automatically conclude that the claimed damages  
18 were proximately caused by the Defendant's actions. In other  
19 words, as we said from the start of this case, the Plaintiffs  
20 have the burden of proving their case in this issue, just as  
21 the Defendants have the burden of proving the affirmative  
22 defense that they asserted back against the Plaintiffs.

23 All right, now, the party who must meet the burden of  
24 proof must meet that burden by proving their claims by the  
25 preponderance or the greater weight of the evidence. All



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1 right, well, okay, what does that mean? I will tell you that  
2 the word, preponderance, means that the facts sought to be  
3 proved is more likely true than not, more likely true than  
4 not. There's your answer right there, but I can show you what  
5 the greater evidence -- I can show you an example of that,  
6 what the greater weight of the evidence is, and that means the  
7 same thing as preponderance, and we've heard it referred to  
8 earlier in arguments.

9 If you can see in your mind's eye the picture of justice,  
10 she's blindfolded and she's got a set of scales on her hands.  
11 Well, if that scale is done appropriately, well, those -- the  
12 scales are even if the statue is done right. Well, that's  
13 where we were when this case started. Before we had any  
14 testimony at all, the scales were even when we walked in here  
15 Monday a week ago.

16 Now, we're at the end of the case and there's been  
17 evidence put into the scales, and so if those scales tip, and  
18 even if it's ever so slightly in favor of the Plaintiffs, then  
19 the Plaintiffs will have met their burden of proof and your  
20 verdict to some degree, to some extent, should be for the  
21 Plaintiffs.

22 If, on the other hand, with regard to a particular  
23 Defendant you find the scales remain even or tip, even if it's  
24 ever so slightly back in favor of that Defendant, well, then,  
25 the Plaintiff has failed to meet the burden of proof on that

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1 party, and your verdict should be for that Defendant. Again,  
2 you'll have to go through the same process when weighing the  
3 affirmative defense that has been asserted by the Defendants  
4 back against the Plaintiff.

5 Now, again, I've been back in your jury room, and well,  
6 not really much while you've been back there, but there's not  
7 a set of scales to go back there and weigh the evidence. Some  
8 of you have probably noticed that. While I will say that to  
9 you, that's obvious and that's because it's entirely a mental  
10 process, but I will say this to you, evidence which weighs  
11 with you is evidence that convinces you of its truth, again  
12 regardless of from which witness or which side of the case it  
13 may come.

14 Now, let's talk a little bit about damages, once we get  
15 beyond the liability decision. If you determine the Plaintiff  
16 is entitled to a verdict, then your next decision is to  
17 determine the amount of that recovery, and we call that  
18 damages. This is a case for actual damages. There are no  
19 punitive damages involved here.

20 Actual damages are intended to compensate an injured  
21 party, that is to put them in as near as possible the same  
22 position they were in before this injury ever occurred as best  
23 as monetary damages can do that. In other words, actual  
24 damages are the actual losses, expenses, and harm that the  
25 Plaintiffs have suffered because of the Defendant's actions.

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1        In this case, the Plaintiff has actually made two claims,  
2        one of which we call a survival action and the other is a  
3        wrongful death action. A survival action is brought on behalf  
4        of the deceased's estate for the conscious pain and suffering  
5        and other damages sustained by the deceased up until the time  
6        that she died, in other words during her lifetime.

7        And in a survival action in determining the amount of  
8        compensation to be awarded for injuries suffered by the  
9        Plaintiffs, if you find that the Defendants were negligent in  
10       causing Plaintiff's injuries, then it is proper for you to  
11       consider, should you find applicable from the facts of the  
12       case, the following areas of damages.

13       Again, this is talking about the survival action for the  
14       deceased's estate for damages sustained during her lifetime,  
15       medical expenses, physical pain and suffering, loss of normal  
16       life expectancy, mental anguish and emotional distress, and  
17       loss of enjoyment of life. As with all other claims in the  
18       case, the Plaintiff must prove actual damages by the greater  
19       weight of the evidence.

20       Now, let's talk a little bit about some of these specific  
21       areas of damages I just mentioned to you. First of all,  
22       medical expenses. The measure of damages for medical expenses  
23       consists of all reasonable expenses necessarily incurred for  
24       doctors and medical bills that were proximately caused by the  
25       Defendant's negligence.

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1       Let's talk about pain and suffering. Pain and suffering  
2 is recognized by the courts of this state as a material  
3 element of damages on which a recovery can be grounded. Pain  
4 and suffering is recognized as a separate kind of damage, and  
5 it is separate and distinct from something like loss of  
6 enjoyment of life, or medical bills, or some other applicable  
7 damage. Damages for pain and suffering are unliquidated.  
8 They are indeterminate in character, and the assessment of  
9 unliquidated damages always rest in your sound discretion,  
10 ladies and gentlemen of the jury.

11       As you know, pain and suffering have no market price.  
12 They are not capable of being exactly and accurately  
13 determined. There's no fixed rule or standard whereby you can  
14 measure them. The amount of damages to be awarded for pain  
15 and suffering must be left to your judgment, to your sound  
16 judgment, ladies and gentlemen, but again, the universal  
17 principle of actual damages is that an injured party should  
18 receive compensation equal to his or her loss, no more and no  
19 less.

20       Now, let's talk about mental suffering. The injured  
21 party may also recover for mental anguish brought about by  
22 bodily injury and suffering. If you find the injured party is  
23 entitled to recover damages, you may take into account anxiety  
24 or worry about the Plaintiff's condition that she suffered.  
25 However, the Plaintiff may only recover for that mental

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1 anguish that's brought about by bodily injury and suffering  
2 and in the absence of such connection, there can be no  
3 recovery for mental pain and suffering, and mental anguish  
4 must be distinguished from just mere annoyance, regret, or  
5 vexation. It is intense mental suffering.

6 Now, in deciding an amount of money to include in your  
7 award for loss of life damages, if you find such damages are  
8 applicable, it's going to be necessary for you to decide the  
9 probable life expectancy of Plaintiff's deceased. Now, to aid  
10 you in making this determination, you may consider the South  
11 Carolina's Code of Laws, what we call the actuarial table,  
12 which recognizes that a person of any particular age in South  
13 Carolina has a particular life expectancy.

14 The statute recognizes that a woman who is twenty-five  
15 years of age has a life expectancy of approximately fifty-five  
16 point forty-three years, and I will say that again, fifty-five  
17 point forty-three years if you're twenty-five years of age and  
18 female.

19 Life expectancy is merely an estimate of the probable  
20 average remaining length of the life of all persons in our  
21 state of a given age, and that estimate, of course, is based  
22 on a limited record of activity and experience, so the  
23 inference may be drawn from this statute that bears on the  
24 life expectancy of the Plaintiff, which would include her  
25 state of health, or habits, occupation, and other things that

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1 you may find relevant.

2 Now, let's talk about -- this is a survival action.  
3 Let's talk about wrongful death damages. In the wrongful  
4 death action -- remember, the survival action was for the  
5 Plaintiff, what she suffered during her lifetime.

6 The wrongful death action is brought by the Plaintiff as  
7 the personal representative for the deceased. It claims that  
8 the deceased wrongfully died as a result of the negligent act  
9 or omissions, and whenever the death of a person is  
10 proximately caused by the wrongful or negligent act of another  
11 and the act is one that would have entitled the deceased to  
12 recover damages if she had not died, then the personal  
13 representative of the estate may bring an action for what we  
14 call wrongful death, and the personal representatives have a  
15 right to recover compensatory damages for a wrongful death.

16 It's not necessary to show the monetary value of the  
17 deceased's life since direct proof of a value of a human life  
18 is not possible. What is reasonable compensation is left to  
19 your sound discretion and judgment.

20 I will tell you that the damages in an action for  
21 wrongful death include, and these are different from what I  
22 just talked about in a survival, wrongful death include  
23 pecuniary loss. That is the loss of the deceased's ability to  
24 earn money in which the Plaintiff might logically and  
25 reasonably have been expected to share, such as money for the

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1 care and protection of the deceased spouse, and where the  
2 relationship of husband and wife exists, pecuniary loss is  
3 presumed. Further, mental shock and suffering of the  
4 surviving spouse, wounded feelings, grief and sorrow, loss of  
5 companionship, loss of the use and comfort of the deceased's  
6 society, including a loss of the deceased's experience,  
7 knowledge, and judgment in managing the affairs of the  
8 deceased and her beneficiaries, and funeral expenses.

9 It's not necessary to show the exact amount of damages  
10 suffered by the beneficiaries or that the beneficiaries  
11 suffered a monetary loss. In addition, the person for whom  
12 the ben- -- for whose benefit the action is brought does not  
13 have to be dependent upon the deceased for support.

14 All right, now, let's talk just one or two more things.  
15 Let's talk about the burden of proof in proving actual  
16 damages. Plaintiffs have the burden of proving actual damages  
17 by the greater weight of the evidence, which I have already  
18 defined, but the amount of damages cannot be left to  
19 conjecture, or guess, or speculation.

20 Now, this doesn't mean they have to be proved to some  
21 mathematical certainty or that the Plaintiffs must produce  
22 precise evidence of the exact amount of actual damages  
23 suffered. Whereby the evidence put forth by the Plaintiffs  
24 should be such as to enable you, the jury, to determine what  
25 amount of damages is fair, just, and reasonable under the

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1 circumstances.

2 The universal principle of actual damages, I'm going to  
3 say it one more time, is that an injured party is entitled to  
4 be compensated in an amount to put them as near as possible  
5 the same position they were in prior to the injury as far as  
6 monetary damages can do that.

7 All right, now, in conclusion, in just a few moments,  
8 ladies and gentlemen, Mr. Foreman, you are going to retire to  
9 begin your deliberations, and while you do that, when you do  
10 that, I want to express to you the hope that each of you are  
11 mindful of the importance of your responsibility. You're not  
12 called upon often to serve as jurors, and for that, I'm sure  
13 you at this point probably say, well, thank goodness, but  
14 there's a reason for that.

15 You may recall during qualifications you were told you  
16 cannot be required to serve more than one time in three years  
17 in the same court. Well, this is the reason for that. It's a  
18 difficult task. It requires you and I to free our minds of  
19 all outside and improper influences because you and I are  
20 acting for the community to see to it that every trial here is  
21 fair and every verdict is just, and I will say to you that a  
22 finding of liability and an award of damages in this case  
23 cannot be based upon sympathy, passion, prejudice, or emotion,  
24 or some other consideration that's not found in the evidence.

25 You've probably noticed throughout this trial that the



## CHARGE BY THE COURT

1 presiding officer, which is me, is referred to as Your Honor,  
2 and I know you know that's not some title given to me  
3 personally. It's a title that is assigned to the position  
4 that I am privileged to hold, because this Court is entrusted  
5 with the honor of this community, this county, this state, and  
6 indeed this nation, in seeing to it that every trial here is  
7 fair and every verdict here is just.

8 Now, in just a few moments, you're going to take  
9 preservation of the honor of this community, county, state,  
10 and nation with you into the jury room to decide this case.  
11 Now, when I say that to you, please understand I'm not trying  
12 to tell you how to decide this case. That's not my point.  
13 That would not be proper.

14 I'm just saying this: As the presiding officer of this  
15 Court, it is of vital importance to me that whatever verdict  
16 you reach will be the result of your going back in the jury  
17 room, confining your considerations to the evidence put forth  
18 in this courtroom, weighing it fairly, and weighing it  
19 impartially, and applying it to the law that I've given you in  
20 this proceeding.

21 I have every confidence that that is what you will do. I  
22 will say to you that everyone in this case is entitled to  
23 justice. Both the Plaintiff and the Defendants all are  
24 entitled to justice, nothing more, nothing less. We owe no  
25 support to any party. We owe no sympathy to any party, and I

## CHARGE BY THE COURT

1 am of the confirmed opinion that whatever verdict you reach  
2 will represent truth and justice for all the parties before  
3 the Court.

4 Now, Mr. Foreman, I will tell you now that in your  
5 deliberations you may find some of your jurors seated at the  
6 table. You have a spacious jury room. I travel all over the  
7 State. You're in a beautiful jury room. Many jury rooms are  
8 like closets in other parts of the State. You have a spacious  
9 room.

10 Some may be standing by the window, some by the wall,  
11 some seated at the table. If someone wants to express a ver-  
12 -- an issue on a particular point within the verdict form,  
13 please make sure that everyone is heard so that not only will  
14 your verdict be a consensus verdict, but ultimately it will be  
15 a unanimous verdict, which is required by law.

16 Now, here's what we're going to do. We're going to stop.  
17 We're going to let you go back and take a break. We are going  
18 to get the evidence together, get the verdict form together,  
19 bring you back in, discuss anything else I need to discuss  
20 with you about the charge, as well as the verdict form itself,  
21 and then let you retire to deliberate, so please don't begin  
22 discussing the case yet.

23 Just enjoy your break. If you want to go outside,  
24 probably a good afternoon -- good point to do that if you wish  
25 before you begin deliberation, so we'll be subject to your

JURY OUT  
COURT TO COUNSEL

1 return and at that time we'll reconvene.

2 Let's all remain where we are while this jury departs the  
3 courtroom.

4 (THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE  
5 JURY.)

6 THE COURT: All right, the jury is clear.

7 Let's do this; I'm going to ask for Counsel to step back  
8 and join me in the back and let's review the verdict form, but  
9 before we do, while we're all here together and while we have  
10 a moment, let me just say something to the parties. I may not  
11 have an opportunity to say this again. It just depends on  
12 what happens with the jury.

13 I know for our physicians, I have physicians who are in  
14 my family, that a courtroom is not the place that you prefer  
15 to be. I know for the Plaintiff who, you know, has a wife and  
16 a business, a courtroom is not the place where he would  
17 normally be, and you're probably uncomfortable here. This is  
18 where I live. I work here every day, and I try cases every  
19 day. It's my privilege.

20 This case, as I think about the issues, what can be more  
21 pivotal than, for the Plaintiff, the loss of a life, and for  
22 the Defendants, the very thing that you have spent your life  
23 preparing, teaching, or learning, studying, teaching, and  
24 practicing, to have that attack made on your actions taken in  
25 the furtherance of your profession, and because of the pivotal

## COURT TO JURY - VERDICT FORM

1       **MR. FOSTER:**   No sir, Your Honor.

2       **THE COURT:**   From either Defendant?

3       **MR. AIKEN:**    No sir, Your Honor.

4       **MR. TODD:**    No sir.

5       **THE COURT:**   Okay, and again, this form, you will notice,  
6       is asking you to make a decision on the Defendants  
7       individually and also is asking you by a preponderance or  
8       greater weight of the evidence each of these questions, but  
9       that the answers must be unanimous, and so the last statement  
10      on this, Mr. Waldowski, is I certify that these decisions are  
11      the unanimous decisions of the jury, so you're telling me when  
12      you sign that, that it's unanimous.

13      All right, now, what I'd like for you to do is we're  
14      going to give you the verdict form right now. We're going to  
15      put the evidence together and then bring it in to you within  
16      the next minute or two, but you can go ahead and begin your  
17      deliberations at this time.

18      Now, there's not going to be somebody back there  
19      listening to hear the verdict. We couldn't hear it even if we  
20      tried. Those doors are pretty solid back there, but if you  
21      need the Court, for whatever reason, or if you need to take a  
22      break, just knock on the door. Someone is there to answer the  
23      knock, and we'll respond to whatever your need may be.

24      If you have a question, please make sure you write it and  
25      give it to the bailiff who can then respond to it. If you

COURT TO JURY - VERDICT FORM  
JURY OUT/DELIBERATION

1 need to take a break or separate during the proceedings, and  
2 if some people want to go outside and take a break, you've  
3 been at it for a while, that's fine. You just let us know  
4 that, but if you do that, please, I'd like for both groups to  
5 stop deliberations because it's conceivable that two different  
6 groups at two different places could reach an inconsistent  
7 result at the same time, so just stop deliberations until  
8 you're all back together again.

9 All right, any questions now from the jury? (No  
10 response.) All right, at long last, then, here at three  
11 o'clock on Thursday afternoon, we're going to turn the case  
12 over to you.

13 Ms. Bell, I'm going to give you this verdict form and if  
14 you will escort the jury back to begin deliberations, we will  
15 send the evidence in as soon as we compile it and make sure  
16 it's in the right order, it will come to you as well.

17 **(THE FOLLOWING TAKES PLACE AT 3:05 P.M. OUTSIDE THE**  
18 **PRESENCE OF THE JURY.)**

19 **THE COURT:** All right, before we take exceptions to the  
20 charge, how about come forward, let's look at all the  
21 evidence. If you would meet with Ms. Eubank and make sure the  
22 exhibits are in order, and then they will all go back there.

23 **(THE EXHIBITS ARE REVIEWED BY COUNSEL FOR THE PLAINTIFF**  
24 **AND COUNSEL FOR BOTH DEFENDANTS.)**

25 **THE COURT:** All right, let me just ask, is there any

## JURY OUT/EXCEPTIONS TO CHARGE

1 finds that just neither of those are applicable to the facts  
2 here.

3 (PLAINTIFF'S REQUEST TO CHARGE NUMBER 91 AND 92 MARKED AS  
4 COURT'S EXHIBIT NUMBER 2.)

5 MR. FOSTER: And the only other thing we would have,  
6 Your Honor, is what -- as we talked about in Chambers, we  
7 except to number five on the verdict form. We would like the  
8 Court -- no, not number five. Excuse me. I've got an old  
9 verdict form, so I've got ---

10 THE COURT: Well, you don't want -- you want it to be  
11 divided among the two -- the percentages to be divided  
12 Plaintiff, and then both Defendants listed individually?

13 MR. FOSTER: Yes.

14 THE COURT: And the Court declined to do that because,  
15 number one, it was not necessary, because this is a joint and  
16 several case under the old law, and secondly, I just didn't  
17 think it was necessary to put the jury to a decision that was  
18 not required for their deliberation.

19 Anyone else want to be heard on those issues? (No  
20 response.)

21 All right, anything further from the Plaintiff?

22 MR. FOSTER: Your Honor, just for the record, we wanted  
23 to object to any of the evidence going into the record in the  
24 Exhibit Number 5 about marital difficulties, and we're going  
25 to except -- object to that.

1       **THE COURT:** And the record should reflect that what we  
2 did with that was I had excluded any evidence of an  
3 extramarital affair and that was redacted. Plaintiff wanted  
4 to go further and take out the issue of marital difficulties,  
5 which I felt was inappropriate, that it was something that  
6 should go to the jury as it was a fact in the case, again, on  
7 marital difficulties only.

8       All right, now from the Defendants, any exception or  
9 objection to the charge?

10       **MR. AIKEN:** No sir, not from Dr. Law.

11       **MR. TODD:** Yes sir, Your Honor. I would object to the  
12 charge, the Simmons v. Tuomey charge, the charge that a  
13 hospital has an absolute duty to provide competent medical  
14 care in its emergency room. While **Simmons** is the case that's  
15 the agency, which really isn't applicable in this case, and  
16 also the charge concerning an absolute duty creates the  
17 impression that the hospital is almost an insurer of its  
18 competence, and we would object to it on that ground.

19       **THE COURT:** All right. Your objection is noted. We'll  
20 let you place those, if you wish, in a separate Court's  
21 Exhibit for appellate review purposes.

22       **MR. TODD:** Yes sir, and then the other charge -- the  
23 other objection to the charge is that the physician or  
24 provider was negligent in failing to administer a test or  
25 examination and that was just which we talked about in

## JURY OUT/EXCEPTIONS TO CHARGE

1 Exhibit 3 if you want to look at ---

2 MR. FOSTER: Yes sir, we would.

3 THE COURT: All right.

4 MR. FOSTER: Thank you. Your Honor, I think **Durr v.**  
5 **McElrath** is clear law from South Carolina and that -- I think  
6 that any physician that's negligent in failing to administer a  
7 test or examination in aid of a diagnosis is the recognized  
8 professional standard, skill, et cetera, require the making of  
9 those tests. That's basically just what the rest of the  
10 charge says, but it's in -- in this case, it's specifically  
11 relevant because of the failure of our allegations or failure  
12 to take temperature, proper blood tests, et cetera.

13 On Number 69, **Simmons v. Tuomey**, we think that's good  
14 law, Your Honor, and that a hospital does have an absolute  
15 duty to provide competent medical care in its emergency room  
16 and that it cannot be delegated to someone else.

17 THE COURT: All right. The Court found those were  
18 appropriate and applicable under the facts of the case and  
19 decided to charge those. Objection noted for the record.

20 Anything further now before we close the record awaiting  
21 the call of the jury, from any party? (No response.)

22 All right, then, ladies and gentlemen, we will be in  
23 recess, hearing nothing and recess until we receive a message  
24 from the jury. All right, very good.

25 MR. FOSTER: Thank you, Your Honor.



1       **MR. AIKEN:**   Thank you, Your Honor.

2       **THE COURT:**   Thank you.

3       All right, ladies and gentlemen, we still haven't heard  
4       from the jury, so we will still be at ease waiting -- waiting  
5       on their call.

6       **(THE FOLLOWING TAKES PLACE OUTSIDE THE PRESENCE OF THE**  
7       **JURY.)**

8       **THE COURT:**   We have a note from the jury. It has  
9       actually a typo on it or a misspelled word. The note actually  
10      says we are at a point where we can agree, but I am certain  
11      that he meant cannot agree, on something in the next twenty  
12      minutes or so. We have some ways to go and think starting new  
13      in the morning might be best. Is that okay? It's signed by  
14      the Foreperson.

15      My intention would be just to tell them nine-thirty  
16      tomorrow morning. We'll go home. I'm not even going to bring  
17      them back into the courtroom, just tell them not to discuss  
18      the case overnight with any of the jurors or any of their  
19      loved ones at home, just come back, get a good night's rest,  
20      start back at nine-thirty. Does that suit -- anyone object to  
21      that?

22      **MR. FOSTER:**   Absolutely not.

23      **THE COURT:**   All right.

24      **MR. FOSTER:**   My hearing is -- is really not ---

25      **THE COURT:**   Well, here, look at it.

JURY OUT FOR DAY/  
JURY IN FOR DELIBERATION ON MAY 28, 2010

1       **MR. FOSTER:**   I just couldn't hear you, what ---

2       **THE COURT:**   Well, it has a typ- -- it has a misspelled  
3 word in it. He says can when he meant to say cannot. I think  
4 he's just tired.

5       **(THE COURT HANDS NOTE FROM JURY TO COUNSEL.)**

6       **THE COURT:**   So y'all work on the copy of that, but may I  
7 go back and -- I'm just going to release them, then.

8       We will just declare this session adjourned and we will  
9 see you in the morning at 9:30.

10       **(NOTE FROM JURY MARKED AS COURT'S EXHIBIT NUMBER 4.)**

11       **(NOTE FROM JURY MARKED AS COURT'S EXHIBIT NUMBER 5.)**

12       **(ON MAY 28, 2010, THE JURY CONTINUES DELIBERATIONS AT**  
13 **9:30 A.M.)**

14       **(THE FOLLOWING TAKES PLACE ON MAY 28, 2010, AT 11:40**  
15 **A.M., OUTSIDE THE PRESENCE OF THE JURY.)**

16       **THE COURT:**   Counsel, I'm advised that the jury has a  
17 verdict. Before we receive the verdict, let me ask if there  
18 are any issues that you wish to put on the record with regard  
19 to any jury delibera- -- to any discussions we've had during  
20 jury deliberations, including any responses to jury questions  
21 that have been posed, from any party? If so, now would be the  
22 time to put that on the record.

23       Anything from the Plaintiff?

24       **MR. FOSTER:**   No sir.

25       **THE COURT:**   And Defendants?

1       **MR. TODD:** Just a question. Are you okay with post-  
2 trial motions within ten days?

3       **THE COURT:** Yes sir, we'll -- we'll do that. We'll take  
4 them within ten days, and because the verdict form is  
5 generally complicated, what my intention would be would to get  
6 Ms. Lilly -- actually, if you -- or actually, probably, Gloria  
7 Bell will hand me the form, and then I will review it, and I  
8 will publish the form, all right, and then we will have an  
9 opportunity to ask any questions of the jury if necessary.

10       **MR. AIKEN:** Can you give me sixty seconds? I need to do  
11 one quick thing.

12       **THE COURT:** Yes sir, we'll do that; we'll wait a moment.

13       **MR. AIKEN:** Thank you, Your Honor.

14       **THE COURT:** Very good; thank you.

15 And let's bring in the jury, please.

16       **(THE FOLLOWING TAKES PLACE WITHIN THE PRESENCE OF THE**  
17 **JURY AT 11:45 A.M.)**

18       **THE COURT:** All right, welcome back to the courtroom,  
19 ladies and gentlemen, and Mr. Foreman, I'm advised that you  
20 have reached a verdict, you and the jury have reached a  
21 verdict. Is that correct, sir?

22       **THE FOREMAN:** Yes sir.

23       **THE COURT:** Would you please give the verdict form to  
24 Ms. Bell. Thank you.

25 Thank you. Let me take just a moment to review it,

1 please.

2 All right, let's let the record reflect that the verdict  
3 form is appropriately filled out and has been signed by the  
4 Foreperson, and the Court will now publish the verdict.

5 In the matter of **Sean D. Fay, as Personal Representative**  
6 **for the Estate of Kelly Fay versus the Grand Strand Regional**  
7 **Medical Center, doing business as South Strand Ambulatory Care**  
8 **Center, and Dr. Stephen W. Law, Defendants,** the verdict is as  
9 follows:

10 Question Number One: Was the Defendant, Grand Strand Regional  
11 Medical Center negligent?

12 Answer: Yes.

13 Part One, B: Was the Defendant, Grand Strand Regional Cares  
14 -- Medical Center's negligence a proximate cause of the  
15 Plaintiff's injury?

16 Answer: Yes.

17 Question Two: Was the Defendant, Dr. Stephen W. Law,  
18 negligent?

19 Answer: Yes.

20 Two-B, Question Two-B: Was Defendant, Dr. Stephen W. Law's,  
21 negligence a proximate cause of the Plaintiff's injuries?

22 Answer: Yes.

23 Question Three: Was the Plaintiff negligent?

24 Answer: Yes.

25 Number Four: Was the Plaintiff's negligence a proximate cause

1 of the Plaintiff's own injuries?

2 Answer: Yes.

3 Number Five: Using the combined negligence that proximately  
4 caused the Plaintiff's injuries as one hundred percent, what  
5 percentage of negligence is attributable to Plaintiff and what  
6 percentage is attributable to each of the Defendants?

7 To the Plaintiff: Four percent.

8 To the Defendants collectively: Ninety-six percent, which is  
9 broken down in the following way: Grand Strand, ninety  
10 percent; Dr. Stephen Law, six percent. The total of those  
11 percentages is one hundred percent.

12 Answer to Number Six: Was the Plaintiff's negligence greater  
13 than fifty percent?

14 Response: No.

15 Question Seven: Please state the amount of damages, if any,  
16 sustained by the Plaintiffs.

17 The jury's verdict, Three Million Dollars.

18 Now, the signature of Michael Waldowski, Foreperson, is  
19 appropriately affixed to the verdict form.

20 Now, ladies and gentlemen, if this is your verdict and I  
21 have published it correctly, please raise your right hand.

22 **(AT THIS TIME EACH AND EVERY JUROR RAISED HIS OR HER**  
23 **RIGHT HAND AFFIRMING THE VERDICTS AS PUBLISHED.)**

24 **THE COURT:** Let's let the record reflect that the -- you  
25 may put your hands down; thank you -- that all of the jurors

1 have raised their right hands, and thus the jury's verdict is  
2 confirmed by the jury.

3 Now, while we are in the presence of the jury, are there  
4 any motions or issues for which a jury response would be  
5 necessary? First, to the Plaintiffs, what say the Plaintiffs?

6 **MR. FOSTER:** No, Your Honor.

7 **THE COURT:** Very good, and then next to the Defendant,  
8 Grand Strand Regional Medical Center, while in the presence of  
9 the jury?

10 **MR. TODD:** None, Your Honor.

11 **THE COURT:** And as to the Defendant, Dr. Law, while in  
12 the presence of the jury?

13 **MR. AIKEN:** No sir.

14 **THE COURT:** None.

15 All right, then, ladies and gentlemen, what that means is  
16 that your service in this case is concluded, and I want to  
17 thank you for your contribution of two weeks of your lives,  
18 the personal attention you've given this matter, the verdict  
19 which you've reached, which is just and true as you determined  
20 justice to be in this case.

21 Now, in a few days, the county is going to send you a  
22 check, which is going to be your per diem and your mileage.  
23 It's not going to be a large sum, but nevertheless, it will be  
24 coming your way. That's the county's expression of gratitude,  
25 but I'm going to come around, if you'll give me just a moment,