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SC Court of Appeals

STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Maite Murphy
Circuit Court Judge

Case No.: 2018-CP-10-02109
Appellate Case No. 2023-000029

Rebecca Turisk,

Appellant,

v.

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

Respondents.

RECORD ON APPEAL – VOLUME II (Amended)

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1 A I believe so. I don't know without having that in front of
2 me.

3 Q But all of those are, what I've learned are, bacteria that
4 can be acquired, even in a healthcare setting, correct?

5 A Yes. They can be acquired anywhere.

6 Q And any one of us could -- or, all of us have staph aureus?

7 A All of us have all of those.

8 Q All of those. Now, do I hear you correctly saying that
9 Rebecca should have stayed with you as a patient even though you
10 never told her that she had venous insufficiency and was going to
11 be in great danger of losing the nipple and ultimately a double
12 mastectomy?

13 A Can I answer? I don't believe I told her that. I believe
14 counsel asked me what I would have done had she stayed. And I
15 would have taken care of her and been happy to do that.

16 I believe the timing of when her nipple was debrided, in my
17 clinical judgment and practice, was adequate, and telling her
18 stuff ahead of that without me knowing stuff is not helpful to
19 the patient or her family.

20 Q Even though you knew on November the 6th?

21 A Again, on November 6th I knew from the pictures she had
22 venous congestion. I did not know the ultimate outcome or the
23 severity of it.

24 Q Doctor, your position with Sweetgrass Plastic Surgery is
25 what?

1 A Owner.

2 Q And you direct personnel that work there?

3 A I do.

4 Q And that's where you operate?

5 A Yes. We have three operation sites. Three offices, three
6 different locations that have operating rooms. Yes.

7 Q Rebecca testified that she and her caregivers would text you
8 at various times during the first six days, and even after that;
9 is that correct?

10 A I believe we texted and talked different times. Yes.

11 Q And the photographs were sent to you on the 6th, at least?

12 A I don't know where they were sent. They weren't sent
13 directly to me. I believe they were sent to one of my providers,
14 and they shared it with me --

15 Q Okay.

16 A -- but I don't know the date of that. I did see pictures
17 somewhere in the first two weeks.

18 Q And I don't believe those things are produced in your chart.
19 That's why I'm asking.

20 A Well, I believe the picture is produced because the picture
21 that she sent is the picture that went to our nurse practitioner
22 or PA.

23 Q Can you identify that photograph from the -- that may be
24 true, but I haven't -- do you have the chart? You have the
25 chart.

1 A Yeah. I don't have -- I didn't receive any personal
2 pictures from her early on.

3 Q I don't know where it is. So, your lawyer asked you to look
4 at the photographs. That is November 30th, I think. Do you know
5 when those were taken?

6 A I don't. There's no date on them.

7 Q But these were taken at your office?

8 A I have no idea if they were the office or hers.

9 Q If they were produced to us from your office as being taken
10 by your office, then that would be correct?

11 A I don't know where they came from. I know she took pictures
12 and we took pictures.

13 Q And the text messages back and forth, you don't have those?

14 A No.

15 Q Do you agree that it was reasonable for Rebecca to have
16 fat-grafting procedures to try to restore some shape of her
17 breasts?

18 A I do. I do.

19 Q Is any treatment that Rebecca had after this occurrence,
20 after November the 30th, that you believe was unreasonable?

21 A I don't.

22 Q And it's certainly reasonable for her to have some procedure
23 which might contribute to the way she looks to help her feel
24 better about herself --

25 A Yes.

1 Q -- because you're in that business?

2 A Yes, sir.

3 Q I think that's all the questions, but let me check with my
4 cocounsel. Thank you very much, Doctor.

5 THE WITNESS: Thank you, sir.

6 THE COURT: Redirect?

7 ATTORNEY SMYTH: Very briefly, Your Honor.

8 THE COURT: Yes, sir.

9 **REDIRECT EXAMINATION**

10 BY ATTORNEY SMYTH:

11 Q Dr. Schimpf, you were asked a number of questions about
12 whether you told Ms. Turisk there was a possibility she might
13 lose her nipple prior to your last visit.

14 A Yes.

15 Q If you would turn to page 37 of the chart, please. Are we
16 on the same page?

17 A Yes, sir.

18 Q All right. Is that a note from Ms. Turisk on November the
19 28th?

20 A It is.

21 Q Is that your note?

22 A Yes.

23 Q Is this the one that you were confused about the dates on?

24 A Yeah. She had gone two out of three nights, I believe, to
25 urgent care and ER.

1 Q And as we go to the bottom here, I highlighted a section
2 there. Can you read that to the jury what you put in your note
3 on the 28th.

4 A Yes. Again, they have my phone number, and I have talked
5 and texted with them multiple times. I have instructed them to
6 contact me if they have any additional concerns or problems.

7 The patient today had questions about her nipple and about
8 the wound. I explained to her that our main goal at this point
9 is to get the wound healed, and once that is completed there are
10 various things that we can do to reconstruct the nipple, as well
11 as tattooing.

12 Q And is there a second page of that note?

13 A I don't know. Yeah.

14 Q On page 38.

15 A 3D versions -- that refers to nipple tattooing which is done
16 by a specialized tattoo artist -- which will dramatically improve
17 her outcome. She states today that she is not overly concerned
18 about the presence of a nipple and that overall her neck and back
19 pain feel better and she has had less migraines. I will see her
20 back in 48 hours for continued evaluation.

21 Q So does this refresh your recollection as to whether you had
22 a conversation with Ms. Turisk about the possibility she might
23 lose her nipple during the healing process?

24 A Yes. I know we spoke about it late at this timeframe, but I
25 don't remember, you know, when.

1 Q Nothing further. Thank you.

2 THE COURT: You may step down, Doctor. Thank you.

3 ATTORNEY TANENBAUM: May I, please?

4 THE COURT: No, sir. Nothing new was brought up. You may
5 step down, Doctor.

6 THE WITNESS: Thank you, ma'am.

7 THE COURT: Ladies and gentlemen, it's about 12:20, so it's
8 a good time for us to take our lunch break. If you would be back
9 in your jury room at 1:30, we'll resume with the trial of the
10 case. Have a nice lunch.

11 Please remember not to discuss the case amongst yourselves
12 or with anyone else.

13 (Jury escorted out of the courtroom at 12:17 p.m.)

14 THE COURT: All right. Counsel, anything before we recess
15 for lunch?

16 ATTORNEY SMYTH: No, Your Honor.

17 THE COURT: Anyone have anything?

18 ATTORNEY TANENBAUM: Nothing.

19 THE COURT: Thank you.

20 ATTORNEY TANENBAUM: What time are we supposed to be back?

21 THE COURT: 1:30.

22 (Court recessed at 12:18 p.m. and reconvened at 1:34 p.m.,
23 without the jury.)

24 THE COURT: Parties ready to proceed?

25 ATTORNEY SMYTH: Defense is, Your Honor.

MATTER(S) OF LAW

1
2 ATTORNEY BURKE: Your Honor, I have one matter to take up
3 before the next witness testifies. And I spoke previously with
4 opposing counsel. Dr. Joseph is sort of an interesting expert in
5 that he is not coming to testify as to any breaches of the
6 standard of care. That is borne out extensively in his
7 deposition, in addition to a document he created called selected
8 history and abbreviated opinions for deposition.

9 And I just wanted to confirm on the record with opposing
10 counsel that this witness will not be offering any opinions on
11 the violation of standard of care.

12 ATTORNEY SMYTH: That's correct, Your Honor. He's not a
13 plastic surgeon. He is an infectious disease provider, so he's
14 going to talk about his opinions in that field.

15 THE COURT: All right.

16 ATTORNEY BURKE: Your Honor, if I may, we'd like to note for
17 the record our previous objection to the references that I
18 anticipate will be made during his testimony to the three
19 specific kinds of bacteria that were cultured, with particular
20 emphasis on the enterococcus faecalis, and our concerns about the
21 prejudicial effect that will have on the jury in this case where
22 the real issue is the blood flow that set the stage for the
23 infection, and that this particular type of bacteria made no
24 difference in the outcome.

25 But I understand the Court's ruling on this. I think it's

1 going to come up again, and I just want to make sure my record's
2 protected.

3 THE COURT: Yes, ma'am. Certainly your objection is noted,
4 and the same ruling applies.

5 ATTORNEY BURKE: Thank you.

6 THE COURT: Anything further before I bring the jury out?
7 (Off-the-record discussion.)

8 THE COURT: Let's have our jury, please.

9 (Jury seated in the courtroom at 1:38 p.m.)

10 THE BAILIFF: All jurors are present and seated, Your Honor.

11 THE COURT: Thank you. Welcome back, ladies and gentlemen
12 of the jury. We're now ready to proceed. You may call your next
13 witness.

14 ATTORNEY SMYTH: May it please the Court, Your Honor. The
15 defense calls Dr. Patrick Joseph to the stand.
16 follows:

17 WILLIAM PATRICK JOSEPH,
18 having first been duly sworn, was examined and testified as
19 follows:

20 CLERK OF COURT: Please state your name for the record, and
21 spell your last name.

22 THE WITNESS: William Patrick Joseph, J-o-s-e-p-h.

23 THE COURT: Your witness.

24 ATTORNEY SMYTH: Thank you, Your Honor.

DIRECT EXAMINATION

(on voir dire)

BY ATTORNEY SMYTH:

Q Good afternoon, Dr. Joseph.

A Good afternoon.

Q Or good morning. I understand you've taken a red-eye flight from the West Coast to join us today.

A I did.

Q Well, we appreciate you being here. If you would, please introduce yourself to the jury.

A My name is Patrick Joseph. I am from Appalachia, but I did all my training at the University of California San Francisco. I'm a physician. I trained in internal medicine, infectious diseases, and clinical pathology, which is laboratory medicine.

When I finished my training in 1980, I was invited to join the faculty of the university, and I have been on the faculty of the University of California San Francisco since. I split my time between patient care, teaching, and laboratory medicine.

Q And if you could, please take us through your educational training and background, starting with your undergraduate degree.

A Yes. I went to the University of West Virginia. I'm from West Virginia. Went to the University of West Virginia. I graduated in three years, and went to medical school there, and graduated from medical school.

And right after medical school, moved to California and did

1 all of my subsequent training there. Initially it was an
2 internship in internal medicine; then two years of residency in
3 internal medicine; an additional year as chief medical resident;
4 and two years of additional training in infectious diseases; and
5 one year in laboratory medicine.

6 Q And when we talk about the practice of the medicine as it
7 relates to infectious disease, can you give the jury an idea of
8 what types of things that includes?

9 A Yes. Clinical infectious disease, unless otherwise
10 specified, is adults. There is a separate specialty for
11 pediatric infectious disease. So, I only see adult patients, and
12 my practice is almost always dedicated to seeing patients who
13 have been referred from another physician.

14 With the exception of the AIDS era, which was about 10
15 years, by and large patients that I see are patients that have
16 serious infectious complications or suspected infectious
17 complications when they're in the care of another physician, and
18 they are referred to me to assist in their management.

19 Q And are you licensed to practice medicine?

20 A I am. I am licensed to practice medicine to see patients in
21 California, Florida, and Arizona, and licensed to be a laboratory
22 director in all 50 states.

23 Q Are you board-certified in any specialties of medicine?

24 A Yes. I'm board-certified in two specialties of the American
25 Board of Medical Specialties, and those are the ones that are

1 considered the most important. I'm board-certified in internal
2 medicine and in infectious diseases. I have numerous other
3 boards, but they are from other organizations and don't carry the
4 status of those first two.

5 Q And as it relates to your practice in infectious disease,
6 are you a part of any national organizations or bodies?

7 A Yes. There are three major organizations. There is the
8 National Foundation of Infectious Disease Physicians of which I'm
9 a past president, the Infectious Diseases Society of America of
10 which I am a fellow and part of the national faculty, and the
11 Society of Healthcare Epidemiologists of the America of which I
12 am a fellow, and I have been on their board examination
13 committee.

14 Q And do you maintain hospital privileges?

15 A I do. I have teaching privileges at the University of
16 California teaching hospitals. There are five of those, so
17 whichever one I am assigned, I will get privileges at that
18 hospital while I'm on a teaching service. And I have full-time,
19 active privileges at a private hospital called San Ramon Regional
20 Medical Center.

21 Q And have you done any research or published anything in the
22 field of infectious disease?

23 A I have. I think I have approximately 70 or 75 publications.
24 Essentially all of them, except the first one, I dedicated to the
25 field of infectious diseases in laboratory medicine. My first

1 publication was the valedictorian speech from medical school.

2 Q And have you given any presentations to other physicians in
3 the field of infectious disease?

4 A Yes. I think in 40 years I've probably given hundreds, but
5 I don't keep a list of them. But, I am on the National Faculty
6 of the Infectious Diseases Society of America, so there's a
7 national meeting once a year, and there are several of us who are
8 on the national faculty of teaching other physicians.

9 Q Have you had the opportunity to take care of patients who
10 had a similar complication like Ms. Turisk has in this case?

11 A Yes, sir, I have.

12 Q Can you give the jury an idea of your experience in that
13 regard.

14 A Well, this is an unusual complication of surgery when fat
15 necrosis, which is her diagnosis, gets to be so severe that it
16 gets a secondary infection.

17 And when I'm involved with these patients, they are patients
18 just like Ms. Turisk, when it's very difficult to understand why,
19 in the 21st Century, we can't cure an infection within 10 days or
20 so with the powerful antibiotics we have. And I have probably
21 seen, in my career, maybe 40 or 50 such patients.

22 Q And so that's a part of your regular clinical practice?

23 A Yes. My clinical practice is seeing only patients who are
24 unusual, or unusually complicated, with the exception of COVID,
25 and that was a very unusual past three years.

1 Q And have you specifically seen patients who have had similar
2 issues following breast-related surgery?

3 A Yes, sir, I have.

4 Q Do you believe that you have the requisite knowledge,
5 experience, and training to sufficiently inform this jury about
6 the issues that might pertain to your field in infectious
7 disease?

8 A Yes, sir.

9 ATTORNEY SMYTH: At this time, Your Honor, we would offer
10 Dr. Joseph as an expert in infectious disease.

11 THE COURT: Any voir dire?

12 ATTORNEY BURKE: None from the plaintiff, Your Honor. Thank
13 you.

14 THE COURT: He's qualified.

15 ATTORNEY SMYTH: Thank you, Your Honor.

16 **DIRECT EXAMINATION**

17 BY ATTORNEY SMYTH:

18 Q Dr. Joseph, did I hire you to take a look at this case for
19 us?

20 A You did. I remember our first discussion, and it was a
21 request of me to review the medical records, and pretty much the
22 question that I just relayed, Why in the heck would someone not
23 get cured?, Why do you have an infection that can go on for more
24 than a year in a person who doesn't have a damaged immune system?
25 And that was my charge, to read the records and explain how

1 that can happen.

2 Q Are you being paid for your time here as an expert witness?

3 A Yes, sir.

4 Q And do you know how much you're being paid?

5 A I don't know the total amount. My office charges \$525 per
6 hour for my time regardless of whether I'm teaching or doing
7 consulting.

8 Q And you had to take time away from your practice to join us
9 here this week?

10 A Yes, sir.

11 Q Does the fact that you're being compensated for your time to
12 look at this case, is that going to influence your opinions in
13 any direction?

14 A No. My opinions are more as a teacher, just to explain what
15 happened. It's not really opinions about anything other than the
16 pathophysiology of infectious diseases.

17 Q Have you had the opportunity to work as an expert witness
18 before?

19 A I have.

20 Q Have you been accepted as an expert in the other courts that
21 you've worked at as well?

22 A Yes, sir.

23 Q And do you routinely testify in medical malpractice cases on
24 behalf of both patients like Ms. Turisk and in cases involving
25 physicians like Dr. Schimpf?

1 A Yes, sir, I do. Almost always, my opinions are not
2 controversial; it's more as an educator. And I have done that
3 many times over the past 20 years.

4 Q As part of your review, have you reviewed Ms. Turisk's
5 medical records in this case?

6 A Yes, sir.

7 Q Have you reviewed photographs and deposition testimony as
8 well?

9 A I have.

10 Q Based on your review of those materials, have you come to
11 form any opinions as it relates to your role as an infectious
12 disease physician?

13 A Yes, sir.

14 Q Can you tell the jury what those opinions are.

15 A Well, I think I -- my role is to understand and explain what
16 the heck happened; why an infection, that occurs after surgery,
17 goes on and on and on; and explain the culture results; and, most
18 importantly, to be able to explain the differences between a
19 positive culture and infection.

20 As simply stated, if I cultured everybody's throat in here,
21 we would identify many, many bacteria, some of which could be
22 life-threatening, but no one in here is infected. So
23 understanding the difference of a positive culture and the
24 presence of an infection is what I am here to explain today.

25 Q And do you also have some opinions as it relates to the

1 process of fat necrosis?

2 A Yes, sir.

3 Q Can you tell us what those opinions are, just broadly.

4 A Broadly, an infection occurs after surgery and leads to a
5 scar, and it's healed. But, if that infection, or if the
6 postoperative complication, involves inadequate blood flow or
7 blood return from fatty tissue, it's completely different.
8 There's actually nothing in the body like it.

9 Fat cells, when they die, release fat, or this oil, and this
10 oil is metabolized into a very caustic alcohol that can damage
11 surrounding tissue. So even in the absence of infection, dying
12 fat cells represent a tremendous problem, and then they may or
13 may not get secondarily infected.

14 So it has come into the realm of my field of, How do you
15 deal with a person in whom fat cells have died and are releasing
16 this caustic, or very damaging, oils into the surrounding tissue?

17 Q Would an illustration help you explain the fat necrosis
18 process?

19 A I think so, sir. Yes.

20 ATTORNEY SMYTH: Permission to have the witness get down out
21 of the stand?

22 THE COURT: Yes, sir.

23 ATTORNEY SMYTH: And where would you like me to put this?

24 THE COURT: If you can use that same spot. That way we can
25 all see.

1 ATTORNEY SMYTH: Sure. I'll try to hold it up so there's no
2 glare. If you can come around, Doctor.

3 THE COURT: Mr. Smyth, can you --

4 ATTORNEY SMYTH: Sorry.

5 THE COURT: There you go.

6 ATTORNEY SMYTH: Is that better? I'll be a good banner [ph]
7 one day, I promise.

8 BY ATTORNEY SMYTH:

9 Q Dr. Joseph, can you tell us what we have depicted in this
10 demonstrative graphic here.

11 A This is a cartoon, or a sketch, or a graphic, that is often
12 in medical books. This is a breast. The neck is up here, this
13 is the breast tissue, and it's cut right down the middle. This
14 is a sketch of what the breast looks like.

15 And in the breast, it has a tremendous amount of fat
16 compared to other tissues, certainly compared to the arm or even
17 the thigh. The abdomen may parallel to the amount of fatty
18 tissue.

19 What this is showing -- this is not intended to be what
20 happened to Ms. Turisk exactly. This is a sketch showing fat
21 necrosis. In fact, the nipple is down in this area down here.

22 Fat necrosis means that the fatty tissue -- these things are
23 fatty tissue, the yellow stuff -- means that it dies, and that's
24 what this area is right here. So that is dying, or dead, fat
25 cells. And when they die, what's inside these fat cells is

1 released into the surrounding tissue. It's oil. It's very, very
2 caustic. And it happens all the time. It happens after tummy
3 tucks and face lifts and fat transfers. And if it's small, then
4 it presents itself as a lump and goes away. But depending upon
5 an individual's genetics -- and we're all different -- if it's
6 large, then it creates an ongoing problem.

7 So this is large. This is a large amount of fat necrosis.
8 This tells us that there's just a whole lot of oil just oozing
9 out into the tissue. And these tissues don't want to be exposed
10 to this oil. This oil is caustic. It's a combination of an
11 alcohol, a soap, and an acid, and it spreads out and causes more
12 tissue damage, and it affects blood flow, all kinds, arteries and
13 veins. It will cause them to close down. So many, many blood
14 vessels, if they're exposed to a chemical on the outside, will
15 just shut down, and it can happen to both arteries and veins.

16 And when that does, the skin overlying the fat necrosis can
17 die. And that's a problem. Those are the patients that I see.
18 I don't see the ones where postoperatively you can feel a lump,
19 and it goes away. I see the ones that are much more severe where
20 the skin dies.

21 Now, the most important defense that all of us have for
22 infection is our skin. It's surprising. Bacteria and viruses
23 and parasites and fungi, you can just pour them on the skin and
24 nothing will happen. But when there's damage to the skin, that
25 barrier is lost.

1 So typical of fat necrosis is it starts off with necrotic,
2 which means dead, tissue. If it affects the skin, then the
3 barrier to bacteria is lost and bacteria invade.

4 So always fat necrosis, following breast surgery, is not an
5 infection that occurs at the time of surgery but one that occurs
6 during the postoperative period because the skin dies.

7 And when skin dies, it gets a black scab, or a black scar,
8 and then bacteria go in around it, and that's when the problems
9 start. The bacteria go through the skin, they get in this area,
10 and that's when an infectious disease person is typically called.

11 The cultures will always be positive, always, but that
12 doesn't mean it's an infection. So the specialty of infectious
13 diseases, my specialty, is making a clinical judgment, Are the
14 positive cultures just present, or are the positive cultures
15 representing ongoing damage such that antibiotics are necessary?

16 And it's always a judgment call; short-term antibiotics,
17 longterm. Antibiotics don't cure anything. Antibiotics, for a
18 person like Ms. Turisk, keeps the bugs that are in this area from
19 spreading to brain, spreading to the bones, spreading to the
20 heart, so antibiotics are to prevent someone like Ms. Turisk from
21 getting seriously infected. But it can't cure dead tissue.

22 And as you probably heard, in my review of the medical
23 records, this was never cured. You can't cure something that
24 doesn't have a blood flow, and the only way this was cured was by
25 surgery, by removing it.

1 So although she always had positive cultures, her record is
2 replete with people in my specialty saying the cultures are
3 positive, today it's not an infection; the cultures are positive,
4 but now it looks like an infection, and so they start antibiotics
5 for a limited period of time.

6 And so when I was asked to look at this and try to explain
7 How could this happen?, it happens because drugs or antibiotics
8 don't go where the blood doesn't flow. And that's exactly what
9 happens to fat necrosis after breast surgery.

10 Q Thank you, Doctor. I think you described how this is an
11 immensely complicated process.

12 A It's complicated, and it's devastating.

13 Q Does it take time to treat?

14 A You know, six months to a year is common, and depending on
15 the location and depending upon an individual's genetic
16 background, it may never go away. It may require surgical
17 incision, more surgery.

18 And I always empathize with patients who have this, because
19 it consumes their life. This is something that you have to deal
20 with for months and months and yet, sadly, in the 21st Century,
21 we don't have a cure.

22 Q You've made reference, I think, in some of the testimony you
23 just gave about something called a secondary infection. In your
24 field of medicine, is there a difference between something that's
25 primary and secondary with infections?

1 A Well, there is. The reason it's important to understand
2 primary versus secondary is for prevention. So a primary
3 infection is an infection that occurs at the time of surgery.
4 And we work very, very hard on trying to prevent those from
5 occurring. The reason we have sterile operating rooms and wear
6 sterile gloves and gowns and give antibiotic before surgery, that
7 is to prevent an infection that might occur during surgery.

8 A secondary infection is one that occurs after surgery and
9 almost always because there's something done to hurt the skin
10 overlying the operative procedure. And you can see it anywhere
11 in the body. A gallbladder surgery could be an infection that
12 occurs at the time of the gallbladder surgery, or it could occur
13 because the incision breaks down, and then it's a secondary
14 infection.

15 Fat necrosis is always a secondary infection, one that
16 occurs after the surgical procedure.

17 Q And do you believe that to be the case in Ms. Turisk's
18 situation?

19 A Absolutely.

20 Q So if I'm understanding correctly, she would have had the
21 fat necrosis first, and then the infection developed later?

22 A Right. The fat necrosis is invisible, it's under the skin,
23 and all you can feel after surgery is a lump or something that's
24 painful. But when it causes skin damage, then it creates the
25 secondary infection, and that's something visible by examination.

1 Q If it was suggested in this courtroom that Ms. Turisk should
2 have gotten some topical antibiotics on the incision in the
3 postoperative period, do you have an opinion as to whether that
4 would have made any difference in her outcome?

5 A I do. Topical antibiotics are -- they're minor. They don't
6 prevent anything. I won't say that we all don't use them because
7 we all do, but the reality is they don't treat anything at all,
8 they just keep surface bacteria at a lower level. Rarely will I,
9 in my practice, ever use a topical antibiotic.

10 In fact, many of them are quite caustic, and some of them
11 can actually cause slowing down on wound healing because they're
12 very acidic. Most people in my field don't use topical
13 antibiotics. They have a very minor role, if any.

14 Q Did you have a chance to look at the records in Ms. Turisk's
15 case about the antibiotics that she was given and the blood
16 cultures, or wound cultures, that were taken?

17 A Yes. Yes.

18 Q And what did your review of that information reveal?

19 A From my review of the records, the findings were typical.
20 You could always get a positive culture. In fact, if you fall
21 down and scrape your knee, you can get a positive culture, but
22 that doesn't mean an infection. But if you fall down and scrape
23 your knee and then there starts to get redness going up your
24 thigh or down your calf, that's an infection.

25 So whether there is an infection or not is a clinical

1 judgment, it's a physical diagnosis, it's a conclusion. The
2 culture just tells you what's causing it, but a culture never
3 makes the diagnosis of an infection. It's the other way around.

4 A doctor makes the diagnosis, or a nurse makes the diagnosis
5 of an infection. Then the culture tells you what antibiotics to
6 pick.

7 Q And to that point, in your review of the records, do you
8 have an opinion as to whether Ms. Turisk was treated
9 appropriately with the correct antibiotics when the culture
10 returned?

11 A Oh, she was, and she was very typical. I didn't see her, so
12 I have to rely on the medical records, but she was seen by a
13 board-certified infectious disease physician who, every day, made
14 a decision, I will start antibiotics today, because you don't
15 want to give a drug that no one needs. Then you create risk for
16 problems.

17 I thought all of the antibiotics that she got was evidenced
18 by the fact that she did not get a very, very severe
19 life-threatening infection.

20 Q Have we covered all the opinions that you would inform the
21 jury about with regard to your review of the case?

22 A I think so. My role here was just to be a teacher.

23 Q All right. The opinions that you've expressed here today,
24 do you hold those to a reasonable degree of medical certainty as
25 a board-certified infectious disease specialist?

1 A Yes, sir.

2 Q I believe those are all the questions that I have, Doctor.
3 Please answer any questions opposing counsel may have.

4 A Thank you.

5 THE COURT: Cross-examination?

6 ATTORNEY BURKE: I have some brief questions, but I need one
7 moment.

8 THE COURT: Yes, ma'am.

9 ATTORNEY BURKE: Your Honor, I'll get started while I wait
10 on that record.

11 **CROSS-EXAMINATION**

12 BY ATTORNEY BURKE:

13 Q Good afternoon, Dr. Joseph.

14 A Good afternoon.

15 Q Welcome to South Carolina.

16 A Thank you. It's beautiful.

17 Q Is this your first visit?

18 A I think I was here once 20 or 25 years ago. It's an
19 absolutely beautiful city.

20 Q Thank you. You've been working since the 1980s as an expert
21 witness, correct?

22 A Yes.

23 Q And how many depositions do you give a year?

24 A Prior to COVID, about six.

25 Q How many depositions do you think you've given over the

1 course of your career as an expert witness?

2 A 150 to 200.

3 Q And how many trials do you think you participated in for the
4 last 10 or 15 years?

5 A Well, it was about two per year prior to COVID, and I think
6 it stayed that way for at least 10 years prior.

7 Q Would it be fair to say that the majority of your expert
8 witness work is on behalf of the defense rather than the
9 plaintiff?

10 A Yes. I think about two-thirds of the time I'm hired by the
11 defense to explain complicated infectious disease.

12 Q And just so we're clear today, you're not here giving any
13 opinions about the standard of care, correct?

14 A Correct. No opinions.

15 Q And you're not here to testify as to whether or not there
16 was any breach?

17 A That is correct.

18 Q And it would be outside of your area of expertise to give
19 opinions about what caused the insufficient blood flow in
20 Ms. Turisk; is that correct?

21 A That is correct.

22 Q Do you have any criticisms of anything that Ms. Turisk did
23 in her postoperative care?

24 A Oh, of course not.

25 Q Do you have any criticisms of anything Ms. Turisk's

1 caregivers, the laypeople in her life who took care of her, do
2 you have any criticisms of them?

3 A I do not.

4 ATTORNEY BURKE: The Court's indulgence. I'm very sorry.

5 THE COURT: That's fine.

6 BY ATTORNEY BURKE:

7 Q Dr. Lefkowitz [sic], do you recall preparing a list of
8 materials that you reviewed for your deposition back in September
9 of 2019?

10 A Yes, I recall providing that to you. Yes.

11 Q Okay. And do you remember reviewing -- well, have you
12 looked at her records lately?

13 A No, ma'am.

14 Q Okay. All right. Do you recall reviewing the Summerville
15 Medical Center record?

16 A Well, I don't recall that, but I'm sure that whatever's on
17 the list would have been what was provided to me to review.

18 Q And so do you recall reviewing a discharge summary
19 from February 5th of 2017?

20 A I do not recall that.

21 Q Did you recall that Rebecca was diagnosed with severe sepsis
22 in September of 2017?

23 A I don't recall that. No.

24 Q I'd like to introduce the record, if I could ever get it.

25 Did you prepare a chronology --

1 A Yes.

2 Q -- to prepare for your deposition?

3 A Yes, ma'am.

4 ATTORNEY BURKE: Your Honor, may I approach the witness?

5 THE COURT: Yes, ma'am.

6 BY ATTORNEY BURKE:

7 Q Is this the chronology that you prepared?

8 A It is. I dictated that.

9 Q All right. And would you look at page 27 of your
10 chronology.

11 A Yes.

12 Q And if you look at your chronology, do you see where the
13 plaintiff, Rebecca Turisk, was diagnosed with severe infection --
14 I'm sorry, severe sepsis in February of 2017?

15 A I do.

16 Q All right.

17 ATTORNEY BURKE: No further questions, Your Honor.

18 THE COURT: All right. Thank you, ma'am.

19 ATTORNEY BURKE: Thank you.

20 THE COURT: Any redirect?

21 ATTORNEY SMYTH: No, Your Honor.

22 THE COURT: You may step down, Dr. Joseph. Thank you.

23 THE WITNESS: Thank you.

24 THE COURT: You may call your next witness.

25 ATTORNEY SMYTH: Your Honor, defense calls Dr. Todd

1 Lefkowitz to the stand.

2 TODD LEFKOWITZ,

3 having first been duly sworn, was examined and testified as
4 follows:

5 CLERK OF COURT: Sir, you may have a seat. Please state
6 your name for the record, and spell your last name.

7 A Sure. Todd Lefkowitz, L-e-f as in Frank-k-o-w-i-t-z.

8 THE COURT: Your witness.

9 ATTORNEY SMYTH: Thank you, Your Honor.

10 **DIRECT EXAMINATION**

11 (on voir dire)

12 BY ATTORNEY SMYTH:

13 Q Good afternoon, Doctor.

14 A Good afternoon.

15 Q If you would, please introduce yourself to the jury, and
16 tell them a little bit about yourself.

17 A Sure. Todd Lefkowitz from Columbia, South Carolina. I'm a
18 board-certified plastic surgeon up the road off I-26 in Columbia,
19 South Carolina, and here to discuss the case of Dr. Schimpf
20 versus Turisk.

21 Q Let's talk a little bit about your educational background.
22 Can you tell the jury where you went to college, and then your
23 training behind that.

24 A Sure. So I got an undergraduate degree from Tulane
25 University in New Orleans. Then came back here to Charleston, to

1 MUSC, about 2004, long time ago. Lots of changes. Then I did
2 most of my training in general surgery in New York City. After
3 New York City, I went to Louisville, Kentucky, for my plastic
4 surgery training. And then I was very fortunate enough to get a
5 cosmetic fellowship off of that back in New York City for a year
6 of training.

7 Following that, I started the surgeons line of plastic
8 surgery in Lexington Medical Center in Columbia, South Carolina,
9 and just recently have transitioned into private practice.

10 Q When you said that you completed a fellowship in plastic
11 surgery, tell us a little bit about what that is and how it's
12 different from your regular training.

13 A Sure. So during your general surgery, or during your
14 general surgery training, some people decide to do some extra
15 training on top of that. I decided to do plastic surgery. So
16 off of general surgery, I did two years of plastic surgery in
17 Louisville, Kentucky, and then did an optional third year of
18 strictly aesthetic plastic surgery back in New York City, to give
19 me a total of three years of plastic surgery specific training.

20 Q And when you say aesthetic surgery, what does that include?

21 A It includes really any kind of aesthetic surgery of the
22 face, breast and body, for which is what composes the large
23 majority of my practice these days.

24 Q Are you licensed to practice medicine here in South
25 Carolina?

1 A I am.

2 Q How long have you been licensed?

3 A 2012, before I come back.

4 Q And are you licensed in other states as well?

5 A Kentucky. I kept my Kentucky license.

6 Q We've heard discussion about board certification. I think
7 you referenced that during your introduction. Tell the jury a
8 little bit about that process.

9 A Sure. So board certification just simply means it's a
10 standardized approach and way for the United States to determine
11 whether or not somebody has the sufficient training and knowledge
12 base to practice in that particular field. Every field has board
13 certification, and ours is very particular to the American Board
14 of Plastic Surgery, for which I was admitted in 2013.

15 Q And have you remained board-certified since that time?

16 A I have. Yes, sir.

17 Q Are you a member of any professional organizations?

18 A Yes, sir. The American Society of Plastic Surgeons, which
19 is our largest overarching society; the Aesthetic Society, which
20 is also another national organization; and a fellow for American
21 College of Surgeons, the ACS, as well.

22 Q Are you board-certified in general surgery as well?

23 A Technically I am, but I do not perform any general surgery
24 to date.

25 Q And do you have hospital privileges?

1 A Yes, sir.

2 Q Where do you have those?

3 A At Prisma Health System in Columbia, as well as Lexington
4 Medical Center in Columbia.

5 Q Are you familiar with the surgery that Ms. Turisk had in
6 this case?

7 A I am.

8 Q Tell the jury a little bit about your experience with that
9 particular surgery, or breast surgery, in general.

10 A Sure. So I do approximately 100 to 150 breast surgeries a
11 year, of which I probably do about 8 to 10 of this very specific
12 type of surgery per year.

13 Q And has that been a pretty repeatable average for you?

14 A Yes, sir. Yes, sir.

15 Q Have you done any teaching of other doctors or training of
16 other physicians?

17 A I have, but not particularly in breast surgery.

18 Q And have you participated in any research of any
19 publications or anything like that in the field?

20 A I have, but not in breast surgery.

21 Q In terms of your private-practice experience, you talked a
22 little bit about breast surgery. Are you familiar with the
23 techniques that are available to a plastic surgeon that are
24 medically accepted in performing a breast-reduction surgery like
25 Ms. Turisk had?

1 A Yes, sir, I am.

2 Q In your private practice -- is that something you perform,
3 both in your private practice, as well when you're in the
4 hospital, or a clinic, setting?

5 A Yes, sir. Yes, sir.

6 Q So would that include things like implant removal and breast
7 lifts as well?

8 A That is correct. Yes.

9 Q Are you knowledgeable and familiar about what the standard
10 of care requires of a plastic surgeon who undertake these
11 procedures?

12 A Yes, sir.

13 Q Are you knowledgeable and experienced about the risks
14 associated with those procedures?

15 A Yes, sir.

16 Q Are you knowledgeable and experienced about the potential
17 complications that can occur?

18 A Yes, sir.

19 Q And are you knowledgeable and experienced in the
20 postoperative care of patients who have undergone this surgery?

21 A Yes, sir.

22 Q Based on your training and experience in the field of
23 plastic surgery, do you believe you have the requisite knowledge
24 to help the jury understand some of those issues?

25 A I believe I do.

1 ATTORNEY SMYTH: At this time, Your Honor, we would offer
2 Dr. Lefkowitz as an expert in plastic surgery.

3 ATTORNEY TANENBAUM: No objection, Your Honor.

4 THE COURT: He is qualified.

5 ATTORNEY SMYTH: Thank you.

6 **DIRECT EXAMINATION**

7 BY ATTORNEY SMYTH:

8 Q Have I hired you to take a look at this case, Dr. Lefkowitz?

9 A Yes, sir, you have.

10 Q Are you being paid for your time here today?

11 A I am.

12 Q And how much are you being paid?

13 A So it's \$375 per hour to review medical records, and then
14 \$550 per hour for conferences and time away from my practice
15 itself.

16 Q And so I understand you've got a newborn as well?

17 A I do. Yes, sir.

18 Q So you're being paid to be away from home today to spend
19 time with us?

20 A Not enough, but -- no, I'm just kidding.

21 Q Fair enough.

22 A I'm being paid. Sure.

23 Q We're all overworked and underpaid. We get that. Does the
24 fact that you're being paid for your time here today, is that
25 going to influence the opinions you're going to give to the jury?

1 A No, sir. In fact, when I do do this type of work, the first
2 thing I do is get asked to review a case, and then I have to form
3 my own opinion before I decide whether or not I will take the
4 case on.

5 Q Do you believe you're able to give this jury fair and
6 objective opinion evidence about your review of the records and
7 the care that was rendered?

8 A Yes, sir.

9 Q Have you testified before at trial?

10 A One other time.

11 Q Was that a case about breast surgery as well?

12 A It was. Yes, sir.

13 Q And as part of your review in this case -- tell the jury
14 what you reviewed in this case.

15 A So, all the medical records that were provided to me, along
16 with pictures and illustrations.

17 Q Have you reviewed any deposition testimony?

18 A I have, as well, yes.

19 Q Do you remember which depositions you read? Was that all
20 the witnesses?

21 A I believe all the witnesses that were provided to me. Yes,
22 sir.

23 Q So let's talk about your review of those items. Did you
24 review Dr. Schimpf's notes where he first met and had an
25 encounter with Ms. Turisk about the surgical procedure?

1 A Yes, sir.

2 Q What was your opinion in terms of whether Dr. Schimpf met
3 the standard of care during his initial consultation with the
4 patient?

5 A I believe he met the standard of care and they had a very
6 typical consultation in which all parts of the surgery were
7 discussed, including the risks, the benefits, as well as the
8 aftercare.

9 Q What was your understanding of what the goals of the surgery
10 Ms. Turisk was requesting were?

11 A To hopefully and significantly change and improve some of
12 her issues that she was having, specifically with regards to the
13 larger breasts that she presented with.

14 Q And what types of symptoms do those larger breasts cause, in
15 your experience?

16 A Typically you can have upper back pain, some neck pain, even
17 a mid to lower back pain, which is not always associated but can
18 certainly be improved as well.

19 Q Do you have an opinion as to whether Ms. Turisk was an
20 appropriate candidate to have this kind of procedure?

21 A I believe she was. Yes.

22 Q And I believe she also wanted to have some implants removed.

23 A Yes, sir.

24 Q And is that something that you perform as part of your
25 practice as well?

1 A Yes, sir.

2 Q Do you believe she was an appropriate candidate to have that
3 done?

4 A Absolutely. Yes, sir.

5 Q Given the goals that we talked about with the surgery, what
6 are the different options that you, as a plastic surgeon, can
7 recommend to a patient who is looking to achieve those goals?

8 A From a surgical standpoint, certainly the surgery that she
9 had by Dr. Schimpf, from my perspective, was a very good option
10 because you're taking the implants out, which themselves, people
11 really don't realize they carry a certain weight themselves which
12 can actually cause some of those symptoms.

13 For instance, in a patient that we do breast augmentation,
14 when we put implants in and that's all we do, it is not
15 completely atypical for them to come back later and say they're
16 starting to have neck and back pain just from the implants that
17 we're putting in.

18 So for somebody presenting with very real health symptoms,
19 taking those implants out, along with reducing the size of the
20 breasts and lifting the breasts, which also changes the
21 trajectory of the breasts and it helps with those symptoms, I
22 felt was a very reasonable way to go.

23 Q And the implants were 400 grams each?

24 A I don't remember off the top of my head, but I believe it
25 was in that range. Yes.

1 Q If you assume for me that they were, is that a sizable
2 implant?

3 A Yes, sir. It certainly can augment those symptoms that she
4 was having.

5 Q And did you review Dr. Schimpf's findings and measurements
6 that he performed in the preoperative visit in terms of the
7 nipple-to-clavicle measurements, those types of things?

8 A I did. Yes, sir.

9 Q And based on those measurements was she an appropriate
10 candidate for the surgery as well?

11 A She was. Yes.

12 Q And in terms of the surgical options that you talked about,
13 if you just were to remove the implant, what type of condition
14 would that leave the breast in?

15 A I think it might slightly improve her, but my guess would be
16 that the reduction of breast tissue, along with the lifting, was
17 going to produce the most beneficial parts of that surgery.

18 Q There was a finding in the record of ptosis. Can you
19 explain what that is?

20 A Yes, sir. So ptosis is simply a description of where the
21 nipple-areolar complex falls on the breast. Typically they go
22 three main grades; Grade 1, Grade 2, Grade 3. Grade 1 is where
23 the nipple is positioned appropriately on the breast, at more of
24 a youthful position; Grade 2, where it's a little bit lower; and
25 Grade 3 is at its maximal lowest point, meaning that most

1 patients that we describe as Grade 3 ptosis, we consider the most
2 Grade 3.

3 Q And what was Ms. Turisk?

4 A I believe she was a Grade 3.

5 Q And you mentioned that you reviewed the chart. Did you
6 review the informed consent form that Dr. Schimpf used to
7 document that they had had a discussion about the risks of the
8 surgery?

9 A Yes, sir, I did.

10 Q Do you have an opinion as to whether that form meets the
11 standard of care?

12 A It is my opinion it certainly met the standard of care.

13 Q And what types of things do you tell your patients who are
14 considering this type of surgery in terms of the risks or
15 complications of the procedure?

16 A Sure. So typically if anybody comes into my office, I say
17 the exact following: That there's always risks of bleeding;
18 infection; poor scarring; loss of the nipple-areolar complex;
19 what I call both partial and complete; the need for further, more
20 complex surgery; a sensation alteration in the operative site in
21 and around the operative site; inability to breastfeed; and the
22 set complications, DVT/DD; and even very rarely, even death.

23 Q DVT and DD, those are blood clots?

24 A That's correct. Yes, sir.

25 Q They can be fatal?

1 A Yes, that's correct. Yes, sir.

2 Q And in your review of the records do you find that
3 Dr. Schimpf discussed those same risks with Ms. Turisk?

4 A I did, yes.

5 Q And did that meet the standard of care?

6 A Yes.

7 Q And did she sign the form?

8 A Yes, sir.

9 Q Did Ms. Turisk ultimately experience one of those
10 complications that was discussed on the form?

11 A She did.

12 Q In your experience, just because a patient does experience
13 one of those complications, does that mean the surgeon did
14 something wrong or something negligent to cause it?

15 A It does not. No.

16 Q Are you familiar with the term "known complication"?

17 A Yes.

18 Q Can you explain to the jury what that is.

19 A Known complication, essentially what that means is that
20 these are complications that may occur even despite best efforts,
21 even despite best practices from both a surgical standpoint in
22 the planning, during the surgery, and after the surgery.

23 Q And do you believe that Ms. Turisk suffered one of those
24 known complications in this case?

25 A I do.

1 Q Do you believe that was a result of any negligence by
2 Dr. Schimpf or anyone from his practice?

3 A I do not.

4 Q Did you have a chance to review Dr. Schimpf's operative note
5 during the procedure?

6 A Yes, sir.

7 Q Tell the jury what your opinions are with regards to what's
8 described in his operative note.

9 A Sure. A couple things that, when I initially reviewed the
10 case before I even decided whether or not I would accept it as an
11 expert witness, a couple of things that, as a surgeon, you're
12 starting to think about are from a planning standpoint, from a
13 risk standpoint, and how you start to think about how you're
14 going to execute the operation and do it in a way that's as safe
15 as possible for the patient but also give them the results that
16 they're looking for.

17 And a couple things with regards -- and I know that the
18 sticking point in this case is blood flow -- a couple maneuvers
19 that he planned for and executed in the operating room told me
20 that he was not only thinking about that from the git-go, meaning
21 that he was already thinking about it before he was in the
22 operating room, but he executed that plan as he was thinking
23 about it as well.

24 Q And specifically what were those things that led you to
25 believe Dr. Schimpf was thinking about blood flow before surgery?

1 A So in my training we talk about the base, or the width, of
2 that pedicle that the nipple-areolar complex sits on. In my
3 training, we typically used a 6 to 8 centimeter width. That was
4 historically always taught to me that that was going to be
5 adequate blood flow to get to the nipple-areolar complex.

6 And one of the first things that stood out in the operative
7 report was the fact that Dr. Schimpf actually used a much larger
8 pedicle in order to capture even more blood flow to get to the
9 nipple-areolar complex and out of the nipple-areolar complex.

10 Q And we talked a little bit about pedicle. Which technique
11 did Dr. Schimpf use when he was performing the surgery?

12 A He used something called an inferior pedicle technique.

13 THE COURT REPORTER: I'm sorry. Can you repeat that,
14 please.

15 THE WITNESS: Sure. Inferior pedicle technique.

16 THE COURT REPORTER: Thank you.

17 BY ATTORNEY SMYTH:

18 Q So are you familiar with the inferior pedicle technique?

19 A I am. Yes sir.

20 Q Tell the jury a little bit about what your understanding of
21 that technique is.

22 A So the inferior pedicle technique is what I believe is the
23 oldest technique utilized for this operation, which has been
24 around for about 50 to 60 years now. The inferior pedicle
25 technique is where you use the bottom part of the breast tissue,

1 the parenchyma, as we call it, to where the nipple-areolar
2 complex is attached, and we use that in order to get blood flow
3 to and away from the nipple-areolar complex. And then what you
4 do is you actually formulate the breast around that pedicle.

5 It's a pedicle that I think that American Society of Plastic
6 Surgeons actually, in the last couple of years, have -- what they
7 do is they asked all of the board-certified plastic surgeons
8 across the country what pedicle they tend to use, and I think it
9 was well over 50 percent used that particular pedicle. So it's a
10 widely accepted and widely known and used technique.

11 Q You mentioned the American Society of Plastic Surgeons. Did
12 you provide us with a video that you think kind of displays some
13 of those techniques? Would that be helpful for you to
14 illustrate?

15 A I think from an educational standpoint it might help,
16 because we're thinking about it in three dimensions, and I think
17 it can be very helpful to use.

18 ATTORNEY TANENBAUM: Without objection.

19 THE COURT: Thank you, sir.

20 ATTORNEY SMYTH: So we brought a couple --

21 (Counsel confer off the record.)

22 BY ATTORNEY SMYTH:

23 Q So I think we figured out the easiest way to present those
24 to the jury is to perhaps to take some screenshots from the video
25 itself. Is that what you see on the screen?

1 A Yes, sir. That's correct.

2 Q Can you describe for us what you see? And if it's easier,
3 if you want to turn around and point on that monitor, that might
4 be easier. I don't know.

5 A Well, I was going to say, if anybody has a pointer, I can
6 certainly use that. Otherwise, I can just kind of describe it.
7 That's fine.

8 Q This doesn't show up on the screen.

9 A That's okay. I can describe it. It's not a problem. So if
10 you look at the blue line, that blue outline is essentially what
11 we call the outer cuts. The top of that blue line is where the
12 new position of the nipple-areolar complex is going to go.

13 So then the question becomes, How do we get the
14 nipple-areolar complex up to that new position? You can see it
15 looks like a red line but really what it is is a scored cut by a
16 knife around the nipple-areolar complex, and then around that
17 follows down to the bottom of the breast, okay.

18 And if you go to the next slide, what you can see now, this
19 is with the skin removed. Okay. And that yellow is the breast
20 tissue, the parenchyma, that has all the blood flow that goes in
21 and out that attaches to the nipple-areolar complex.

22 If you can go to the next slide, please. What you're seeing
23 here is all of the extra tissue that gets taken away through the
24 breast to help what we call "unload" the breast. So when we take
25 off that extra tissue, we're using an inferior pedicle technique,

1 it's the top part of the tissue that goes all the way around that
2 we take off.

3 Before we go any further, what I'd like to note is what we
4 had talked about a little bit earlier with the base width of the
5 tissue. If you look the at bottom there of the breast, that
6 width, as I said, in my training, we were always taught 6 to
7 8 centimeters was adequate for blood flow. What Dr. Schimpf did
8 was he used a much larger and wider width in order to capture
9 more blood flow to get in and out without compromising the amount
10 of tissue that he could take out from the topside.

11 Next slide, please. And what you can see now is this is
12 that pedicle that's still there. That's that pedicle that I
13 think has probably been discussed quite a bit during this trial.
14 And what's happening is now we can see that empty space where
15 that tissue, that extra tissue, was removed.

16 Next slide, please. So these arrows, what we're doing now
17 is we're redistributing the breast skin and the breast tissue
18 that's still there. It's going to come together to cover those
19 areas and to cover the pedicle, keeping in mind that that tissue,
20 where that space was was that extra tissue that was removed.

21 Next slide, please. And this is your final, what we call,
22 scar pattern. This is called an inverted-T, anchor pattern, Wise
23 pattern, all different names for the same scar pattern. And you
24 can kind of see why it's called an anchor pattern. You can see
25 the final scar is around the nipple-areolar complex, down

1 vertically, and in that crease called the inframammary fold.

2 Q And is this the technique that you understand that
3 Dr. Schimpf used to perform the surgery on Ms. Turisk?

4 A Yes, sir.

5 Q And do you believe it is a medically accepted technique
6 within the field of plastic surgery in light of Ms. Turisk's
7 clinical presentation?

8 A Yes, sir, I do.

9 Q Plaintiff's expert, as prior read, Dr. Hultman's deposition,
10 do you understand he was critical of the choice of that
11 technique?

12 A I do.

13 Q And what is your understanding of his criticism?

14 A My understanding of his criticism was the fact that she had
15 a small scar at the bottom of the nipple-areolar complex; that
16 that scar prevented enough blood flow, in his mind, to get in to
17 supply blood flow to the nipple-areolar complex.

18 Q Do you have an opinion on that issue?

19 A My opinion is that that scar is not, in any way, an issue
20 for him to choose an inferior pedicle technique.

21 Q So if it was suggested that having that 4 centimeter scar
22 from the prior breast implants was a contraindication to doing
23 this procedure, would you agree or disagree with that?

24 A I would disagree with that.

25 Q And what is the basis for your opinion in terms of why you

1 believe that was not a problem with proceeding with the inferior
2 pedicle approach?

3 A For a couple of reasons. Number one is, based on how
4 Dr. Schimpf designed his original pedicle there was plenty of
5 room -- even if you want to take the worst-case assumption -- and
6 I'll tell you why I disagree with this in a second. If you took
7 the worst-case assumption and said that not a drop of blood got
8 through the scar, even if you took that worst-case assumption, he
9 still designed a pedicle of tissue that allowed plenty of blood
10 flow, just as we had talked about, the 6 to 8 centimeters versus
11 the amount that he chose, that will give enough blood flow to get
12 in and around that scar to get to the nipple-areolar complex.
13 That's in the absolute worst-case scenario.

14 Where I will go a bit further, though, is that I actually
15 believe that blood flow does get through the scar. In fact, we
16 had multiple examples in plastic surgery. In fact, our field of
17 plastic surgery is based, in large part, that blood flow has to
18 get through scar. And so not only that, I don't believe that
19 scar was any type of contraindication to the pedicle that he
20 chose, specifically for those reasons.

21 Q You said that you have a lot of examples in your field of
22 when blood maybe goes through or around the scar.

23 A Yes.

24 Q Give us an example of what you're talking about there.

25 A There are many. One that I will give you is a surgery that

1 we perform quite often for women that have breast cancer. They
2 have breast cancer and they have that droop, so they have that
3 ptosis. What we have been doing is we want to try to do what we
4 call a nipple-sparing-technique surgery, try to save the original
5 native nipple-areolar complex.

6 So what we do is, I will go in and perform a breast lift,
7 kind of like a reduction, and then six to eight weeks later the
8 general surgeon will come behind me and remove every bit of that
9 breast tissue that is underneath that nipple-areolar complex. So
10 the only blood flow that is getting to that nipple-areolar
11 complex is blood flow from the skin itself that has to get
12 through an entire circumferential scar.

13 That is the most extreme way that I can think of how blood
14 flow can get through a scar. And that, to me, is at least one
15 example of many that we use in terms of assuming that blood flow
16 can get through -- can get through a scar.

17 Q And the surgery and the procedure and the approach that you
18 just talked about, is that within the standard of care in your
19 field?

20 A Well within, yes, sir. And I'm happy to give many other
21 examples as well.

22 Q Sure. Give us a few more just so we have a feeling of how
23 that works.

24 A Sure. So in facial reconstruction, so, for instance, after
25 skin cancer, oftentimes if the dermatologist takes enough tissue

1 off of the nose, we have to reconstruct the nose with using
2 tissue from somewhere else on the face. One example is called a
3 forehead flap where we actually have to take tissue from the
4 forehead, lift it up, we swing it down, it attaches to the nose.
5 For four weeks it's attached to the forehead and to the nose.
6 After four weeks, and only four weeks, we actually detach it from
7 its original blood flow of the forehead, and it survives solely
8 on the blood flow that it gets from the nose.

9 And so that's, again, yet another example of how, to me, it
10 gives you even more of an extreme example than what we're talking
11 about today.

12 Q And in that scenario, is the vascularity of the nose greater
13 or less than what you've got in the breast?

14 A It's much less.

15 Q So there's more chance of blood flow in the breast?

16 A Correct. That's correct.

17 Q Back to the operative note of Dr. Schimpf. Did you observe
18 anything in the surgery itself that would let you know
19 Dr. Schimpf was paying attention to whether he had adequate blood
20 flow during the surgery?

21 A Yes, sir. So first and foremost was in the design of his
22 surgery, of the width of the pedicle that he chose. In addition
23 to that, he went back and tested what we call capillary refill of
24 the nipple-areolar complex. And what that is is simply, it's a
25 way to determine whether or not blood flow was getting in or out

1 of the nipple-areolar complex. And we base that essentially on
2 the timing of what we see visually in the operating room or in
3 the office in deciding whether or not there's not enough blood
4 flow getting in or there's difficulty in blood flow getting out.
5 In his test, everything was exactly as you would hope it would
6 be.

7 Q There were multiple procedures done at this setting.

8 A Yes, sir.

9 Q Which procedures were done first?

10 A I believe the breast was done first, and then the tummy was
11 done second.

12 Q And was there any indication that Dr. Schimpf checked on the
13 status of the breast after completing the tummy portion of the
14 procedure?

15 A Yes. So that was something that I also thought about when I
16 read his operative report, is if you think of it from a timing
17 standpoint, is that he did the breast portion first, and then it
18 took, I think it was, a couple hours -- and I will defer to
19 Dr. Schimpf or to the operative report on exactly how long it
20 took for the belly, but it was certainly a significant amount of
21 time -- during that time you would expect to see some type of
22 changes on the nipple-areolar complex blood flow. When he went
23 back, he still saw it as normal.

24 Usually if we're only doing breast surgery, we don't have
25 that luxury of having that extra time to test it in the operating

1 rooming, so we're actually testing it right after that breast
2 portion of the surgery and we don't have the luxury of actually
3 getting to go back after two or three more hours.

4 Q It has been suggested in this case that Dr. Schimpf
5 performed a surgery that was doomed to fail. Do you have an
6 opinion about that issue?

7 A Yes. I don't believe that to be the case at all. I believe
8 he kept well within the standards of care, utilizing a very
9 well-accepted technique based on what we've discussed.

10 Q And is that borne out by the fact that there was adequate
11 blood flow at the time he closed the procedure?

12 A Yes, sir.

13 Q Did Ms. Turisk receive appropriate preoperative antibiotics
14 and skin preparation for the surgery, in your review of the
15 record?

16 A Yes, sir.

17 Q Did that comply with the standard of care?

18 A Yes, sir.

19 Q Did you find any evidence in your review of the medical
20 records that there was a complication experienced during the
21 procedure?

22 A Not that I could see. No.

23 Q Reading the operative note, did you have any concerns that
24 Ms. Turisk might develop a complication later?

25 A No, not in the operative note. No, sir.

1 Q Was there anything about the way the surgery was performed
2 that was inadequate or departed from generally accepted plastic
3 surgery principles?

4 A No, sir.

5 Q Did you find any evidence that Dr. Schimpf damaged any
6 arteries that would have cut off the blood flow to the
7 nipple-areolar complex?

8 A No, sir.

9 Q Have you had a chance to read the postoperative visits that
10 Ms. Turisk had with Dr. Schimpf's office?

11 A Yes, sir.

12 Q And you're aware that she did experience a complication in
13 this case?

14 A A very difficult complication, and I feel for her.

15 Q Based on your review of the notes from the postoperative
16 period, do you believe that Dr. Schimpf and the practice met the
17 standard of care in terms of the postoperative treatment that was
18 provided?

19 A Yes, sir.

20 Q Tell us a little bit about your thoughts on those issues.

21 A Yes, sir. I think first and foremost, when you look at your
22 responsibility as a surgeon you want to be accessible to a
23 patient that's having issues or having concerns, and I thought he
24 did all of the things that you would expect a reasonable and
25 responsible surgeon to do, and that is to be in communication

1 with your patient and even certainly offer to see that patient at
2 a time of his or her concerns.

3 Q You're aware that there were multiple telephone
4 conversations with Ms. Turisk and her caregivers in the
5 postoperative period?

6 A Yes, sir, I am.

7 Q Based on your review of that information, did you have any
8 concerns that Dr. Schimpf missed something or didn't respond
9 appropriately to any of the complaints that were given to him?

10 A No, sir.

11 Q Did you have any concerns that Dr. Schimpf may have missed
12 an infection in his postoperative care and treatment of
13 Ms. Turisk?

14 A Not from my review of the medical records. No, sir.

15 Q You were in the courtroom, I believe, when our infectious
16 disease expert, Dr. Joseph, just testified about his experience
17 with fat necrosis. What has been your experience with that
18 process?

19 A So my experience with fat necrosis is that I do feel that it
20 can happen, especially with breast-reduction surgery. It's known
21 to happen with breast-reduction surgery. I've had it in my own
22 practice. If you have fat necrosis, it does not necessarily mean
23 you will develop an infection, but it also means that you could
24 develop an infection. And so, in my experience, it's a known
25 risk, a known complication, that I try to prepare my patients for

1 if this comes up.

2 Q And do you believe that the treatment Dr. Schimpf and his
3 office provided to Ms. Turisk with regard to this complication of
4 fat necrosis was appropriate and met the standard of care?

5 A Yes, sir.

6 Q Was there anything that you saw that he should have done and
7 didn't do in order to be in compliance with the standard of care?

8 A No, sir.

9 Q You're aware that she ultimately developed an infection
10 about a month after surgery?

11 A I am. Yes.

12 Q And I believe she received antibiotics for that infection?

13 A I believe so. Yes, sir.

14 Q Do you have any criticisms of that, or do you believe that
15 care was appropriate as well?

16 A No. I believe it was appropriate.

17 Q Did you see the wound-care techniques that were being
18 utilized during the postoperative period by Dr. Schimpf and his
19 staff?

20 A Yes.

21 Q Do you have an opinion as to whether those meet the standard
22 of care?

23 A I felt they met the standard of care.

24 Q Are those some of the same things that you would do in this
25 situation?

1 A They are, in fact, almost exactly what I do. Yes.

2 Q It was suggested yesterday by the plaintiff's expert that a
3 topical antibiotic would have preserved breast tissue and stopped
4 an infection. Do you have an opinion on that based on your
5 experience in treating these wounds?

6 A I typically do not use topical antibacterial, but I would
7 defer to his lab expertise on that. But it's not used and is not
8 a part of my practice.

9 Q It's not the standard of care?

10 A Not that I am aware of. No, sir.

11 Q Do you believe that Dr. Schimpf and all of Ms. Turisk's
12 providers were doing their best to help her with a difficult
13 problem?

14 A Yes, sir.

15 Q Did you have any concerns that Dr. Schimpf was not willing
16 or capable of taking care of Ms. Turisk in the postoperative
17 period?

18 A No, sir.

19 Q In your experience as a private practice physician, when a
20 patient develops a complication is it standard for the physician
21 to continue to take care of that patient throughout the
22 complication?

23 A Yes.

24 Q And do you typically charge for those visits?

25 A Me, personally, I do not.

1 Q And do you have any reason to believe that Dr. Schimpf would
2 not have done the same thing for Ms. Turisk had she stayed in his
3 care?

4 A No, sir.

5 Q I'm going to show you what we'll mark as -- what was
6 previously marked as Defendant's Exhibit 4. First of all, do you
7 recognize that document?

8 A It looks like a progress note from an office visit.

9 Q Is that one of the documents that you reviewed in order to
10 formulate your opinions in this case?

11 A Yes.

12 Q Is it the type of medical record that you would typically
13 review in your practice?

14 A Yes, sir.

15 Q And who is the note done by?

16 A It looks like Dr. O here in Charleston.

17 Q Is he a plastic surgeon?

18 A Yes, sir.

19 Q And what's the date of the note?

20 A It is November 29th, 2016.

21 ATTORNEY SMYTH: And at this time, Your Honor, we would
22 offer Defendant's Exhibit 4 into evidence.

23 THE COURT: Any objection?

24 ATTORNEY TANENBAUM: No objection, Your Honor.

25 THE COURT: It's in.

1 (Defendant's Exhibit 4 is marked for identification.)

2 (Defendant's Exhibit 4 is received in the record.)

3 ATTORNEY SMYTH: Permission to publish?

4 THE COURT: Yes, sir.

5 BY ATTORNEY SMYTH:

6 Q Let's take a look at this note, Doctor. First of all,
7 what's the date of the note?

8 A 11/29/2016.

9 Q And so that's the day before Ms. Turisk's last visit with
10 Dr. Schimpf?

11 A Yes, sir.

12 Q You had a chance to review the note?

13 A Yes, sir.

14 Q What were Dr. O's impressions and findings?

15 A What I took away was really the recommendations in terms of
16 the fact that he seemed to believe that the patient and
17 Dr. Schimpf had a good relationship. He felt that Dr. Schimpf
18 can certainly continue to assess and evaluate the patient and
19 care for the patient in a way that was in the best interest of
20 the patient.

21 Q Under the physical examination there, the last sentence says
22 There's no evidence of active cellulitis or redness. What's the
23 significance of that finding?

24 A So to me, that tells me that there was no -- he did not find
25 anything on examination that was suggestive of an infection.

1 Q And then under the recommendations, I think we referred to
2 that. Could you read that last paragraph into the record? Let
3 me see if I can zoom in a little bit so we can all read it.

4 A Sure. Sure. I had a reasonable discussion with Rebecca and
5 her boyfriend and told them they seem to have --

6 THE COURT REPORTER: Sir? Doctor, slow down a little when
7 reading, please.

8 THE WITNESS: Sure. I'm from South Carolina. I don't get
9 that, usually. I had a reasonable discussion with Rebecca and
10 her boyfriend and told them that they seemed to have faith and
11 confidence in their doctor who performed an additional
12 liposuction and tummy-tuck procedure at the time of this breast
13 reduction and seemed to have a good relationship with them.

14 My recommendation is that they make an appointment to see
15 the doctor, who can assess what is going on in that right breast
16 to formulate the treatment plan so she can get some peace of mind
17 as regarding to what her plan or course of action is. They
18 agreed to that and will follow up with their surgeon.

19 Q Thank you.

20 A Yes, sir.

21 Q Based on your reading of that record, what was Dr. O's
22 recommendation?

23 A To continue to follow up with Dr. Schimpf for continued
24 treatment.

25 Q From what you could read of that record, he didn't refer her

1 to the emergency room or to the hospital, or anything like that?

2 A No, sir.

3 Q And he found that she had an appropriate relationship with
4 her physician and trusted him?

5 A Yes. He seemed to give a very appropriate second opinion,
6 and thought that she would be in good hands with Dr. Schimpf.

7 Q You agree Ms. Turisk suffered an unfortunate complication
8 from this procedure, correct?

9 A I do. Yes, sir.

10 Q Is that something that surgeons have to deal with throughout
11 the course of their career?

12 A It is. It's the worst part of our job, 100 percent.

13 Q Does the fact that she suffered this difficult complication
14 change your opinions at all as to whether Dr. Schimpf met the
15 standard of care in this case?

16 A No. And as we have discussed, unfortunately, very, very
17 difficult and tough complications can occur even in the best of
18 circumstances.

19 Q In your opinion, did Dr. Schimpf use the gold standard, or
20 go-to technique, in performing her surgery?

21 A I believe he very easily met the standard of care with a
22 very well-known and accepted technique.

23 Q And did he perform the surgery in a technically correct
24 manner?

25 A Yes, sir.

1 Q Was Ms. Turisk's complication caused by any negligence at
2 all, based on your review?

3 A Not that I could see. No, sir.

4 Q Doctor, do you hold all the opinions that you've expressed
5 here today to a reasonable degree of medical certainty and most
6 probably as a board-certified plastic surgeon?

7 A I do. Yes, sir.

8 Q Thank you, Doctor, for being here. Please answer any
9 questions opposing counsel may have.

10 ATTORNEY TANENBAUM: Thank you very much. Excuse me one
11 second.

12 THE COURT: Yes, sir.

13 **CROSS-EXAMINATION**

14 BY ATTORNEY TANENBAUM:

15 Q Hey, Dr. Lefkowitz, how are you doing?

16 A I'm great. How are you, sir?

17 Q I think I took your deposition by Zoom.

18 A By Zoom. That's correct.

19 Q That's something we all got used to over COVID, right?

20 A Yes, sir.

21 Q So first of all, thank you for being here today.

22 A Thank you.

23 Q One of the things I want to ask you about just so we're sure
24 of the timeline is, you've reviewed the chart from Dr. Schimpf's
25 office, correct?

1 A Yes, sir.

2 Q And were you here for his testimony?

3 A I was not. No, sir.

4 Q So I want to get the timeline of when it was that he did the
5 debridement, because the note is confusing.

6 A Okay.

7 Q Rebecca Turisk -- you've seen the note of November the 3rd
8 when a telephone call came in about how upset, how physically and
9 medically upset, she was and needed fluids, I guess?

10 A I remember vaguely reading his note.

11 Q I think her blood pressure and pulse was stable, but -- that
12 was actually November 1st, is that call, the day of the surgery.
13 Then on the 3rd, because she had been taking fluids as
14 recommended, she was feeling better, correct?

15 A I believe so. I have no reason to doubt you.

16 Q And then November the 7th a phone call came in about a
17 fever, that she had a fever of 102 degrees. Do you recall that?

18 A I recall that, seeing that in the notes. Yes, sir.

19 Q And then she was in on November the 8th, and apparently --
20 well, she was in on November the 8th, and at that point the
21 drains from her breast were removed and she had been bathing and
22 cleaning the wound as she was supposed to, correct?

23 A Again, I have no reason to doubt you.

24 Q And have you seen the photograph that was taken on November
25 the 6th?

1 A I've seen multiple photographs. You'd have to show me
2 exactly which one.

3 Q I'm sorry. Let me show you Plaintiff's Exhibits 1 and 2.
4 How would you describe the right breast and its appearance there?

5 A Well, number one, I see a lot of Steri-Strips.

6 Q A lot of Steri-Strips?

7 A The Steri-Strip tapes on the incision. So I would say that
8 she has, what I would consider, the normal scar pattern that we
9 talked about, that anchor pattern, with the Steri-Strips over
10 those incisions.

11 Q And how about the appearance of her nipple?

12 A Well, to be honest with you, I hesitate to say because,
13 again, on a photograph, coloration is very different, so I don't
14 have any opinion in terms of the coloration on the photograph.

15 Q Would you agree that it is at least very bruised?

16 A I would agree that whatever the notes said in the office are
17 fair.

18 Q Okay. Thank you very much. And then on November the 15th
19 she went back and, again, it was described as very bruised, that
20 right nipple, and eschar had formed. And the incisions were
21 clean and intact without erythema, warmth, or discharge.

22 A Okay.

23 Q Now, it was not until November the -- excuse me -- yeah,
24 November 29th that she saw Sonny O for a second opinion --

25 A Yes.

1 Q -- and he sent her back to Dr. Schimpf --

2 A Yes.

3 Q -- on November the 30th.

4 A That was his recommendation. Right, sir.

5 Q Okay. So what I'm concerned about is, you've got a record
6 from November the 28th, and we know that Rebecca was seen by
7 Dr. Schimpf's office because there's a note from Rebecca Johnson.

8 A Okay.

9 Q Now, Dr. Schimpf's note is dated November the 28th, and in
10 that he says that he saw Rebecca after receiving a phone call
11 from the Summerville Medical Center on November -- the night
12 before, correct?

13 A Okay.

14 Q And if I tell you that the -- and I'll show you his record.
15 As with Sonny O's record, is this -- are you able to identify
16 that?

17 A This just looks like this was one of her visits to
18 Summerville Medical Center.

19 Q To the emergency room?

20 A Yes, sir.

21 Q Okay. And the date of that?

22 A Appears as 11/29/2016.

23 Q And so Sonny O saw her on the 29th?

24 A Uh-huh.

25 Q And he recommended she go back to Dr. Schimpf?

1 A Uh-huh.

2 Q And then she went to the emergency room that night, correct?

3 A Yes, sir.

4 Q Summerville Medical Center, --

5 A Yes.

6 Q -- as his note says?

7 A Yes, sir.

8 Q And then it was the next day that she went in, on
9 November 30th, correct? You've seen that record?

10 A Yes, sir.

11 Q And it was that day that the eschar, the nipple, was
12 debrided, correct?

13 A Yes.

14 Q For the timeline for the ladies and gentlemen of the jury,
15 we didn't get it straight until --

16 A Sure.

17 Q Just trying to get that straight.

18 A Sure.

19 Q So in his note of November -- he says it's November the
20 28th. Appears to have really been November the 30th because he
21 received a phone call from Summerville Medical Center the night
22 before. Correct?

23 A I guess what I'm -- I'm -- I'm a little bit confused. Are
24 you saying that his visit after -- after she saw Dr. Sonny O and
25 went to the emergency room, that the actual visit was on the

1 30th --

2 Q Yes.

3 A -- and not on the 28th?

4 Q She was there on the 28th, but his note reflects the visit
5 on the 29th, the night before.

6 A Okay. I have no reason -- I have no reason to --

7 Q Okay.

8 A -- argue about the timestamp of anything.

9 Q Very good. Now, the surgery that you showed us your
10 pictures of, I guess, the slides --

11 A Yes, sir.

12 Q -- that's for breast reduction, correct?

13 A It's for breast reduction. We use it in breast reduction,
14 breast lifting, and some kind of augmentation mastopexy where we
15 put in implants at the same time that we lift the breasts.

16 Q Okay. Could you put that video back up? Thank you. So I
17 don't know if you all can see through this Plexiglas, so I'm
18 going to come around here, if you don't mind. May I stand behind
19 you?

20 A Sure.

21 ATTORNEY TANENBAUM: May I ask to approach the witness, Your
22 Honor?

23 THE COURT: Yes, sir.

24 THE WITNESS: Need me to move?

25

1 BY ATTORNEY TANENBAUM:

2 Q No. You're welcome to stand up, please, because I'm going
3 to ask you a question. So this is the inferior pedicle, correct?

4 A Yes, sir.

5 Q And the tissue that's coming out is all of this tissue
6 behind it, correct?

7 A Yes, sir.

8 Q And that includes this fatty substance, correct?

9 A Correct. That's breast tissue and fat. Yes, sir.

10 Q Is the only source of blood supply this inferior pedicle
11 here?

12 A Yes. That's correct.

13 Q And it's going to be pushed down, so to speak, and tightened
14 up with these two flaps here by the skin?

15 A Yes and no. The flaps are made such that when we bring the
16 flaps over, there's minimal tension or pressure on the pedicle.

17 Q Right. Right. I didn't mean to insinuate there was
18 pressure. So it's really this yellow blood supply capsule,
19 capsulator [sic] -- capillaries and arteries, and things like
20 that --

21 A Uh-huh (yes).

22 Q -- and veins, correct, --

23 A Sure.

24 Q -- that come out, right?

25 A Of that breast tissue?

1 Q Out of the breast tissue.

2 A Everything that would come out with that breast tissue,
3 including any vasculature, would come out.

4 Q So the vasculature does come out?

5 A Sure.

6 Q And the blood supply has to come from here?

7 A Correct. Yes, sir.

8 Q And would you agree with me that when the implants were put
9 in through this periareolar --

10 A Almost.

11 Q -- Periareolar, they're put in through there, they -- sort
12 of goes all the way down through that same musculature right
13 there?

14 A Yes, sir.

15 Q That's right there?

16 A Yes.

17 Q I'm learning every day.

18 A Yeah.

19 Q And that there's scar tissue that forms when it's opened up
20 like that?

21 A Yes, sir.

22 Q Now, the scar tissue -- thank you very much.

23 A Sure.

24 Q Thank you. The scar tissue that you've talked about where
25 you connect -- I've had a skin flap, say -- for the nose, skin

1 cancer on your nose, if you need a flap, you can either do the
2 cheek or the forehead flap?

3 A Yes, sir.

4 Q And in both of those cases it's left connected to the tissue
5 in the forehead and in the cheek, correct?

6 A Correct.

7 Q It's got footing there?

8 A Correct.

9 Q And it's placed on top of the scarred nose, correct?

10 A Yes, sir.

11 Q And that footing is there for what reason?

12 A The footing keeps that blood flow going until the four
13 weeks -- until that gets pure blood flow.

14 Q Exactly. And whether that's on the face and nose -- or, I
15 don't remember the other examples you used. What's the other
16 example you used?

17 A The breasts.

18 Q I'm sorry?

19 A The breasts.

20 Q Oh, yeah, right.

21 A Yes.

22 Q The nipple raising.

23 A Uh-huh.

24 Q The nipple-saving mastectomy.

25 A Uh-huh.

1 Q So a flap is also created there?

2 A That's a little bit -- it's a little bit -- that's a little
3 bit different.

4 Q Okay.

5 A That's different. That flap is not connected to anything.
6 That flap is not -- it's not there --

7 Q Okay.

8 A -- in that case.

9 Q So whatever it's connected to is supplying blood until it's
10 well-seeded, correct?

11 A It's not quite the case in that particular -- in that
12 particular case, that blood flow is cut off from that, so it's
13 not seeded from anything for that amount of time.

14 Q Okay. But it stays in place --

15 A Uh-huh.

16 Q Whatever it is anchored to stays in place for four to eight
17 weeks, I think you said? Six to eight weeks.

18 A Yes, sir. That's correct.

19 Q And the way it's connected, so to speak, is supplying blood,
20 correct?

21 A In the way that you describe it, yes.

22 Q All right.

23 A We'll go with yes. Yes.

24 Q And then when it's disconnected, it's firmly -- it's
25 established its own bloodroot system, so to speak?

1 A Not in that case, it's not. It's not in that case. It has
2 to purely get blood flow through a pure, pure scar. And it's a
3 little bit different than what you were describing with the face
4 where it's rooted with that blood flow, with this different blood
5 flow, for four weeks.

6 In a breast case, there is not -- we don't have that
7 timeline from where it gathers its own blood flow. That blood
8 flow has to go through the scar based on the original surgery.

9 Q Okay. And so that scar, as I've seen it, is the same sort
10 of cookie-cutter scar?

11 A Correct. Yes, sir. In fact, it goes all the way around.

12 Q Goes all the way around, but there's still live tissue
13 underneath there?

14 A There is still live tissue. Right.

15 Q So it's on top of live tissue that has adequate blood
16 supply?

17 A Yes.

18 Q That was my point. Sorry.

19 A Sure.

20 Q Thank you. So in either case, it's getting adequate blood
21 flow, whether it's the nose scar or the nipple --

22 A Yes.

23 Q -- from the beginning --

24 A Yes.

25 Q -- and until it has a chance to really get seeded --

1 A Correct, yes.

2 Q -- and established?

3 A Correct.

4 Q Thank you. Now, I think that you've agreed, if I understand
5 it correctly, that when you obtain a consent form from a
6 client -- excuse me, from a patient -- there's no mention of, If
7 I make a mistake by choosing a technique -- and I'm sure you
8 wouldn't, but if -- you wouldn't choose a wrong technique but, if
9 I make a mistake by choosing the wrong technique, I don't have
10 any responsibility to you? That's not part of any consent?

11 A No, not that I know of.

12 Q Okay. So informed consent means, Yes, I understand there
13 can be untoward complications, but it doesn't mean if I make a
14 mistake, that is, choosing the wrong technique, for example,
15 then --

16 A I'm absolved. Correct.

17 Q Does nothing like that?

18 A Does nothing like that. That's right.

19 Q I think we got the scar and the muscle. And you've agreed,
20 also, in this case -- you were deposed once before?

21 A The deposition by yourself. Yes, sir.

22 Q And you agree then that this is a more complex procedure
23 because of the previous scars?

24 A Yes. Anytime you have any, what we would consider a,
25 revision surgery, that always makes it more complex. Yes.

1 Q All right. And you've agreed, as I recall -- or, you
2 understand and you've agreed -- that there was a disruption of
3 the blood flow that was caused by something that occurred during
4 the surgery?

5 A I disagree with that based on the fact that there was
6 obviously a disruption of blood flow. When exactly that
7 occurred, that, I cannot answer. And that's based on what
8 Dr. Schimpf, himself, observed in the operating room during his
9 surgery and at the end of his surgery. There was obviously a
10 disruption, but the timing of that, there's no way for me to
11 answer.

12 Q All right. So you've also agreed that -- I think you
13 responded to this on direct -- that Ms. Turisk, nor her
14 caretakers, nor any of her subsequent physicians, did anything to
15 cause the condition she finds herself in today?

16 A No, sir. Nothing would suggest that.

17 Q And the procedures that she's had since then were done
18 appropriately and were medically necessary?

19 A I have no criticisms with any of that.

20 Q And I think one of the things you've testified to earlier
21 was that part of making surgical decisions, what you do is you do
22 that ahead of time?

23 A Yes.

24 Q I'm going to take such and such an approach, you draw it
25 out, and that's part of the planning process, correct?

1 A Yes, sir.

2 Q And the teaching and publication that you've done --
3 publications -- they had nothing to do with breast surgery?

4 A Not with breast surgery. No, sir.

5 Q And I'm curious. Do you do breast-implant removal?

6 A Yes, sir. I do a lot of breast surgery. Yes, sir.

7 Q The reason I ask is you called that "little scar" down
8 there. You used the term "little scar."

9 A Uh-huh.

10 Q And --

11 A Everything is relative. It's a small scar when you take
12 into consideration a much larger scar for a breast reduction.
13 So, for instance, anytime I talk about breast augmentation --
14 because that was the original surgery that she had, which is very
15 common surgery -- that scar is usually placed in one of three
16 positions: One is either under the breast; one is kind of at the
17 bottom part of that areola. But either way, in terms of length
18 and in terms of visibility for patients, that is certainly much
19 less compared to a large scar that we use for breast reduction.

20 Q And I think what I was asking you earlier ...

21 (The Court unseals a transcript.)

22 (Court's Exhibit 4 is marked for identification.)

23 THE COURT: There, you go.

24 ATTORNEY TANENBAUM: Thank you very much.

25

1 BY ATTORNEY SMYTH:

2 Q Doctor, I'm going to hand you the original of your
3 deposition --

4 A Sure.

5 Q -- that we've discussed that's been opened by the Court as a
6 certified transcript. It's been sealed since -- it was delivered
7 sealed.

8 A Okay.

9 Q And my question to you was -- if you would take a look at
10 page 25, and line 7.

11 A Okay.

12 Q My question was: I think we've agreed -- y'all with me?
13 Okay. I think we've agreed that the blood supply, unfortunately,
14 was -- had been disrupted by the incision in the breast from the
15 breast-augmentation procedure. Do you agree with that? And your
16 answer was?

17 A No, sir, I cannot agree with that. I agree that the blood
18 flow was disrupted at some point during surgery, but I certainly
19 can't assume that it was directly related to the previous
20 breast-augmentation surgery.

21 Q And then go on to line 18, please.

22 A It was resulted at some point.

23 Q It was disrupted?

24 A Disrupted during the surgery.

25 Q I'm sorry. That's me.

1 A Okay.

2 Q But it was disrupted as a result of this surgery, correct?

3 A It was resulted at some point during the surgery.

4 Q Okay. And during this surgery, Dr. Schimpf's surgery?

5 A That's correct.

6 Q All right. Thank you. Does that refresh your memory now
7 about you testifying that it was disrupted during the surgery?

8 A It was disrupted during the surgery. What I can tell you
9 is, from the timing of when it appears, you just don't know when
10 that's going --

11 Q Right.

12 A -- to happen. Clearly she had some type of disruption.
13 Just like we've talked about, she had a very difficult
14 complication. There was obviously some disruption of blood flow
15 at some point, but it was not known during surgery whether it was
16 disrupted or not based on his findings.

17 Q All right. And I think you've agreed with me -- well, that
18 the only blood going to that nipple was through the inferior
19 pedicle, correct?

20 A The inferior pedicle is what carries blood flow to and away
21 from the nipple-areolar complex for every single breast reduction
22 that's done through that -- that technique. So I hear you say
23 "only", but that is the way the blood flow gets to the nipple
24 areolar complex --

25 Q I'm sorry. That was my question to you. Look at page 26,

1 please, line 3. And my question was: The only blood supply that
2 would have been left in the nipple would have been from the
3 pedicle; is that correct? The inferior pedicle. This is before
4 the surgery and then after the surgery, correct?

5 A Yes, that's correct. That's correct.

6 Q And there was no qualification of that answer?

7 A No.

8 Q And thank you, sir. Let me just make sure my cocounsel
9 doesn't say I left something out. Do you still have anything?

10 The deposition.

11 A The deposition.

12 ATTORNEY TANENBAUM: I will hand it to the court reporter.

13 Is that who gets this now?

14 THE COURT: Yes, sir.

15 ATTORNEY TANENBAUM: That's all. Thank you very much.

16 THE COURT: Any redirect?

17 ATTORNEY SMYTH: Just briefly, Your Honor.

18 **REDIRECT EXAMINATION**

19 BY ATTORNEY SMYTH:

20 Q I'd like to pull that picture back up that you were being
21 asked about from the video slide. Just to make sure we're clear,
22 that pedicle is that yellow swath of tissue that's underneath the
23 nipple?

24 A That is correct. Yes.

25 Q And that's the blood supply to the nipple?

1 A That entire area that you see, that yellow that is beneath,
2 three dimensionally, not only beneath the nipple but that goes
3 deep towards the chest wall as well.

4 Q And you were asked questions about footing. Is that the
5 footing for the blood supply?

6 A I've never heard it put that way, but the blood flow comes
7 from that entire area, yes. That is considered the pedicle, that
8 three-dimensional tissue that supplies the nipple-areolar
9 complex.

10 Q When you say three dimensional, you're talking about blood
11 flow that comes from underneath that you can't see in that image?

12 A That is correct. That's correct, yes.

13 Q And that is the pedicle that you described as being 10
14 centimeters?

15 A That is correct. So it's a block of tissue. If you can
16 imagine this without -- so sorry, but let's say this is -- It is
17 a three-dimensional block of tissue in which the nipple-areolar
18 complex sits on. That width is the width here, which is much,
19 much wider than anything that the original augmentation scar had.
20 In fact, I think it may have said 4 centimeters, something like
21 that, so it's three times as wide.

22 Q So that 10 centimeter pedicle, in your opinion, is that
23 sufficient blood supply to keep the nipple viable?

24 A Yes, sir. In fact, I will say I was trained that the
25 standard of care is 6 to 8 centimeters. So anything wider than

1 that gives you more and better blood supply.

2 Q And you believe that if the surgery's done appropriately,
3 like you do in this case, that that's more than adequate?

4 A Yes, sir.

5 Q And meets the standard of care?

6 A Meets the standard of care, yes.

7 Q Thank you.

8 ATTORNEY SMYTH: Nothing further, Your Honor.

9 THE COURT: You may step down, Doctor. Thank you.

10 THE WITNESS: Thank you.

11 THE COURT: You may call your next witness.

12 ATTORNEY SMYTH: That's all of our witnesses. At this
13 point, Your Honor, the defense would rest.

14 THE COURT: Thank you, sir. Ladies and gentlemen of the
15 jury, both sides have rested their case. I must take some
16 matters up outside of your presence, so I will let you go for the
17 afternoon, and we'll resume with the closing arguments in the
18 morning. If you, again, will be back in your jury room at 9:15,
19 we'll get started once we gather everyone up. Have a nice
20 evening.

21 And again, please remember my instruction not to discuss
22 this case amongst yourselves or with anyone else. Have a nice
23 evening.

24 (Jury escorted out of the courtroom at 3:16 p.m.)
25

1 MATTER(S) OF LAW

2 THE COURT: Counsel, any motions or any other matters before
3 we recess for the evening?

4 ATTORNEY BURKE: Yes, Your Honor. We have one. Plaintiff
5 would move for directed verdict on the issue of comparative
6 negligence. We don't believe there's been any testimony
7 presented that our client contributed, in any fashion, to the
8 outcome, and no one has testified that she's been negligent in
9 any fashion.

10 THE COURT: Any response?

11 ATTORNEY BURKE: In fact, I think every doctor's testified
12 that she did nothing wrong.

13 ATTORNEY SMYTH: I think we agree, Your Honor. This is not
14 a comparative case. We do have the assumption of the risk, that
15 still remains. But I think as far as comparative goes, we're not
16 asking for that to be charged.

17 THE COURT: Motion's granted.

18 ATTORNEY BURKE: Thank you.

19 ATTORNEY TANENBAUM: I'd like to move for a directed verdict
20 on the subject of risk defense. Certainly she was never ever
21 informed of the choice of techniques and which one to participate
22 in choosing, so to speak, and everyone agrees that the disruption
23 of the blood supply occurred during this surgical technique that
24 this doctor chose. She had nothing to do with that, and she was
25 not even aware that that was an issue that was going to be

1 decided in this case or could be chosen for her.

2 THE COURT: Thank you, sir. There has been evidence
3 presented to create a question of fact for the jury to determine
4 on that issue. I'll respectfully deny your motion.

5 ATTORNEY TANENBAUM: Yes. Thank you, Your Honor.

6 ATTORNEY SMYTH: Is that everything?

7 ATTORNEY TANENBAUM: I think so.

8 ATTORNEY SMYTH: On behalf of the defense, Your Honor, we
9 would renew our motions for directed verdict. I think we
10 originally moved with regard to the issues of damages. As the
11 Court may recall, we argued that the damages following the
12 initial surgery, those fat-grafting procedures, were not linked
13 up with the necessary requisite expert testimony to connect them
14 to be a proximate cause as required by the law, and so we will we
15 renew our motion that those damages be removed from the case and
16 a directed verdict in that regard.

17 THE COURT: Same ruling applies, counsel. Certainly the
18 testimony is adequate to give it to the jury.

19 ATTORNEY SMYTH: And I guess we'll renew the other motion
20 that we argued with regard to standard of care. I think the
21 evidence has been pretty clear that the technique that was
22 employed in this case is the gold standard, and while physicians
23 certainly have wide latitude to choose what technique they would
24 like to employ, there's been no testimony that that technique was
25 performed improperly or that it was outside of the standard of

1 care to use this technique for this surgery. So in that regard,
2 we would move for directed verdict on all causes.

3 THE COURT: And the same ruling applies, counsel. The
4 plaintiff's expert had a differing opinion which would create a
5 question of fact for the jury to determine.

6 ATTORNEY SMYTH: Those are our motions. Thank you, Your
7 Honor.

8 THE COURT: I know that you all emailed proposed jury
9 instructions. I have not had an opportunity to review them.

10 ATTORNEY BURKE: I apologize. Those are coming late. We'll
11 have them printed for you in just a couple of minutes now that
12 we're on break. We have a printer in the break room. We'll get
13 them to you in just a minute.

14 THE COURT: Perfect. So if y'all would get together and see
15 what you can agree upon, we can just meet before the jury comes
16 in and make sure we're all on the same page. If you all can get
17 together and agree to a proposed verdict form and then proposed
18 jury selections, that might save us some time.

19 ATTORNEY BURKE: We'll do our best to agree.

20 THE COURT: Sounds good. If you can't, then we'll figure it
21 out, but it should be pretty straightforward, I would anticipate.
22 Anything else before we recess for the evening?

23 ATTORNEY SMYTH: I don't think so. I think we've got all
24 the evidence.

25 (Off-the-record discussion.)

1 (Court recessed for the day at 3:21 p.m.)

2 (End of Transcript of Record, Volume III of IV.)

3 CERTIFICATE OF REPORTER

4 I, Cathy J. Provost, Official Court Reporter for the
5 Fourteenth Judicial Circuit of the State of South Carolina, do
6 hereby certify that the foregoing is a true, accurate and
7 complete Transcript of Record of the proceedings had and evidence
8 introduced in the trial/proceedings of the captioned case in the
9 Court of Common Pleas for Charleston County, South Carolina, on
10 the 16th day of November, 2022.

11 I do further certify that I am neither of kin, counsel, nor
12 interest to any party hereto.

13
14 Date: January 7, 2023

15
16 /s/ Cathy J. Provost
17 Cathy J. Provost, RMR
18 Official Circuit Reporter
19
20
21
22
23
24
25

STATE OF SOUTH CAROLINA	)	COMMON PLEAS COURT OF THE
	)	
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
REBECCA TURISK	)	NO. 2018-CP-10-02109
VS.	)	
DENNIS K. SCHIMPF, M.D.	)	TRANSCRIPT OF RECORD
	)	Jury Trial - Volume IV of IV
	)	(Pages 431 - 496)

B E F O R E:

The Honorable Maite Murphy, Judge; and a jury
Charleston, South Carolina

DATE: Thursday, November 17, 2022
10:55 a.m.

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Reported by: Cathy J. Provost, RMR, Official Court Reporter

1 (Indexes contained in Volume I, Transcript of November 14, 2022)

2 -- P R O C E E D I N G S --

3 (Plaintiff's Exhibit 24 is marked for identification.)

4 (Plaintiff's Exhibit 24 is received in the record.)

5 (Court called to order, without the jury present.)

6 MATTER(S) OF LAW

7 THE COURT: It's my understanding that there will not be any
8 reply testimony; is that correct?

9 ATTORNEY TANENBAUM: That's correct, Your Honor.

10 THE COURT: And we have had a charge conference, and the
11 parties have had an opportunity to review the proposed jury
12 instructions. Are there any exceptions or objections to the
13 proposed jury instructions from either the plaintiff or the
14 defense?

15 ATTORNEY TANENBAUM: I'm sorry, Your Honor. None.

16 ATTORNEY SMYTH: Your Honor, we had one objection that we
17 discussed in chambers, was regarding the charge on duty of due
18 diligence in attending to the patient that we objected to.

19 It's our position that the evidence in this case is
20 undisputed that Dr. Schimpf was attentive and responsive
21 throughout the entire doctor-patient relationship, and there's no
22 evidence that he abandoned his duty in any way, so we don't think
23 that charge fits the facts.

24 THE COURT: Yes, sir. I understand your objection.
25 However, the testimony does create a question of fact. The

1 plaintiff's claim that there should have been a topical
2 antibiotic placed on the wound site through some of their
3 testimony, so I will leave that instruction in there.

4 ATTORNEY SMYTH: Thank you, Your Honor.

5 THE COURT: Anything further before we bring the jury out?

6 ATTORNEY BURKE: Your Honor, Mark has a wrong copy of the
7 charge, and I just want to go over everything to make sure we
8 have everything. If you'll indulge us for just one minute.

9 ATTORNEY TANENBAUM: So I would ask Your Honor to give them
10 the language about one acceptable approach.

11 ATTORNEY BURKE: It's been a long week. I apologize. Ms.
12 O'Neal is going to handle this.

13 ATTORNEY O'NEAL: Your Honor, we do take exception with the
14 charge for assumption of the risk. I don't think that there's
15 been any evidence that Dr. Schimpf informed the plaintiff as to
16 he considered her to be a higher risk. I believe he testified
17 that she was a high-risk patient, and his record does not reflect
18 that. There was no conversation that he had with her about the
19 station of her nipple being a factor that would put her at
20 greater risk for complications postoperatively.

21 In fact, prior to testimony here, at his deposition he
22 testified that there was nothing that was presented with her case
23 that gave him any indication that she would have the kind of
24 complications that she had.

25 I don't think there's substantial, or sufficient, evidence

1 to charge the jury that she assumed the risk.

2 THE COURT: I respectfully disagree. He did go over the
3 assumption of the risk form with her, and the potential outcomes
4 were listed in there as to what happens. So your motion is
5 respectfully denied.

6 ATTORNEY BURKE: Understood.

7 THE COURT: Anythings further on the jury instructions?

8 ATTORNEY BURKE: No, ma'am. Thank you.

9 ATTORNEY SMYTH: No, Your Honor.

10 THE COURT: All right. Let's have our jury, please.

11 (Jury seated in the courtroom at 11:01 a.m.)

12 THE BAILIFF: All jurors are present, Your Honor.

13 THE COURT: Thank you. Good morning, ladies and gentlemen
14 of the jury. I apologize for the delay this morning. Sometimes,
15 through no fault of any of the parties, things take us a little
16 longer than we anticipate. And I certainly apologize, because we
17 certainly want to be mindful of your time and respectful of your
18 time.

19 We are now ready to proceed with the closing arguments.
20 Please pay close attention. Counsel.

21 CLOSING STATEMENT ON BEHALF OF PLAINTIFF

22 ATTORNEY BURKE: Thank you, Your Honor. May it please the
23 Court.

24 THE COURT: Yes, ma'am.

25 ATTORNEY BURKE: Ladies and gentlemen of the jury, I've been

1 looking forward to this opportunity to speak with you all again.
2 When I introduced myself to y'all on Monday, I thanked you for
3 your service, and I told you that this was an important case, and
4 I hope that has been borne out. It's important to Rebecca, and
5 it is also important to Dr. Schimpf. And I know you all have
6 been here since Monday, and I thank you all for that. You've
7 been excellent jurors, and I hope you are excited to get to the
8 conclusion of the case.

9 I'm going to be speaking to you all from notes for my
10 closing, and I hope you'll indulge me on that. The judge is
11 going to charge you on the law, and I think I also mentioned in
12 my opening, that we have the burden of proof, so I have to help
13 you understand our burden of proof and also talk with you about
14 the evidence and the testimony that's been presented in this case
15 that show that we've met our burden of proof. And that's not
16 something I can wing. I don't want it to mess it up, so I have
17 some outlines here.

18 On Monday I talked to y'all about duty, breach, proximate
19 cause, and damages. Physicians have a duty of care to their
20 patients, and when that duty is breached and that breach is the
21 proximate cause of injuries and damages, the plaintiff is
22 entitled to recover.

23 I believe we proved that there was a breach. We proved that
24 through Dr. Hultman's testimony. Dr. Hultman testified that
25 Dr. Schimpf's failure to provide reasonable care under the

1 circumstances when he performed the wrong surgical approach on
2 Rebecca's breasts. And then we had testimony from Dr. Hultman
3 and Dr. Herrera. You heard from Dr. Herrera by videotape
4 deposition on Monday that the breach, that the loss of the blood
5 supply, which was the actual breach, was the proximate cause of
6 Rebecca's injuries. And I know that we talked a lot about
7 Rebecca's damages through her testimony, as well as Dr. Herrera.

8 So what is the burden of proof? And the Judge is going to
9 instruct you on burden of proof that we, the plaintiff, that we
10 have. And we embrace that burden. Our burden is not to a
11 reasonable doubt. I know people -- a lot of people are familiar
12 with that from television or movies or from our daily lives. The
13 criminal standard is beyond a reasonable doubt. This is not a
14 criminal case. This is a civil case, and the standard of proof
15 is lower. The standard of proof is called preponderance of the
16 evidence. And what that means is if the scales tips, even ever
17 so slightly in favor of the plaintiff, we've met our burden.
18 Fifty-one percent, the greater weight, or the preponderance, of
19 the evidence is our burden.

20 And one of the ways that we are required to meet that burden
21 is to present expert testimony, and the Judge will charge you
22 about the importance and the necessity of expert testimony. So
23 we had expert testimony from Dr. Hultman, and we had expert
24 testimony on the defense side as well.

25 And I think one thing we've all learned this week is that

1 doctors do not come to court for free. Expert witnesses
2 generally do not testify for free. They all got paid to be here.
3 Don't hold that against any of them. But, you do need to
4 evaluate their testimony.

5 Dr. Hultman went to college at Brown. He went to medical
6 school at the University of Pittsburgh. He went on to practice
7 medicine, practice plastic surgery, and teach at the University
8 of North Carolina. He taught medicine, he taught plastic
9 surgery, and taught at Johns Hopkins, and now he's practicing
10 medicine and teaching at WakeMed in Raleigh, North Carolina.

11 Dr. Hultman is one of the board examiners. I know we've
12 heard -- I think every doctor that's testified this week has been
13 board-certified. Dr. Lefkowitz is board-certified; Dr. Herrera
14 is board-certified; Dr. Schimpf is board-certified; Dr. Hultman
15 is board-certified, and Dr. Hultman is a board examiner. He
16 writes the questions. He gives the tests for plastic surgery
17 board certification. He is an expert -- expert in plastic
18 surgery.

19 Dr. Hultman was the only expert in this case who did not
20 equivocate on his opinion. Dr. Hultman testified that the
21 inferior pedicle approach was contradicted for Rebecca. Not --
22 you know, there's other ways you can do it. The way that
23 Dr. Schimpf did it contradicted it should not have been done in
24 this patient.

25 We've heard testimony from Dr. Schimpf's experts, and maybe

1 from Dr. Schimpf, too, that Dr. Schimpf's approach is the gold
2 standard, it's the most widely used approach. That may be true,
3 but that's not true for Rebecca. You can't just make a blanket
4 assertion this is the one that's the most widely used so it is
5 right one for this patient. It was not right for Rebecca. It
6 was contraindicated.

7 We talked about the pedicle, that piece of tissue under the
8 nipple. An alternative pedicle should have been chosen, and
9 Dr. Hultman was very clear about that. The inferior approach was
10 the wrong approach. The superior approach was the correct
11 approach, coming in from the top instead of coming in from the
12 bottom. And he was pretty clear about why. And it's because
13 Rebecca had prior implants. She already had surgery through the
14 bottom of her areolae and, for that reason, the superior approach
15 should have been chosen to ensure there was enough vascularity to
16 that nipple and the breast tissue. To do it the other way was
17 not safe.

18 He talked about why you don't want to go back into that scar
19 that's already on the bottom. He talked to you all about the
20 tunneling that you have to do to get that implant in there when
21 you go in those scars. He said when the skin is taken off the
22 breast when you put the implant in, if you go back and do it
23 again, and even if it's 20 years later, it doesn't work, the
24 pedicle of the skin may not survive.

25 And even with a wide pedicle -- you heard some talk about,

1 well, he made a 10 centimeter pedicle -- even with that wide
2 pedicle, the surgery needs to be done from the top. Even with a
3 wide pedicle, the blood flow won't get across that old scar.

4 Dr. Hultman also testified that that breach, choosing the
5 wrong approach, choosing the wrong inferior approach instead of a
6 superior approach, that breaches the standard of care and was the
7 proximate cause of the plaintiff's injuries.

8 When Dr. Schimpf chose the inferior pedicle approach, it
9 prevented the appropriate blood supply from reaching the nipple
10 on the right side, as well as the left. The left is a little bit
11 better than the right, but the left also had tissue necrosis.

12 Dr. Hultman also testified that the necrosis came first; the
13 infection comes later. And that was also borne out in the
14 testimony of Dr. Joseph, the infectious disease specialist, who
15 flew in from California. Dr. Joseph came in -- and I thought
16 Dr. Joseph was a pretty helpful witness -- and he said very
17 plainly the necrosis comes first; the infection comes second.
18 And that is 100 percent in line with Dr. Hultman's testimony.

19 I'm going to come back to the damages. I'm now going to
20 talk about what Dr. Schimpf has presented to you all this week.
21 And again, I think this boils down, really, to two issues; was
22 the surgery done properly or not, and did the surgery cause a
23 lack of blood supply? Dr. Hultman said unequivocally the
24 surgical approach caused the lack of blood supply.

25 Dr. Lefkowitz from Columbia, he testified -- Columbia, South

1 Carolina, he testified -- that the inferior pedicle approach is
2 the gold standard. We talked about that earlier. And then
3 again, Dr. Hultman, in his testimony, really debunks that blanket
4 assertion by explaining why that approach is contraindicated in
5 this particular patient. Just because, again, it's done enough
6 times and a lot of surgeons really like it, it doesn't mean it
7 was right for Rebecca.

8 But where I feel Dr. Lefkowitz really struggled in his
9 testimony with was, again, related to when the compromised blood
10 flow actually happened. And on direct examination, my
11 recollection is that he said he doesn't know. He couldn't tell
12 you when the blood flow was compromised. And then Mr. Tanenbaum
13 refreshed his recollection on that point with his prior sworn
14 testimony, and at that point Dr. Lefkowitz remembered that he had
15 previously testified that it happened during surgery. And again,
16 that is 100 percent consistent with Dr. Hultman's opinions in
17 this case. The blood flow was compromised during the surgery.

18 A really interesting thing that came out in Dr. Schimpf's
19 testimony was his new theory of venous congestion. And when I
20 back up to Dr. Lefkowitz for a minute, I didn't hear
21 Dr. Lefkowitz talk about venous congestion on direct or cross.
22 Dr. Schimpf testified on direct examination that he came up with
23 this theory. And "theory" is his word; this is not my word. He
24 came up with the theory of venous congestion to explain the blood
25 loss to Rebecca's breast after he read Dr. Hultman's deposition.

1 Let that sink in. His words; not mine. This means that he
2 didn't think she had venous congestion at the time he treated her
3 in 2016. This means that he didn't come up with this theory
4 until Rebecca filed this lawsuit after he read her expert's
5 deposition.

6 Now he says the bruising and eschar -- he talked about the
7 black eschar on the right nipple in particular -- are related to
8 the venous congestion, but he did not tell Rebecca that in 2016,
9 and it's not in the chart. And here's Dr. Schimpf's chart. It
10 is in evidence. It will be in the jury room with you.

11 Just a few more things I want you to think about that are or
12 are not in his chart related to this new theory of venous
13 congestion. Dr. Schimpf's operative note does not indicate where
14 Rebecca's prior scars are. The prior implant surgery scars are
15 not identified in his operative note, and the operative note does
16 not indicate how the implants, prior implants, were placed, two
17 things that were important, in Dr. Hultman's opinion, in
18 determining the proper approach for the breast surgery that
19 Dr. Schimpf performed on Rebecca.

20 In talking about this new theory of venous congestion
21 yesterday, Dr. Schimpf explained that there is a timeline in
22 which you can address that complication, and I believe he said
23 you have to take action within the first 48 hours. And I know
24 there was a lot of discussion about that. You'll see in
25 Dr. Schimpf's office note -- and we've talked about this --

1 Rebecca's first follow-up appointment with him was scheduled for
2 November 8th, seven days after her surgery.

3 If Dr. Schimpf were correct, if his new theory of venous
4 congestion were actually true, if that was actually true, by the
5 time he saw the patient again there was nothing he could do.
6 According to him, you've got to do something within 48 hours.
7 You've got to poke that breast with a needle within 48 hours to
8 get that congestion out. Her follow-up visit was scheduled with
9 his office seven days later.

10 In talking about this new theory of venous congestion, he
11 says that massive -- again, it's his word, not mine, massive
12 swelling can cause venous congestion. His note's in evidence.
13 No indication of massive swelling in her record.

14 We've talked a lot about the calls between Rebecca's
15 caregivers and Dr. Schimpf in the immediate postoperative period.
16 Those are documented in his records. As often as Rebecca's
17 caregivers were calling Dr. Schimpf for the first few days,
18 nothing is noted in the chart to indicate mass swelling. And you
19 heard Mary Ackerman testify. You heard Rebecca testify. They
20 were calling him with their concerns.

21 Can you show the jury the November 2nd phone note, please.
22 I hope y'all can read that. If not, you can read it in the jury
23 room. So what does the November 2nd phone note indicate that
24 Dr. Schimpf spoke with Rebecca's caretakers about the
25 blood-pressure issue? And Mary Ackerman testified to that. And

1 we do not dispute Dr. Schimpf took the phone call. No dispute
2 about that. We have not presented one bit of testimony that he
3 didn't take her phone calls, or William's phone calls, or Mary's
4 phone calls. Not an issue at all as far as we're concerned.

5 But pay attention to what Dr. Schimpf noted on this date and
6 what's not noted. He does not note that he asked about swelling,
7 and it is not noted that he asked anything about the appearance
8 of her breast. And that's on the 2nd.

9 If you can pull up the 3rd. And about the 2nd, he testified
10 yesterday -- and I believe I got this right. Let me tell you all
11 though, if y'all think I got any testimony wrong, I'm doing this
12 from memory and my notes. Do not blame Rebecca or blame me.
13 Y'all heard the testimony. If I get some dates mixed up, please
14 don't hold that against my client. But, Dr. Schimpf testified
15 yesterday about the 2nd, that he assumed that Rebecca's
16 caregivers took down the bandages to look at the breasts.
17 Assumed. It's not noted on the 2nd.

18 But by the 3rd, when the note says she's doing better, on
19 the 3rd they have taken down the dressing, which means they've
20 taken off the bandages, and she's beginning to bathe with a
21 sponge. Those two things were absolutely allowed by the
22 postoperative instructions. By the 3rd, she was allowed to take
23 a bath; she was allowed to take the bandages down.

24 So when Dr. Schimpf told you yesterday that he assumed they
25 took the bandages down on the 2nd when they spoke to him, that

1 would not be in accordance with the postoperative instructions.

2 And again, on the 3rd, no swelling is noted, no massive
3 swelling is noted, no mention of any swelling, let alone massive
4 swelling.

5 And again, Dr. Schimpf testified yesterday that under the
6 congestion theory it was too late, three days after the surgery,
7 to do anything. But again, the venous congestion theory, it
8 doesn't matter. It's just dust. I told you all on Monday there
9 was going to be some dust come up, and the venous congestion
10 theory, that was some dust.

11 There's nothing in his chart or anywhere in this case, any
12 evidence, to suggest that venous congestion caused the blood flow
13 issue and eventually the necrosis of her nipple and breast. No
14 expert came in here and told you to a reasonable degree of
15 medical certainty that the blood-flow issues and the necrosis of
16 her nipple and breast were caused by venous congestion.
17 Dr. Schimpf told you it was a new theory.

18 We'll just run through a couple other things in the chart.
19 Let's pull up Exhibit 5. Plaintiff's 5. I know y'all have seen
20 this photograph a couple times. This was the first photograph
21 that we have of Rebecca in the postoperative period. And
22 Dr. Hultman testified during his testimony that, in his opinion,
23 this photograph on the 6th shows evidence of tissue death here.
24 By the 6th, there's already evidence of tissue death. He said
25 the right nipple was in trouble. Those were Dr. Hultman's words.

1 And he went on to say that he would have used a topical
2 antibiotic cream prophylactically on the incision and would have
3 removed the Steri-Strips.

4 You can put up Plaintiff's 6. Plaintiff's 6.

5 ATTORNEY O'NEAL: The same day?

6 ATTORNEY BURKE: Yes. And you've seen this photograph, too.
7 And this one shows the right and the left nipple. What
8 Dr. Hultman said -- and I think a lot of hay was kind of made out
9 of those topical-antibiotic testimony from Dr. Hultman, so I want
10 to try to put it in context for you.

11 What Dr. Hultman said, based on what he says on the 6th --
12 now, keep in mind she sees Dr. Schimpf again for the first time
13 postop on the 8th, and this is on the 6th, two days before that.
14 On the 6th, he would have taken off the Steri-Strips and applied
15 a topical antibiotic, not because he thought it was going to make
16 a significant difference in the outcome, but he thought it might
17 have saved some tissue. It might have saved some tissue. It was
18 worth a shot. Let's do something.

19 So when Rebecca goes in to see Dr. Schimpf on the 8th -- and
20 again, this is in his chart -- she actually sees Rebecca Johnson.
21 That was at Sweetgrass Plastic Surgery -- Rebecca notes that the
22 bilateral breast incisions are intact and healing well. No
23 erythema, which is, you learned, redness; drainage. She did note
24 mild and moderate swelling. Not massive; mild and moderate. And
25 she commented that the right nipple-areolar complex is very

1 bruised. And Dr. Schimpf said -- he said, I'm not going to put
2 it on the bruise; I'll put it on the incision.

3 On the 8th, Rebecca Johnson, Sweetgrass Plastic Surgery.
4 They did nothing. They did nothing. They didn't make any
5 attempt to try to save any tissue.

6 So Rebecca's next follow-up with Sweetgrass -- if y'all put
7 up Plaintiff's 8. Eight.

8 ATTORNEY O'NEAL: What date?

9 ATTORNEY BURKE: Exhibit 8. I'm trying to not make you look
10 at all these again on the screen. I apologize. So this picture
11 is Plaintiff's Exhibit 8, and this is dated the 14th of November.

12 Rebecca's next appointment, related to her breasts at
13 Sweetgrass Plastic Surgery, was on the 15th, so the day after
14 this picture was taken on the 14th. And at that follow-up visit
15 it's noted that the right nipple-areolar complex is very bruised
16 and eschar formed. All incisions are clean and intact without
17 erythema, warmth, or discharge. And she's told to follow up with
18 Sweetgrass Plastic Surgery in two weeks from the 15th. The
19 photo's on the 14th, was at Sweetgrass Plastic Surgery the next
20 day, and was told to follow up in two weeks. No antibiotics. No
21 antibiotics. No topicals.

22 And again, I think at this point we're probably rearranging
23 chairs on the deck of the Titanic, but no effort was made.

24 And then pull up Exhibit 9, photo 7, from the 15th. We've
25 seen the right breast on the 14th. And this is the left breast

1 on the 15th, the day that she went to Sweetgrass Surgery for her
2 second postop visit. You can see the Steri-Strips are off now on
3 the 15th.

4 So in accordance with what Sweetgrass Plastic Surgery asked
5 Rebecca to do, her next follow-up was on November 28th. You want
6 to take that one down. On the 28th -- Plaintiff's 10, the 28th.

7 Now, this photo was taken by Sweetgrass Plastic Surgery on
8 the 28th. The note says that erythema disclosed; an opening on
9 the right; IMF incisions has closed. That's the inframammary
10 fold incision that's closed. Rebecca reports fevers over the
11 weekend. The right nipple-areolar complex was eschar-formed
12 throughout. And they took the photo. The note goes on to say
13 that Rebecca should follow up in a week pertaining to the right
14 nipple-areolar complex. And Bactrim, an oral antibiotic, is
15 prescribed that date.

16 At this visit, Rebecca saw Jordan Harper, and we think she
17 also saw Dr. Schimpf. When you look at the chart, you'll see the
18 note of the 28th. Dr. Schimpf did make a note on the 28th, and
19 he says he saw her and debrided the nipple area. He did not
20 remove the nipple on the 28th, but he debrided the area. He
21 indicates in his note -- and, again, you can read this for
22 yourself in the jury room from the exhibit, that -- it appears
23 they talked about the nipple on this date, and he notes that she
24 is not overly concerned about losing her nipple. She's not
25 overly concerned about losing her nipple.

1 I submit to you that if that is true, the only reason she
2 was not overly concerned about losing a nipple at that point is
3 because she had no idea the storm that was coming. And
4 Dr. Schimpf told you he didn't talk to her about it. And I think
5 he was trying to do her a kindness, but he didn't talk to her
6 about it. So at that point, on the 28th of November, when he
7 notes she's not overly concerned about the loss of the nipple,
8 she didn't understand the full situation.

9 However, on the 29th she did get a second opinion. She went
10 to see Dr. Sonny O. And Dr. Sonny O's note is in evidence for
11 you. I want you to take a look at that. It's not very long.
12 Read Dr. Sonny O's impressions and observation.

13 I believe Dr. Schimpf testified yesterday that when patients
14 get wounds like Rebecca's, they become sensitized to the smell
15 and they can smell it but other people around them can't smell
16 it, they can't tell the odor from the wound. See what Dr. Sonny
17 O says about that in his note.

18 Let's look at the office visit from the 30th. It's a brief
19 note. And I believe November 30th was the last time she saw
20 Dr. Schimpf. And this was the day that he removed her right
21 nipple, and he asked her to follow up on Friday. Did she follow
22 up on Friday? No, she did not follow up with Dr. Schimpf on
23 Friday. And I might be wrong, but I believe that's the only
24 appointment she ever missed with him.

25 As we've heard from Dr. Herrera, on November 30th, the last

1 day that she saw Dr. Schimpf, she went to the emergency room at
2 MUSC that evening, and then just a couple days later, on
3 December 3rd, she was admitted to MUSC for four days, got IV
4 antibiotics, and serial debridement of her breast.

5 Dr. Schimpf told you yesterday that on November 28th he
6 didn't think Rebecca had an infection, and what he was going to
7 do was watch and see; he was going to watch and see what happens
8 until she becomes clinically unwell. Unfortunately, by
9 December 3rd she was clinically unwell and admitted to the
10 Medical University of South Carolina.

11 So I'm going to talk to you now a little bit about informed
12 consent and known complications. And these are two topics that
13 are very important to Dr. Schimpf. And we've heard a lot about
14 informed consent. And the forms that she signed are in the
15 chart. It's in evidence. I think there might be a separate form
16 that's a separate exhibit. Take a look at those. They're in
17 evidence. They're for you to consider.

18 And Rebecca testified that she understood the risks that
19 naturally flow from any surgery. And, as you've heard over and
20 over again from the doctors who testified in this case, patients
21 do not consent to care that falls below the standard of care.
22 That's not what a patient does when they sign an informed consent
23 form.

24 I've got to tell you, I really like the way Dr. Lefkowitz
25 put it. He said that when patients sign an informed consent

1 form, it does not absolve the doctor. The informed consent form
2 does not absolve the doctor of providing care that falls below
3 the standard.

4 I asked Dr. Herrera about informed consent, and
5 Dr. Schimpf's lawyer did, as well, and he also asked about known
6 complications, but I'd like to play for you a clip from
7 Dr. Herrera's deposition where he responded to Dr. Schimpf's
8 lawyer's question about -- one of questions about -- known
9 complications. And it's quick.

10 (Portion of video deposition played to the jury.)

11 ATTORNEY BURKE: And then I also asked Dr. Herrera if, when
12 a patient signs an informed consent form, are they consenting to
13 care that falls below the standards. And here's what Dr. Herrera
14 had to say about that.

15 (Portion of video deposition played to the jury.)

16 ATTORNEY BURKE: And y'all remember in my opening I said
17 Dr. Schimpf was going to kick up some dust; he was going to make
18 this trial about Rebecca. And here's what I heard him say: I'm
19 not blaming Rebecca, but ... I'm not blaming Rebecca, but she
20 might have gotten venous congestion because she wore her bra too
21 tight.

22 Look at those postoperative instructions. She was supposed
23 to wear a bra. But he thinks -- he suggests, he suggests, kicks
24 that dust up there, she might have gotten venous congestion, this
25 new theory of his, because she wore a bra too tight.

1 I'm not blaming Rebecca, but they probably shouldn't have
2 used hydrogen peroxide on her wounds. Postoperative instructions
3 are marked as -- discharge instructions, Defense Exhibit 1, it's
4 going to be in the jury room with you. Nowhere in those
5 instructions does it say don't use hydrogen peroxide. And he
6 testified that he knows his patients do it, he testified that he
7 knows it's commonly done, and he didn't take the trouble to add
8 it to that sheet.

9 At the end of the day it doesn't matter, because no one came
10 in here and testified that her caregivers did anything to impact
11 this outcome. No one has testified that the use of the hydrogen
12 peroxide in caring for her wounds after the surgery performed by
13 Dr. Schimpf made a bit of difference in the outcome. Not a shred
14 of testimony on that from anybody.

15 And this one -- this one, really, it's a doozy. I'm not
16 blaming Rebecca, but her wound culture grew out enterococcus
17 faecalis. And I don't have to tell you what Dr. Schimpf is
18 suggesting with that. And it came up in his opening statement.
19 That's the first time you heard it. He's trying to make you
20 blame Rebecca and her caregivers for contaminating her wound, but
21 there's zero evidence of that. Zero evidence of that.

22 Please do not be distracted by the name of this bacteria.
23 And I'm going to give you very specific reasons why it doesn't
24 matter, it makes no difference in the outcome. Number one,
25 Dr. Schimpf agrees with Dr. Hultman that that particular bacteria

1 is found everywhere in the environment. Everywhere. That means
2 that bacteria could have invaded her wounds from an incident
3 number of sources. That is a rotten seed that he planted,
4 rotten, and it grew into nothing.

5 Again, there's been no evidence presented by anyone, not one
6 witness in this trial, that the particular kinds of bacteria that
7 were cultured made any difference in her outcome.

8 And what I think is most important about this point is, they
9 flew in an infectious disease doctor from California who took
10 that stand and didn't breathe a word about faecalis enterococcus
11 or enterococcus faecalis, whichever way it goes. He did not
12 speak to us about any significance of the particular bacteria
13 that grew out of that culture. Why? Because it doesn't matter.
14 It made no difference in the outcome window. It matters how you
15 treat the bacteria, you've got to prescribe the right antibiotic,
16 but, that's all.

17 What Dr. Joseph did, which was most important and, frankly,
18 helpful to Rebecca, is he explained to you, in detail, that the
19 necrosis comes first; the tissue dies first; and then, because
20 there is no blood supply in dead tissue, then the bacteria come.
21 And that's what Dr. Hultman said. Dr. Joseph is 100 percent in
22 line with Dr. Hultman's opinion that the blood supply was
23 compromised first, and the infection came second.

24 I'm going to talk about damages a little bit now. We talked
25 about Dr. Herrera briefly just a few minutes ago, and I just want

1 to make a couple few comments about Dr. Herrera's deposition. I
2 know that deposition was long and I know it's hard to watch
3 testimony like that on a video screen instead of live in the
4 courtroom but, again, it goes back to our burden of proof. He
5 treated her for six years. She had six surgeries with
6 Dr. Herrera, and we had a lot to cover. We had a lot we had to
7 get out of Dr. Herrera to get things into evidence and meet our
8 burden of proof. So I appreciate you all bearing with me through
9 that process. And I also wanted you all to meet Dr. Herrera
10 because Dr. Herrera's a hero in all this. He took care of
11 Rebecca for six years, and it took six surgeries for him to heal
12 her and reconstruct her breasts. He talked about the care and
13 treatment of Rebecca.

14 Dr. Herrera was not here to testify to any breaches of the
15 standard of care. He was here to talk about his treatment of
16 Rebecca and how that treatment was related to her post-surgical
17 complications. And that's what I did.

18 You have in evidence the summary compilation of Rebecca's
19 medical bills. You can take a look at that while you're in the
20 jury room. And the total amount of Rebecca's medical bills is
21 \$579,677.78. This is evidence. This is the floor of Rebecca's
22 damages. This is the least that Rebecca's case is worth. This
23 is what it cost to heal her body and repair her physically. And
24 it cost over a half-a-million dollars to treat her fat necrosis
25 and reconstruct her breasts.

1 The other thing that Dr. Joseph did that I thought was
2 incredibly helpful to everyone in the courtroom -- I mean, he was
3 more like a professional -- he explained why it's so hard to
4 treat fat necrosis, and I believe he said it usually takes about
5 a year for that process to run its course. He talked about how
6 antibiotics, you know, can't get into dead fat tissue. He talked
7 about his role in this case was to answer the question of how
8 this happens in someone who is not immunocompromised. It takes a
9 lot of medical care to deal with fat necrosis and infection, and
10 Dr. Joseph explained that, defense expert, Dr. Joseph, explained
11 that.

12 When you're looking at these bills, I don't want you just to
13 look at her data, date of service, what happened, how much it
14 cost. I want you to think about what Rebecca was going through
15 at each of those visits. These are the noneconomic damages.
16 This is for her pain and suffering. This is for her
17 disfigurement. This is for what she endured every single day
18 while she was going through this process, and what she's left
19 with going forward. Think of the debridement, the wound VAC, the
20 surgeries, the mastectomies, and the five reconstructive
21 surgeries.

22 I think Dr. Schimpf suggested to you yesterday that Rebecca
23 could have gotten all of her medical care for free if she had
24 stayed with him. If she had stayed his patient, he would have
25 taken care of her for free. And that may be true, but everybody

1 knows that's not realistic because, as the fat necrosis
2 progressed over the next several months, as Dr. Joseph told you
3 it does, she didn't need the plastic surgery care; she needed
4 infectious disease care. Dr. Schimpf's not an infectious disease
5 doctor. She needed prescriptions; she needed medical supplies
6 for wound care; she was placed under anesthesia for two surgeries
7 to deal with the fat necrosis, and then five reconstructive
8 surgeries; and then she was hospitalized on those occasions.
9 That's not realistic.

10 And Dr. Schimpf even has a financial policy in the chart.
11 Let's see. Let me make sure it's in here. It's at page 26. So
12 when you go back in the jury room, you can take a look at page
13 26. And here's what he says in the financial policy: It is our
14 policy not to charge a surgeon fee for revisional surgery for
15 approximately 12 months from the original date of surgery. We
16 do, however, expect the patient to pay whatever other expenses
17 arise as a result of treatment in the hospital or outpatient
18 setting. And even if the revisional surgery occurs in our office
19 facility, the patient is responsible for the expense of the
20 facility and anesthesia.

21 He could have given her plastic surgery care for free, but
22 it wasn't going to cut down on her medical bills, and that's what
23 they wanted to you think. They wanted you to think, Oh, she
24 wasted all this money not dying from sepsis; she wasted all this
25 money at MUSC. She could have done it all with Dr. Schimpf. No.

1 That's a gross oversimplification of the medical issue Rebecca
2 terrific was dealing with.

3 Again, the Judge is going to charge you -- we talked about
4 the Judge's charge -- that Rebecca's entitled to her actual
5 damages, which are her medical bills. She will also charge that
6 you that she's entitled to money for her pain and suffering, her
7 mental anguish, her emotional distress, her loss of enjoyment of
8 life, and her disfigurement, past and future. Rebecca was 50
9 years old when Dr. Schimpf performed his surgery. That was six
10 years ago. She's 56 now.

11 I told you in opening statement that Rebecca literally
12 watched her breasts die on her body over four months. I'm sure
13 you all were like, Where's this lawyer going with this?
14 Dr. Joseph explained, that's what happened; that's how this
15 works.

16 I just want to conclude by reminding you all that there has
17 been no testimony in this case that Rebecca did anything wrong.
18 Not one doctor came in here and said Rebecca did anything wrong.
19 Not one doctor came in here and said her caregivers did anything
20 wrong. The blame does not lie with Rebecca Turisk; the blame
21 lies solely with Dr. Schimpf.

22 And I thank you all again so much. I will -- again, since
23 we have the burden of proof we will have one more opportunity to
24 speak with you after Dr. Schimpf's lawyer delivers his closing.
25 I'm not sure if it's going to be me or Mr. Tanenbaum, but I look

1 forward to speaking with you again.

2 THE COURT: Counsel.

3 CLOSING STATEMENT ON BEHALF OF DEFENDANT

4 ATTORNEY SMYTH: May it please the Court, Your Honor.

5 THE COURT: Yes, sir.

6 ATTORNEY SMYTH: Mind if I rearrange the furniture a little
7 bit?

8 THE COURT: You may proceed.

9 ATTORNEY SMYTH: Thank you, Your Honor. Good morning. It's
10 good to be with you again. On behalf of Dr. Schimpf, we want to
11 thank you, also, for your attention and your time this week. We
12 recognize you all made sacrifices to be here to help us resolve a
13 dispute that we haven't been able to resolve on our own.

14 As I told you at the beginning of the week, this case
15 involves one simple question: Was the doctor negligent? Did he
16 do something that was outside of accepted practices within his
17 specialty? That's the only question that's before you.

18 The question not before you is whether Ms. Turisk had a
19 complication that was difficult. Nobody here is challenging that
20 one bit. She had a difficult course. She had a complication
21 from the surgery.

22 The question that you have to wrestle with and you have to
23 decide for us is, Was that the result of medical negligence, or
24 was that a known complication of the procedure that she was
25 warned about, though rare, but do occur? You heard it from the

1 stand multiple times from every single plastic surgeon who
2 testified that these risks are real. They happen. We don't want
3 them to happen. We do everything in our power to keep them from
4 happening, but medicine is an inexact science. There are no
5 perfect doctors. There are no perfect outcomes. You heard that
6 from the stand as well.

7 When we talked about risks, Dr. Schimpf say there's no zeros
8 and there's no 100 percents. And that's why the law requires a
9 physician to comply with the standard of care, to do what other
10 doctors with the same training do day-in, day-out hundreds of
11 times. These are the accepted practices. There's a reason
12 they're accepted, because, they work most of the time, they're
13 the safest approach.

14 Medical malpractice involves a deviation from that, doing
15 something that other doctors wouldn't do in the circumstance.

16 A lot of the defenses that we've talked about in this case
17 have been referred to as dust. I like to refer to them as facts.
18 John Adams, who was President of our country and a famous lawyer,
19 he had a saying that was attributed to him in one of his trials.
20 He said, Facts are stubborn things. Facts in this case are that
21 Dr. Schimpf was meticulous; he was careful; he paid attention; he
22 was reasonable; he was prudent; he acted like a doctor you would
23 want to have; he acted like any doctor we would want to have, and
24 he did that from day one.

25 We have tried to be respectful of your time and be as

1 efficient as we can in terms of presenting the case. And the
2 defense case, as you'll recall, was very streamlined, because it
3 did focus on that one question, but what I hope you got from that
4 was the detail and the attention that goes into planning a
5 surgery.

6 When you start at the very beginning of the relationship in
7 July of 2016, Dr. Schimpf meets with Ms. Turisk. They have a
8 discussion; he performed a physical examination; takes
9 measurements; he gets her medical history; they talked about
10 surgical options. Detailed, reasonable, prudent.

11 Not one witness took the stand and said anything that
12 Dr. Schimpf did in that preoperative period was below the
13 standard of care, even plaintiff's expert. Then you get to the
14 decision to have surgery.

15 And we talked about the informed consent form that we've
16 gone over a few times. That's one of the most important things a
17 doctor can discuss with his patient. When you're thinking about
18 having surgery, you need to know that there are risks. These
19 aren't hypothetical risks. These aren't risks that happen to
20 other people. These are real risks. And a doctor that is
21 careful, a doctor that is prudent, a doctor that's compliant with
22 the standard of care does the right thing and he tells his
23 patients that. And he didn't just say the risks. He says these
24 risks are real; the bleeding, the infection, nipple loss, tissue
25 loss, the need for more revisional surgery, you might not be

1 happy with the results.

2 A suggestion has been made from the plaintiff's counsel
3 that, well, she didn't sign a form consenting to negligent care.
4 Who would? You don't go to a doctor because you think you're
5 going to get negligent care. You go to a doctor because you
6 think you're going to get the standard of care. And that's
7 exactly what the evidence shows that Ms. Turisk received in this
8 case.

9 Then you go to the planning stage of the surgery. And we
10 walked through that in a lot of detail, talking about
11 measurements that may not make a lot of sense to you in the
12 decision processes, but one thing that should be clear is
13 Dr. Schimpf knew she had implants from her prior surgery; he knew
14 there was a 4 centimeter scar there. And what did he do? Did he
15 ignore it? No, he planned for it.

16 The standard of care, as you listened to Dr. Lefkowitz
17 yesterday, is to use a 6 to 8 centimeter pedicle. He says
18 Dr. Schimpf didn't just meet the standard of care. He exceeded
19 it. He used a 10 centimeter pedicle for the very reasons that
20 we've talking about this week, to make sure there was adequate
21 blood supply to her breasts. That's what only a good doctor
22 would do. You want them to be thinking about those issues.

23 And then during the surgery, we walked through that in
24 meticulous detail, and you saw some pictures that you probably
25 hope you never see again, but the importance of that is that it

1 shows that he was paying attention to blood flow during the
2 surgery.

3 And in the medical record that you'll have, you'll see in
4 his operative note numerous references of him having checked the
5 blood flow to the nipple while he's doing the surgery, to both
6 breasts.

7 And then something that hasn't been talked about a lot but
8 something Dr. Lefkowitz said yesterday, he said at the end of the
9 procedure, after he had done the tummy tuck, he went back and
10 checked again and everything was as it should be. Everything was
11 viable; everything was the right color; there was no blanching;
12 there was no congestion; there was no problem with blood flow.
13 And that was hours after completing another procedure on her
14 body.

15 That's reasonable. That's prudent. That's careful. That's
16 exactly what Dr. Schimpf did, and it's exactly what we would want
17 in our physicians.

18 And his good care continued in the postoperative period. I
19 know some of the dates we talked about may not make sense yet, so
20 I'm going to try to put this in a little bit of order for you
21 because we know the case and have been dealing with it for five
22 years and I know you have just gotten it for a few days, so bear
23 with me, but I'm going to kind of go through the history here.

24 November 1st was the day of the surgery. And the testimony
25 has been uncontradicted. Dr. Schimpf chose and used the single

1 most commonly used approach to this surgery in the United States,
2 if not in the world. And that's coming from a breast surgeon,
3 not a burn surgeon. It's coming from a breast surgeon from
4 Columbia, not a burn surgeon. The burn surgeon had to admit
5 this, because it's the truth. Facts are stubborn things. He the
6 surgery according to the standard of care. There were no
7 complications during the procedure.

8 And then, like a good doctor, he followed up with his
9 patient that night. Ms. Turisk and her friends had his personal
10 cellphone, and he spoke to them. He spoke to them on the 1st;
11 spoke to them on the 2nd; spoke to them on the 3rd. He talked to
12 them about the appearance of her breasts. You heard Dr. Schimpf
13 say that the other day. He didn't have a note from the 1st, but
14 he remembered specifically talking to them about that.

15 And she was having some other complications related to
16 dehydration, but there were no complaints that, Hey, this doesn't
17 look right. Even on the 3rd, when plaintiff's counsel showed you
18 that note saying she took down her dressings, there was no report
19 about, Hey, this doesn't look right. Nothing was said to
20 Dr. Schimpf that would make him think she was having a problem of
21 this nature.

22 But still, being a reasonable, prudent, and caring
23 physician, he offered for them to come in. Come see me. If you
24 want me to check you out, I will. They didn't come. He said,
25 Well, if you don't want to come see me, go to the emergency room.

1 Didn't go. There was really no care that was indicated during
2 that timeframe there nothing that Mr. Schimpf missed. He was
3 responsive to the calls, and he continued to be throughout the
4 postoperative period.

5 On 11/7 Ms. Turisk calls and says, I think I've got a fever.
6 So what did they do? Just ignore it? No. They made an
7 appointment for her to come in and be seen the next day. It's
8 not unusual. That happens all the time. Patients get concerned.
9 Doctors are there for them to evaluate their concerns and to
10 treat them if they need treatment, and so she was seen the very
11 next day, on the 8th. You'll have the notes there. She was seen
12 by a nurse practitioner, or a physician's assistant, and there
13 was nothing in the examination that was performed that indicated
14 she had an infection. There's no redness. There's no warmth.
15 There's no -- none of the typical signs associated with infection
16 were noted on that visit.

17 Dr. Schimpf doesn't hear anything more from Ms. Turisk or
18 her caregivers for another week. At that time she comes back for
19 another visit and, once again, no noticing an issue; that the
20 treatment's appropriate. They provided the wound care as
21 recommended, but there was no infection present. No other signs
22 or symptoms of infection were present. Everybody that has taken
23 the stand from a plastic-surgery standpoint has admitted that.

24 The only infectious disease doctor who came to this court
25 this week was brought to you by us. And that's not a

1 coincidence. Dr. Joseph said there was no infection; that he
2 would have treated -- he really struck a strong chord when he
3 talked about the topical antibiotic. This is a guy who spends
4 his entire care, since 1980, taking care of infected patients,
5 and the suggestion that a topical antibiotic would have made a
6 difference at this point in Ms. Turisk's recovery is completely
7 refuted. There's no evidence that a topical antibiotic would
8 have done anything.

9 The next three interactions come on November 28th,
10 November 29th, and November 30th. At this point Ms. Turisk's
11 condition had deteriorated. And what happens? They let
12 Dr. Schimpf know, and he responds. He asked her to be come in to
13 be seen again.

14 On the 29th, a visit that really wasn't talked about a whole
15 lot in this case but one that I think is important, Ms. Turisk
16 went to Dr. Sonny O's office to be evaluated. He examined her,
17 and he didn't pull the fire alarm. He didn't say, Oh my gosh,
18 we've got to get you to the emergency room; we've got to get you
19 emergency surgery; he didn't prescribe any treatment whatsoever.

20 But what he did do was he recognized -- and you'll see it in
21 his note and you saw it yesterday when I put it up for
22 Dr. Lefkowitz -- he said, I see a patient here who's having a
23 problem, but I also see a patient here who still trusts her
24 physician and has confidence in her physician, so he sent
25 Ms. Turisk back to Dr. Schimpf. He said, The two of you need to

1 come up with a plan to treat this complication.

2 And once again, Dr. Schimpf was there for her. He made that
3 appointment on the 30th. He provided the wound care that she
4 needed at that time. Not one witness took the stand and said
5 that any of the wound care Dr. Schimpf provided, or his staff
6 provided, during this time period fell below the standard of
7 care. It was all appropriate, and it all met the standard of
8 care.

9 And Dr. Schimpf testified yesterday he was ready, willing,
10 and able to continue to care for Ms. Turisk with this problem.
11 He had no idea this would be her last visit. Ms. Turisk never
12 once said, I'm dissatisfied with your care. She never once
13 complained about him or his staff. She never once said, I've
14 been trying to reach you and you won't call me back or you won't
15 see me. She just didn't return. She did not give him the
16 opportunity to continue to care for her.

17 Instead, she started down what would be a very long and a
18 very expensive path, one that probably could have been avoided to
19 a large degree because Dr. Schimpf can do all of the same things
20 that Ms. Turisk needed. He could perform the surgeries with
21 regard to the scars that she developed, with regard to the
22 infection and treatment that she needed, with regard to the fat
23 grafting. And Dr. O knew that. That's why he sent Ms. Turisk
24 back to Dr. Schimpf. So that gives you a little better
25 understanding of the timeline.

1 The other thing that you get to talk about and consider, as
2 a jury, is who you believe, an issue of credibility. None of you
3 are doctors, from what I understand, and all of this is new
4 information, so that's why we brought you expert witnesses.

5 And Judge Murphy's going to tell you it's up to you to
6 decide, Do I want to believe all a witness's testimony, some of
7 their testimony, or none of their testimony? And you get to
8 decide, How do I evaluate these experts? Who do I trust?

9 In a case involving a breast surgery, one question you might
10 ask is, Why did you bring a plastic surgeon whose specialty is
11 burns, who has admitted, when I took his deposition, that he
12 hasn't done this surgery in five years. He may be an excellent
13 burn surgeon, but his knowledge about the breast surgery was
14 evident yesterday when he tried to suggest that this 4 centimeter
15 scar would stop blood flow in the nipple, when the clear evidence
16 in the case shows there was never a blockage of blood flow to the
17 nipple during the surgery or at the end of the surgery. If that
18 had happened, he would have seen it. It didn't happen.

19 He also gave you the opinion that maybe Dr. Schimpf missed
20 an infection and that topical antibiotics should have been given.
21 And Dr. Joseph refuted that directly. A topical antibiotic might
22 have even been more harmful than helpful. These are things you
23 know when you do breast surgery all the time like Dr. Schimpf
24 does; like Dr. Lefkowitz does.

25 Dr. Joseph also talked about the destructive process of fat

1 necrosis and why that's such a difficult complication and why it
2 can sometimes take so long to heal. It's not something that is
3 an overnight fix; it's a process. And, as Dr. Schimpf explained,
4 the body has to kind of demarcate where that process is going to
5 start -- excuse me, stop and start.

6 Dr. Joseph came into the courtroom to tell you a little bit
7 about that process, and hopefully help you understand it a little
8 bit better. But what he also told you is that Dr. Schimpf didn't
9 miss an infection. The infection came later. This process had
10 started, and it's a difficult process. Nobody's downplaying
11 that. I'm not suggesting that Ms. Turisk did not go through a
12 difficult time, but nobody also rendered an opinion that
13 Dr. Schimpf did anything that was negligent or below the standard
14 of care in the way he performed the surgery.

15 Most of the plaintiff's case, as I predicted, was going to
16 be about showing you pictures, trying to develop a relationship
17 and develop some sympathy for Ms. Turisk who, by all accounts, is
18 a nice lady, but one of things that Judge Murphy is going to tell
19 you, is that your verdict in this case cannot be based on any
20 emotion, any sympathy whatsoever. It has to be based on facts
21 and based on evidence.

22 We would submit to you that the overwhelming weight of the
23 evidence in this case shows that Dr. Schimpf not only met the
24 standard of care, his preoperative care, his intraoperative care,
25 and his postoperative care, but he exceeded it. He used the gold

1 standard technique that's used by plastic surgeons everywhere.
2 Not one single witness took that stand and said Dr. Schimpf did
3 something wrong during that surgery. He performed it in a
4 technically correct manner.

5 And, yes, his patient had a complication, but, as Judge
6 Murphy is also going to explain to you, a complication by itself
7 does not mean there was negligence. The plaintiff has the burden
8 of proof. They have to prove there was malpractice in this case.

9 As you heard from Dr. Lefkowitz, this was not malpractice;
10 this is how I would have done the procedure; this is how the
11 majority of plastic surgeons in the country do the procedure.
12 This isn't within the standard of care; it's well over the
13 standard of care.

14 So in conclusion I want to again thank you for your time and
15 your attention. I know some of this stuff is confusing at times,
16 and I hope that anything that we did in our presentation that
17 confused you, that you'll be able to set that aside and focus on
18 that one question, Was Dr. Schimpf negligent?

19 And I think when you've had time to review all the evidence
20 and consider the testimony of the witnesses, you'll come to the
21 same conclusion we did. He's a good doctor. He did the right
22 procedure. And, yes, his patient had an unfortunate
23 complication, but it's not malpractice. Thank you so much.

24 THE COURT: Reply?

25 ATTORNEY BURKE: Your Honor, I do have a brief reply. I

1 don't know if you wanted to give the jury a break, or if you just
2 want me to --

3 THE COURT: You can go ahead.

4 ATTORNEY BURKE: May I consult with my cocounsel first on
5 something?

6 THE COURT: Yes, ma'am.

7 REPLY TO DEFENSE CLOSING STATEMENT

8 ATTORNEY BURKE: I'm going to borrow your timeline.

9 May it please the Court.

10 THE COURT: Yes, ma'am.

11 ATTORNEY BURKE: I'm going to talk about these dates very
12 briefly again. The point I want to make right now is, this is
13 the date, that's where the ship sailed. When Dr. Schimpf planned
14 the surgery, he said, meticulously, he planned it incorrectly.
15 And Dr. Hultman explained that. He picked the inferior pedicle,
16 and he should have picked the superior pedicle. It's the wrong
17 surgery.

18 And it might be the gold standard, the most-often-performed
19 surgery in the country, but it was not the right surgery for this
20 patient. It was not the gold standard for Rebecca. It violated
21 the standard for Rebecca. It went below the standard.

22 So we've all talked a lot about what's going on here. The
23 problem started here, November 1st, in the operating suite at
24 Sweetgrass Plastic Surgery.

25 Now, again, Dr. Schimpf takes the phone calls, but there is

1 no evidence in his chart and there's been no testimony in this
2 case that he asked her about her breasts or that she complained
3 about her breasts. The issue on the 2nd or the 3rd was
4 dehydration, and he offered for her to come in and get fluids or
5 go to the ER and get fluids. Testimony has been that the
6 caretakers were able to deal with it. They got her hydrated at
7 home, and by the 3rd she was doing better with hydration.

8 So don't let them -- they're doing it again. They're trying
9 to blame Rebecca. Well, if Rebecca had come in about her
10 dehydration, I might have detected a problem with her breasts,
11 but you can't stop it. I mean, when the blood flow is
12 compromised to that breast tissue in the surgery, when the
13 pedicle is not vascularized, when the blood can't get to the
14 nipple because it can't get across the old scar that is very deep
15 in her breast, it's not just that little circle scar that Rebecca
16 drew for you, deep in her breasts where the implant went in and
17 was tunneled in there, this is where the problem started. You
18 can't stop it here.

19 But, you can see it. You can see it here. And you've seen
20 the photograph. And this is a plastic surgery case. Is there
21 any better evidence than pictures in a plastic surgery case? We
22 have to tell the story. We have to show you what happened. And
23 when you're in the jury room, you're going to have these
24 pictures. And they're pretty much chronological. You can flip
25 through them, and you can look at them. They're evidence.

1 You know, they said there were no complaints from Rebecca on
2 the 2nd or 3rd that her breasts don't look right. Well, how was
3 she supposed to know? She's not the doctor. Again, they're
4 blaming Rebecca. You didn't tell that your breasts didn't look
5 right. Well, he didn't ask. Check the notes. They're in the
6 chart. No notes he asked her about her breasts.

7 And they're back on Dr. Hultman with his topical. And so
8 we've got the -- I'm sorry. This visit, the 8th, we have -- we
9 do have a picture on this. He says based on what he saw he would
10 have put a topical on there but, again, it wasn't going to change
11 the outcome dramatically. Let's just keep that in mind. He
12 never said this case hinged on a topical antibiotic, and y'all
13 know that. Y'all know that. The case hinges on the surgical
14 technique, which was contraindicated -- not the golden standard,
15 the opposite -- contraindicated in this patient.

16 And again, I feel like I have address again, Dr. Hultman.
17 He is a plastic surgeon; he is a teacher of plastic surgery; he
18 is a professor in plastic surgery. And he testified from that
19 witness stand he's done this procedure, he's done it in the past,
20 and he does it now. Dr. Hultman knows how that surgery is
21 supposed to be done. He's one of the board examiners.

22 So I want to talk another moment about Rebecca's damages
23 because counsel for Dr. Schimpf, he said again Dr. Schimpf could
24 have handled all these surgeries. He could have handled the
25 surgeries, but he couldn't have handled all the costs.

1 And really what I want to say about that today is that your
2 job as jurors is to do justice; it's to do full justice to
3 Rebecca Turisk for her injuries and damages, because we've met
4 the standard of care. We've met our burden of proof. We've met
5 our burden of proof, and we've shown that there was a violation
6 of the standard of care, and it was here. We've proven that
7 through expert testimony through Dr. Hultman, who's been found
8 qualified to testify, sat right there on that witness stand, and
9 explained to you why the golden standard surgery was
10 contraindicated for Rebecca. We've met our burden.

11 And so when you go back in that jury room and you think
12 about the damages to award Rebecca, don't give her discount
13 justice. Justice is not on sale at the courthouse this week.
14 Justice is not 50 percent off as Dr. Schimpf would like you to
15 think.

16 Rebecca Turisk deserves full justice. She deserves her
17 economic loss, and she deserves pain and suffering, loss of
18 enjoyment of life, mental anguish, and compensation for her
19 disfigurement that I showed you/she showed you. She showed you
20 her disfigurement in a photograph from that witness stand on
21 Tuesday.

22 Only you can determine the amount of money that's reasonable
23 to compensate Rebecca for what she's been through and what she's
24 going to live with for the rest of her live. Pain and suffering
25 is an amount to be determined by the jury. That's your job. Do

1 justice today. Don't do discount justice. Full justice. Thank
2 you.

3 JURY CHARGE

4 THE COURT: Thank you, counsel. Ladies and gentlemen, it's
5 now time for me to charge you on the law in this case.

6 I remind you that during this trial you and I have certain
7 duties to perform. As the trial judge, it's my responsibility to
8 preside over the trial of this case, and I also have the duty to
9 rule on admissibility of evidence offered during this trial. You
10 are to consider only the evidence before you. If there was any
11 testimony ordered stricken from the record during this trial, you
12 must disregard that testimony. You are to consider only the
13 testimony which has been presented from the witness stand, any
14 exhibits which have been made part of the record, and any
15 stipulations of counsel.

16 I have the additional duty to charge you the law applicable
17 to this case. It is your duty, as jurors, to accept and apply
18 the law as I state it to you. If you think you any idea as to
19 what the law is or what the law ought to be and it does not agree
20 with what I tell you the law is, you must forget that idea
21 because you are sworn to accept the law and apply the law exactly
22 as I state it to you.

23 In every case tried in this court before a jury, the jury
24 becomes the sole and exclusive judge of facts. A trial judge
25 cannot comment on or make any statement about the facts in the

1 case. Since you are the sole judges of the facts, do not think
2 by anything I have said during the trial that I have any opinion
3 about the facts in this case. The law does not allow me to have
4 an opinion about the facts.

5 The burden of proof in this case is by a preponderance of
6 the evidence. A preponderance of the evidence simply means the
7 greater weight of the evidence. It is evidence which, as a
8 whole, shows that the facts sought to be proved is more likely
9 true than not true.

10 This can be illustrated by imagining a set of scales. When
11 the case begins, the scales are even. After all the evidence has
12 been presented, if the scales remain even or if they tip, even
13 slightly, in favor of the defendant then the plaintiff has failed
14 to meet the burden of proof and would not be entitled to recover
15 in this case.

16 If, on the other hand, the scales tip, even slightly in
17 favor of the plaintiff, the plaintiff will have met the burden of
18 proof and you should return a verdict for the plaintiff.

19 The preponderance of evidence is not determined by the
20 number of witnesses. Instead, it is determined by the greater
21 weight of all of the evidence.

22 Necessarily you must determine the credibility of witnesses
23 who have testified in this case. Credibility simply means
24 believability. It becomes your duty as jurors to evaluate the
25 evidence and determine which evidence convinces you is true.

1 In determining the believability of witnesses who have
2 testified in this case, you may believe one witness over several
3 witnesses, or several witnesses over one witness. You may
4 believe a part of the testimony of the witness, and reject the
5 remaining part of the testimony of that same witness. You may
6 believe the testimony of a witness in its entirety, or reject the
7 testimony of a witness in its entirety. You may consider whether
8 the witness has had an interest in the result of the trial,
9 whether the witness is prejudiced towards either the plaintiff or
10 the defendant, the opportunity for the witness to have seen the
11 matters and the things about which the witness may testify, and
12 the way that the witness acts on the witness stand.

13 The rules of evidence ordinarily do not permit witnesses to
14 testify to opinions or conclusions. An exception to this rule
15 exists for witnesses we call expert witnesses. An expert, who,
16 by education and experience has become an expert in some area,
17 science, or profession may give an opinion as to the subject the
18 witness claims to be an expert in, and they also give the reasons
19 for that opinion.

20 You should consider any expert opinion given by a witness
21 and, like any other evidence, give it the weight that you think
22 it deserves. If you decide that an expert witness's opinion is
23 not based on sufficient education and experience, or if you
24 decide that the reasons given in support of the opinion are not
25 sound or that the opinion is outweighed by other evidence, you

1 may disregard their opinion entirely. An expert witness's
2 testimony is to be given no greater weight than that of other
3 witnesses simply because the witness is an expert, and you do not
4 have to accept an expert's opinion even though it's
5 uncontradicted.

6 The plaintiff claims that the defendant committed medical
7 malpractice, which is a form of careless or negligence. The
8 plaintiff is required to prove that the defendant failed to
9 follow the generally recognized practices and procedures
10 applicable to their field of medicine under the circumstances
11 existing at the time that the professional services were
12 rendered, and that the failure was the proximate cause of the
13 plaintiff's injuries, as well as the alleged medical bills and
14 other damages.

15 In considering whether a physician has, and a healthcare
16 practice has, exercised reasonable judgment in a given case, you
17 must consider whether such judgment in relationship to the facts
18 as they existed at the time the judgment was made and not in
19 light of what hindsight may reveal.

20 Specifically, to establish a cause of action for medical
21 malpractice, the plaintiff must prove each of the following facts
22 by a preponderance of the evidence. If the plaintiff fails to
23 prove any one of them, your verdict must be for the defense:

24 1) The presence of a doctor-patient relationship between the
25 plaintiff and the defendant; 2) Recognizing generally accepted

1 standards, practices, and procedures, which are exercised by
2 competent physicians in the same branch of medicine as the
3 defendant under similar circumstances; 3) The defendant's
4 negligence deviated from generally accepted standards, practices,
5 and procedures; 4) Such negligence being the proximate cause of
6 the plaintiff's injuries; and, 5), An injury to the plaintiff.

7 The plaintiff must prove the standard of care the defendant
8 owed to the plaintiff in treating the plaintiff. When a doctor
9 treats a patient, the law does not require perfection. The law
10 does require that the doctor use that degree of knowledge, care,
11 and skill ordinarily possessed and used by doctors in good
12 standing in the doctor's field of medicine, under the same or
13 similar circumstances, and that the doctor followed generally
14 accepted practices and procedures in the profession.

15 Next, the plaintiff must prove that the defendant
16 negligently departed from this standard of care in treating the
17 plaintiff. Negligence is the failure to do what an ordinarily
18 careful doctor in the defendant's field of medicine would have
19 done under same or similar circumstances, or the doing of
20 something that an ordinarily careful doctor would not have done
21 under the same or similar circumstances.

22 A doctor is not an insurer of a cure or even a positive
23 result. Therefore, the mere fact that a known complication
24 occurs or the treatment does not benefit the patient, or that it
25 even harms the patient, does not in and of itself mean the

1 defendant was negligent. A bad result is not, by itself,
2 sufficient to raise an inference or presumption of negligence on
3 the part of the physician or the healthcare practice. A medical
4 malpractice case must involve charges of deviation from the
5 standard of care.

6 The only way you may properly determine whether or not the
7 defendant's conduct does or does not measure up to that standard
8 is through evidence presented in a trial by healthcare providers
9 called as expert witnesses.

10 A healthcare provider who undertakes to render services to a
11 patient which he or she should recognize as necessary for the
12 protection of the patient's person is subject to liability to the
13 patient for physical harm resulting from his or her failure to
14 exercise reasonable care if his or her failure to exercise
15 reasonable care increases the risk of harm.

16 The plaintiff must prove that the defendant's negligence
17 proximately caused the plaintiff's damages. Proximate cause is
18 something that produces a natural chain of events which, in the
19 end, brings about the injury. It is the direct cause of the
20 injury.

21 To prove the defendant's negligence proximately caused the
22 plaintiff's injury, the plaintiff must prove first that the
23 injury would not have occurred but for the defendant's
24 negligence.

25 The plaintiff must also prove legal cause. Legal cause is

1 proven by showing that the injury was foreseeable. This means
2 the injury occurred as a natural and probable consequence of the
3 defendant's negligence. The plaintiff must prove that some
4 injury from the defendant's negligence was foreseeable, but does
5 not have to prove that the particular injury that occurred was
6 foreseeable. However, the defendant cannot be held responsible
7 for something which could not be expected to happen.

8 In medical malpractice actions, expert testimony is
9 necessary on the following issues: 1) To establish the generally
10 recognized and accepted practices and procedures which would be
11 followed by average, competent practitioners in the defendant's
12 field of medicine under the same or similar circumstances; 2) To
13 establish that the defendant departed from the recognized and
14 generally accepted standards; and, 3) To establish that the
15 defendant's departure from such generally recognized practices
16 and procedures, if any, were a proximate cause of the plaintiff's
17 alleged injuries and damages.

18 The mere fact that the plaintiff's expert witness may use a
19 different approach in treating a patient is not considered a
20 deviation by the defendant from the recognized standard of
21 medical care, nor is this standard violated because an expert
22 disagrees with the defendant as to what is the best, or better,
23 approach in treating a patient. Medicine is an inexact science
24 and eminently qualified persons may differ as to what constitutes
25 a preferable course of treatment. Such differences as to the

1 preference do not amount to malpractice.

2 Negligence is not actionable, because it is a proximate
3 cause to injury, and it may be deemed a proximate cause only
4 when, without such negligence, the injury would not have occurred
5 or could have been avoided.

6 When the opinions of medical experts are relied upon to
7 establish causal connection of negligence to the injury, the
8 expert must, with reasonable certainty, state that, in his
9 professional opinion, the injuries complained of most probably
10 resulted from the alleged negligence of the defendant.

11 Such expert testimony must provide a significant causal link
12 between the alleged negligence and the plaintiff's injuries
13 rather than a tenuous or an a hypothetical connection.

14 Defendants have asserted that the plaintiff assumed the risk
15 of her alleged injuries. There are four elements to establish
16 assumption of the risk: 1) The plaintiff must have knowledge of
17 the facts constituting a dangerous condition; 2) The plaintiff
18 must know the condition is dangerous; 3) The plaintiff must
19 appreciate the nature and extent of the danger; and, 4) The
20 plaintiff must voluntarily expose herself to the danger.

21 Assumption of the risk maybe implied from the plaintiff's
22 conduct. Implied assumption of the risk arises when the
23 plaintiff implicitly, rather than expressly, assumes known risks.

24 In this case, the defendant contends that primarily implied
25 assumption of the risk applies. Primary implied assumption of

1 risk arises when the plaintiff impliedly assumes those risks that
2 are inherent in a particular activity.

3 Primary implied assumption of the risk is not a trial
4 affirmative defense, but instead goes to the initial
5 determination of whether the defendant's legal duty encompasses
6 the risk encountered by the plaintiff. In other words, it is
7 simply a part of the initial negligence analysis.

8 In a medical malpractice case, evidence of a plaintiff's
9 informed consent to a medical procedure may be considered in
10 determining whether the defendant was negligent.

11 A person who signs a contract or other written document
12 cannot avoid the effects of the document by claiming she did not
13 read it. A person signing a document is responsible for reading
14 the documents and making sure of its content. Simply stated, a
15 person who signs a contract or other written document is bound by
16 the terms and conditions of the writing.

17 A person cannot avoid the effects of a writing by claiming
18 that she did not read the document, as she is under a duty to
19 read the document before signing it.

20 However, despite the writings, the defendant remains under a
21 duty to comply with and meet the standard of care in choosing a
22 surgical technique and performing that technique.

23 A physician, in the presence of an agreement to the
24 contrary, remains, during the existence of the physician-patient
25 relationship, under a duty to give the patient all necessary care

1 as long as the case requires attention. An unwarranted lack of
2 diligence in attending the patient after assumption of the case
3 for treatment renders the physician liable for negligence or
4 malpractice.

5 Negligent failure to attend and treat a patient, at a time
6 when the need of treatment is known to the physician and there is
7 an opportunity to apply proper treatment, amounts to the same as
8 negligent treatment.

9 To recover for the lack of diligence of a physician in
10 attending a patient, the plaintiff must show that such lack of
11 diligence was a proximate cause for the injury for which the
12 redress is sought.

13 Actual damages are compensatory in nature; that is, actual
14 damages are designed to compensate, to make the injured party
15 whole, to put the party in the same position she was in prior to
16 the damages received. In other words, actual or compensatory
17 damages include compensation for all injuries which are naturally
18 the proximate result of the alleged wrongful conduct of the
19 defendant.

20 Actual damages are awarded to a litigant in competition for
21 her actual loss or injury. They are such damages as will simply
22 make good or replace the loss caused by the wrong or injury.
23 Actual damages are damages in satisfaction of, or in recompense
24 for, loss of the injuries sustained. The goal is to restore the
25 injured party as nearly as possible, through the payment of

1 money, to the same position she was in before the wrongful injury
2 occurred.

3 The basic measure of actual damages is the amount needed to
4 compensate the plaintiff for the losses proximately caused by the
5 defendant's wrong.

6 Actual damages include compensation for all injuries which
7 are naturally the proximate result of the alleged wrongful
8 conduct of the defendant.

9 When one person is injured by the negligent act of another,
10 the injured person is entitled to be fully compensated for all
11 injuries directly, or proximity, resulting from any negligent
12 acts or omissions by the defendant.

13 In determining the amount of compensation for injuries
14 suffered by the plaintiff as a result of the defendant's
15 negligence, it is proper for you to consider and award past,
16 present, and future damages for medical expenses, including
17 physicians, hospital, and medicine, disfigurement, alteration of
18 lifestyle, pain and suffering, loss of enjoyment of life, and
19 mental anguish.

20 An employer is liable for the negligent acts or omissions of
21 employees which are within the scope of their employment and
22 which proximately caused the injury to another person.

23 A doctor has the duty to inform the patient of the known
24 risks or dangers of the treatment or a procedure the doctor
25 proposes so that the patient will be able to make an intelligent

1 decision as to whether to follow the doctor's proposed treatment.

2 Ladies and gentlemen of the jury, your verdict must be a
3 unanimous verdict which, of course, means that all 12 of you must
4 agree on your verdict.

5 And, ma'am, in the front row, in the black dress, what is
6 your name, ma'am?

7 JUROR NO. 179: Katina.

8 THE COURT: Katina, your last name?

9 JUROR NO. 179: McFadden.

10 THE COURT: Ms. McFadden, since you are sitting in that
11 chair, I'm going to appoint you as the foreperson. You can see
12 it's a very scientific process we have to appoint you as a
13 foreperson. Your voice, of course, will be the same as the
14 others on the jury.

15 You'll merely be the liaison to the Court. You'll be
16 responsible for filling out the verdict form which you will have
17 in the jury room with you. The verdict form is very simple, and
18 it basically states that, the first question, it says: Did the
19 plaintiff prove by greater weight, or preponderance of the
20 evidence, that the defendant deviated from the standard of care?
21 And then you circle the appropriate yes or no. If the answer is
22 no, you are finished and you have found for the defendant.
23 Please sign the certification below. If your answer is yes, then
24 you continue to the next question. So it gives you will
25 instructions on each step that you must take.

1 Once you do come to a unanimous verdict, Madam Forelady, if
2 you will sign and date the verdict form. And when you do come to
3 a verdict, if you would knock on the door, we'll bring you back
4 in to receive your verdict.

5 Before you start your deliberations, please wait until you
6 receive the verdict form and all of the exhibits back in the jury
7 room. And once you've received all those documents, then you may
8 begin your deliberations. Please return to your jury room.

9 THE BAILIFF: May they take their notepads with them back?

10 THE COURT: Yes, ma'am, they can.

11 (Jury escorted out of the courtroom at 12:39 p.m.)

12 THE COURT: Any exceptions or objections to the charge on
13 the law from the plaintiff or the defense?

14 ATTORNEY BURKE: Not from the plaintiff, Your Honor.

15 ATTORNEY SMYTH: No, Your Honor.

16 THE COURT: Thank you. If y'all will get together and make
17 sure we have all the exhibits and the verdict form to go back to
18 the jury. Don't wander too far in case we have a verdict.

19 (Off-the-record discussion held.)

20 (Plaintiff's Exhibit 25 is marked for identification.)

21 (Plaintiff's Exhibit 25 is received in the record.)

22 (Exhibits and verdict form go back with the jury at
23 12:59 p.m.)

24 (Court recessed at 12:59 p.m. and reconvened at 3:49 p.m.,
25 without the jury.)

JURY QUESTION(S)

THE COURT: So we received another note from the jury. And it states: We are currently 10 to 2 in our decision. Can you guide us as to what to do next? So I was just going to give them an Allen charge. Any objection?

ATTORNEY BURKE: None from the plaintiff, Your Honor.

ATTORNEY SMYTH: No, Your Honor.

THE COURT: All right. Let's have our jury, please.

(Jury seated in the courtroom at 3:42 p.m.)

THE BAILIFF: All jurors present, Your Honor.

THE COURT: Thank you. Welcome back, ladies and gentlemen of the jury. Madam Forelady, I'm in receipt of your note. And, ladies and gentlemen, you have stated that you have been unable to agree on a verdict in this case.

As I instructed you earlier, the verdict of the jury must be unanimous. When a matter is in dispute, it isn't always easy for even two people to agree, so when twelve people must agree it becomes even more difficult.

In most cases, absolute certainty cannot be reached or expected. However, you have a duty to make every reasonable effort to reach a unanimous verdict. In doing this you should consult with one another, express your own views, and listen to the opinions of your fellow jurors, tell each other how you feel and why you feel that way, discuss your differences with open minds.

1 Although the verdict of the jury must be unanimous, every
2 one of you has the right to your own opinion. The verdict you
3 agree to must be your own verdict, the result of your own
4 conviction, and you should not give up your firmly held belief
5 merely to be in agreement with your fellow jurors.

6 The majority should consider the minority's position, and
7 the minority should consider the majority's position. You should
8 carefully consider and respect the opinions of each other and
9 reevaluate your position for reasonableness, correctness, and
10 impartiality.

11 You must lay aside all outside matters and reexamine the
12 questions before you based on the law and evidence in this case.

13 If you do not agree on a verdict in this case I must declare
14 a mistrial. In that case, it does not mean that anybody wins.
15 It just means that at some point in a future time I will try this
16 case again with some other jury sitting where you now sit. The
17 same participants will come, and the same lawyers will ask
18 basically the same questions, and give basically the same
19 answers, and we will go through the whole process again.

20 You were selected in the same manner and from the same
21 source as any future jury will be, and there is no reason for me
22 to suppose that the case will ever been submitted to 12 more
23 intelligent, impartial, conscientious, and competent jurors than
24 you, or that any more clearer evidence will be produced for one
25 side or the other.

1 I, therefore, ask you to return to your deliberations with
2 the hope that you can arrive at a verdict within a reasonable
3 period of time. You may return to your jury room.

4 (Jury escorted out of the courtroom at 3:45 p.m.)

5 THE COURT: Any exceptions from either the plaintiff or the
6 defense?

7 ATTORNEY BURKE: None from the plaintiff, Your Honor.

8 ATTORNEY SMYTH: No, Your Honor.

9 THE COURT: We'll mark these notes as a Court's exhibit.
10 Also for the record, we had previously received the first note
11 from the jury foreperson asking for the jury instructions in
12 writing back in the jury room, which I met with both sides, and
13 both parties agreed to provide those to the jury, and they were
14 provided to the jury. So we will mark both of those as Court's
15 exhibits.

16 And no objections to that, as well; is that correct?

17 ATTORNEY TANENBAUM: No, Your Honor.

18 ATTORNEY SMYTH: No, Your Honor.

19 THE COURT: Thank you.

20 (Court's Exhibits 5 and 6 are marked for identification.)

21 (Court recessed at 3:45 p.m. and reconvened at 4:33 p.m.,
22 without the jury.)

23 JURY QUESTION(S)

24 THE COURT: All right. We have received another note from
25 the jury which I have reviewed with both parties, and both

1 parties agree as to bringing the jury back in and explaining to
2 them as to -- the note says: As, we, the jury move closer to
3 unanimous decision, if we find the defendant deviated from the
4 standard of care, no. 1, but not deviation causing plaintiff's
5 injury, can we understand the ramifications to the defendant?

6 The discussion I had with counsel was that it appears that
7 they say although he deviated from the standard of care, question
8 no. 1 would be yes on the verdict form, but as to the no. 2, that
9 it was not the proximate cause of the plaintiff's injuries, then
10 they must stop their deliberations.

11 Is there any objection to me instructing the jury that way?

12 ATTORNEY BURKE: Well, I think the question is what are the
13 ramifications if they find proximate cause, right?

14 THE COURT: Right. Can we understand the ramifications to
15 the defendant. So the answer would then be no. I mean, if
16 that's where they stop their deliberations, that's beyond the
17 jury's question.

18 ATTORNEY SMYTH: And that's exactly what the jury
19 questionnaire says -- or, the verdict form, I mean, Your Honor.

20 ATTORNEY BURKE: We're looking at the verdict form, Your
21 Honor.

22 ATTORNEY TANENBAUM: If answer of question no. 1 would be
23 yes, then the answer to question 2 would be, unfortunately, no.
24 And I oppose it.

25 THE COURT: I understand your objection.

1 ATTORNEY TANENBAUM: Then that means the plaintiff gets no
2 money.

3 THE COURT: Well, basically they want to understand what the
4 ramifications are, which I have to tell them I can't tell them
5 that. If their answer is no to that question, then they must
6 stop their deliberation.

7 ATTORNEY TANENBAUM: I'll stand silent with that, Your
8 Honor.

9 THE COURT: Thank you, Mr. Tanenbaum. All right. Let's
10 have our jury, please. Oh, and it does say, As we move closer to
11 unanimous, so they're not unanimous.

12 (Jury seated in the courtroom at 4:37 p.m.)

13 THE BAILIFF: All jurors present, Your Honor.

14 THE COURT: Thank you. Welcome back, ladies and gentlemen
15 of the jury. I'm in receipt of your question, and I'll go
16 through it with you. It states: As, we the jury, move closer to
17 a unanimous decision, if we find the defendant deviated from the
18 standard of care, no. 1 -- so that would be the first question.
19 If you find that he deviated, unanimously, from the standard of
20 care, no. 1, you would check yes, which would then take you to
21 question no. 2. And no. 2, of course, is the proximate cause of
22 the plaintiff's injuries. If you find that the defendant did not
23 proximately cause the defendant's injuries, then you check no and
24 you stop your deliberations.

25 If you cannot come to a unanimous verdict or it's not

1 unanimous and you checked yes, then you go on to the damages.
2 But if you do not find that it is a proximate cause of the
3 plaintiff's injuries, then you stop your deliberations at that
4 point.

5 And at this juncture I would not be able to instruct you as
6 to any ramifications to the defendant.

7 Does that answer your question? If you'd all like to go
8 back to the jury room, if you have a further question, you can
9 write it down for me.

10 Are there any exceptions or objections from the Court's
11 instructions from the plaintiff or the defense?

12 ATTORNEY BURKE: None from the plaintiff, Your Honor.

13 ATTORNEY SMYTH: No, Your Honor.

14 THE COURT: I'll ask you to return to your jury room. And
15 hopefully that answers your question.

16 (Jury escorted out of the jury room at 4:38 p.m.)

17 THE COURT: We'll mark this as a Court's exhibit.

18 (Court's Exhibit 7 is marked for identification.)

19 (Court came to order at 4:55 p.m., without the jury.)

20 THE COURT: It's my understanding that we have a verdict.
21 Anything before I bring the jury out?

22 ATTORNEY TANENBAUM: Your Honor, I've been thinking about
23 this. It seems to me -- and this will be the subject of our
24 post trial motions, if necessary -- that all of the evidence in
25 the case is -- all of it on both sides -- that the reason that

1 this fatty necrotic tissue was created, so to speak, was a lack
2 of blood flow, adequate blood flow, whether it was, our position,
3 as a result of the inflow being reduced, or the defendant's, the
4 outflow being reduced. Their infectious diseases expert said
5 that; our expert said that; their expert said that; and the
6 defendant said that.

7 So I don't know how then that you'd find a breach of the
8 standard of care, because the only care given was this operative
9 procedure that did, in turn, cause the damages, and the plaintiff
10 would be entitled to a verdict. And I would ask the Court to
11 consider giving that instruction to the jury.

12 THE COURT: No, sir, not at this juncture.

13 ATTORNEY TANENBAUM: Yes, Your Honor. Thank you.

14 THE COURT: Thank you. Let's have our jury, please.

15 (Jury seated in the courtroom at 4:57 p.m.)

16 THE BAILIFF: All jurors present, Your Honor.

17 THE COURT: Welcome back, ladies and gentlemen of the jury.
18 Madam Forelady, have you reached a verdict?

19 THE FOREPERSON: Yes.

20 THE COURT: Would you please hand it to the bailiff.

21 (The Court receives the verdict.)

22 THE COURT: Madam Clerk, if you'd please publish.

23 VERDICT

24 CLERK OF COURT: State of South Carolina, County of
25 Charleston, in the Court of Common Pleas, Class Action No.

1 2018-CP-10-2109, Rebecca Turisk versus Dennis Schimpf and
2 Sweetgrass Plastic Surgery.

3 Did the plaintiff prove by a greater weight, or
4 preponderance of the evidence, that the defendant deviated from
5 the standard of care? Yes.

6 Did the plaintiff prove by a greater weight, or
7 preponderance of the evidence, that the defendant deviating from
8 the standard of care was the proximate cause of the plaintiff's
9 injuries? No.

10 THE COURT: Thank you, Madam Clerk. Do either parties
11 require polling of the jury?

12 ATTORNEY SMYTH: Please, Your Honor.

13 CLERK OF COURT: Ladies and gentlemen of the jury, I will
14 call out your number and, when I do, please raise your hand. I
15 will ask each of you two questions. Please answer yes or no.

16 Juror 277, please raise your hand. Is this your verdict?

17 JUROR NO. 277: Yes.

18 CLERK OF COURT: Is it still your verdict?

19 JUROR NO. 277: Yes.

20 CLERK OF COURT: Please be seated. Juror 179. Is this your
21 verdict?

22 JUROR NO. 179: Yes.

23 CLERK OF COURT: Is it still your verdict?

24 JUROR NO. 179: Yes.

25 CLERK OF COURT: Please be seated. Juror 157. Is this your

1 verdict?

2 JUROR NO. 157: Yes.

3 CLERK OF COURT: Is it still your verdict?

4 JUROR NO. 157: Yes.

5 CLERK OF COURT: Juror 216. Is this your verdict?

6 JUROR NO. 216: Yes.

7 CLERK OF COURT: Is it still your verdict?

8 JUROR NO. 216: Yes.

9 CLERK OF COURT: Juror 167 -- 163. Is this your verdict?

10 JUROR NO. 163: Yes.

11 CLERK OF COURT: Is it still your verdict?

12 JUROR NO. 163: Yes.

13 CLERK OF COURT: Juror 15. Is this your verdict?

14 JUROR NO. 15: Yes.

15 CLERK OF COURT: Is it still your verdict?

16 JUROR NO. 15: Yes.

17 CLERK OF COURT: Juror 231. Is this your verdict?

18 JUROR NO. 231: Yes.

19 CLERK OF COURT: Is it still your verdict?

20 JUROR NO. 231: Yes.

21 CLERK OF COURT: Juror 32. Is this your verdict?

22 JUROR NO. 32: Yes.

23 CLERK OF COURT: Is it still your verdict?

24 JUROR NO. 32: Yes.

25 CLERK OF COURT: Juror 146. Is this your verdict?

1 JUROR NO. 146: Yes.

2 CLERK OF COURT: Is it still your verdict?

3 JUROR NO. 146: Yes.

4 CLERK OF COURT: Juror 241. Is this your verdict?

5 JUROR NO. 241: Yes.

6 CLERK OF COURT: Is it still your verdict?

7 JUROR NO. 241: Yes.

8 CLERK OF COURT: Juror 97. Is this your verdict?

9 JUROR NO. 97: Yes.

10 CLERK OF COURT: Is it still your verdict?

11 JUROR NO. 97: Yes.

12 CLERK OF COURT: And, Juror 176. Is this your verdict?

13 JUROR NO. 176: Yes, ma'am.

14 CLERK OF COURT: Is it still your verdict?

15 JUROR NO. 176: Yes, ma'am.

16 CLERK OF COURT: Your Honor, the jury's been polled, and the
17 verdict stands.

18 THE COURT: Thank you, ma'am. Ladies and gentlemen of the
19 jury, if you'd please return to your jury room one last time,
20 I'll be in there momentarily to relieve you.

21 (Jury is escorted out of the courtroom at 5:01 p.m.)

22 THE COURT: Any other matters before I dismiss the jurors?

23 ATTORNEY TANENBAUM: Nothing further, Your Honor. Post
24 trial motions protected.

25 THE COURT: Yes, sir, 10 days. You need 10 days to file

1 them?

2 ATTORNEY TANENBAUM: Please.

3 THE COURT: Yes, sir. Anything further?

4 ATTORNEY TANENBAUM: Your Honor -- Oh, I'm sorry. Ten days,
5 I think, is going to put us at Thanksgiving. No, after
6 Thanksgiving. I just want to have a day or two.

7 THE COURT: I certainly don't have an objection to that.
8 The rules certainly allow for that, unless you have an objection
9 to it.

10 ATTORNEY TANENBAUM: Can we have two weeks and four days,
11 maybe? That would put us somewhere after Thanksgiving, which is
12 -- and we've got another trial starting on December 12th. Could
13 we have until December the 19th, Your Honor?

14 THE COURT: Any objection?

15 ATTORNEY SMYTH: No, Your Honor. I'm actually in the same
16 trial.

17 THE COURT: I've got a couple myself, so that's fine with
18 me. So, December 19th. That's fine.

19 ATTORNEY SMYTH: Thank you, Your Honor.

20 THE COURT: Thank you, everyone. I enjoyed working with you
21 all.

22 (Court adjourned at 5:02 p.m.)

23 (End of Transcript of Record, Volume IV of IV.)

CERTIFICATE OF REPORTER

I, Cathy J. Provost, Official Court Reporter for the Fourteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial/proceedings of the captioned case in the Court of Common Pleas for Charleston County, South Carolina, on the 17th day of November, 2022.

I do further certify that I am neither of kin, counsel, nor interest to any party hereto.

Date: January 7, 2023

/s/ Cathy J. Provost
Cathy J. Provost, RMR
Official Circuit Reporter

1 STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

2 COUNTY OF CHARLESTON

3 REBECCA TURISK,

4 Plaintiff,

5 vs. CASE NO. 2018-CP-10-2109

6 DENNIS K. SCHIMPF, M.D., AND

SWEETGRASS PLASTIC SURGERY, LLC,

7
8 Defendants.

9 DEPOSITION OF: FERNANDO A. HERRERA, M.D.

10 DATE: October 24, 2022

11 TIME: 2:20 p.m.

12 LOCATION: Medical University of South Carolina
College of Medicine
13 Department of Plastics
96 Jonathan Lucas Street
14 Suite 404, MSC 613
Charleston, SC 29425

15 TAKEN BY: Counsel for the Plaintiff

16 REPORTED BY: KAREN NELLIUS, RPR

17 _____
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25

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843-792-9089

Fairbaiv@musc.edu

1 ALSO PRESENT:

2 Zachary White, Legal Videographer

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4 (INDEX AT REAR OF TRANSCRIPT)
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2 THE VIDEOGRAPHER: All right. We are
3 now on the record. The time is 2:21 p.m. The date
4 is October 24th, 2022. This is the deposition of
5 Fernando A. Herrera, M.D. We are now on the
6 record.

7 FERNANDO A. HERRERA, M.D.,
8 being first duly sworn, testified as follows:

9 EXAMINATION

10 BY MS. BURKE:

11 Q. Good afternoon, Dr. Herrera. I know we
12 met before off record. I'm Beth Burke, and I
13 represent your patient, Rebecca Turisk.

14 Could you please state your full name
15 for the record.

16 A. It's Fernando Antonio Herrera.

17 Q. And do you understand that this
18 proceeding today is a trial preservation deposition
19 to be played at trial before the jury in lieu of
20 your live testimony?

21 A. Yes.

22 Q. Where do you practice medicine?

23 A. At the Medical University of South
24 Carolina.

25 Q. And where are we today taking this

1 deposition?

2 A. At the Medical University of South
3 Carolina.

4 Q. What is your current job title or job
5 position at MUSC?

6 A. Professor of surgery in the division of
7 plastic surgery.

8 Q. Where did you grow up?

9 A. Kansas City.

10 Q. Kansas City. Did you always want to be
11 a doctor when you grew up?

12 A. I did.

13 Q. Good for you. Congratulations.

14 A. Thank you.

15 Q. Where did you go to college?

16 A. University of Kansas.

17 Q. And for medical school?

18 A. Boston University.

19 Q. Did you complete any residencies?

20 A. I did.

21 Q. In what fields did you complete a
22 residency?

23 A. General surgery and plastic surgery.

24 Q. Did you complete any fellowships?

25 A. I did.

1 Q. What fellowships?

2 A. Hand surgery.

3 Q. Are you board certified?

4 A. I am.

5 Q. What does it mean to be board
6 certified?

7 A. Good question. It just means that the
8 governing body, whichever board you are certified
9 by, stands behind you and you've passed the
10 qualifications to be a safe surgeon.

11 Q. Are all physicians board certified?

12 A. I don't think all physicians are board
13 certified.

14 Q. And what do you do to become board
15 certified?

16 A. After completing your training, you
17 have to take a written exam and usually an oral
18 exam and to pass those successfully.

19 Q. Okay. Have you ever testified in court
20 or at a deposition as an expert witness?

21 A. I have not.

22 MS. BURKE: Okay. At this time I move
23 to admit Dr. Herrera as an expert in the field of
24 plastic surgery.

25 MR. SMYTH: No objection.

1 BY MS. BURKE:

2 Q. Doctor, will you agree today that any
3 opinions that you give will be to a reasonable
4 degree of medical certainty in the field of plastic
5 surgery?

6 A. I do.

7 Q. As a part of your practice, do you
8 treat patients such as Rebecca Turisk who have
9 experienced an infection postoperatively?

10 A. I do.

11 Q. Is Rebecca Turisk a current patient of
12 yours at MUSC?

13 A. She is.

14 Q. Is there a particular office or
15 facility where you normally see Rebecca?

16 A. I believe I've seen her at several
17 offices. I would have to double-check.

18 Q. So not always downtown?

19 A. Not always downtown.

20 Q. Okay. Can you tell the jury
21 approximately how long you've been treating
22 Rebecca.

23 A. I'd probably have to refer to your
24 book --

25 Q. Sure.

1 A. -- if that's okay, but I believe it was
2 2016, '17.

3 Q. And I think that's about right. And so
4 if you started seeing her in approximately 2016 or
5 2017, how long has that been?

6 A. It's about seven -- well, about six
7 years.

8 Q. Okay. How would you describe your
9 physician/patient relationship with Rebecca?

10 A. I think we have a very good
11 physician/patient relationship.

12 Q. How would you describe Rebecca as a
13 patient?

14 A. I think she is a very good patient, a
15 very nice person.

16 Q. Were you aware prior to today that
17 Rebecca had filed a lawsuit against Dr. Schimpf for
18 her injuries related to the November 1st, 2016
19 surgeries you performed on her?

20 A. I was aware prior to today.

21 Q. Is this the first deposition you've
22 given in this case?

23 A. It is not.

24 Q. And have you been questioned by counsel
25 for Dr. Schimpf prior to today?

1 A. For a previous deposition, yes.

2 Q. Okay. I'm going to hand you what the
3 court reporter has marked for me as Exhibits 1
4 through 6. If you could just look through these
5 documents, and then I'll ask you some questions
6 about them.

7 MR. TANENBAUM: Beth, while he is
8 reviewing those, let's go off the record.

9 MS. BURKE: Okay. We'll go off the
10 record.

11 THE VIDEOGRAPHER: Off the record at
12 2:26.

13 (A recess transpired.)

14 THE VIDEOGRAPHER: On the record at
15 2:42.

16 (PLAINTIFF EXHIBIT 1A-C, PHOTOGRAPHS,
17 was marked for identification.)

18 (PLAINTIFF EXHIBIT 2A-B, PHOTOGRAPHS,
19 was marked for identification.)

20 (PLAINTIFF EXHIBIT 3, PHOTOGRAPH, was
21 marked for identification.)

22 (PLAINTIFF EXHIBIT 4A-B, PHOTOGRAPHS,
23 was marked for identification.)

24 (PLAINTIFF EXHIBIT 5A-G, PHOTOGRAPHS,
25 was marked for identification.)

1 (PLAINTIFF EXHIBIT 6A-HH, PHOTOGRAPHS,
2 was marked for identification.)

3 BY MS. BURKE:

4 Q. Dr. Herrera, have you had an
5 opportunity to review the documents that have been
6 handed to you and have been marked as Exhibits 1
7 through 6 to your deposition?

8 A. I have.

9 Q. Were you able -- have you ever seen
10 those documents before today?

11 A. I have.

12 Q. And what -- what are the documents that
13 comprise Exhibits 1 through 6?

14 A. These are pictures of Rebecca Turisk's
15 breasts and I believe some of her torso.

16 Q. Okay. Did you or someone else working
17 at MUSC take these photographs?

18 A. Yes.

19 Q. Did you take some of them?

20 A. Some of them.

21 Q. Can you tell us which ones you took, if
22 you can recall?

23 A. Probably offhand I don't know. Most of
24 the ones that appear to be in clinic by, like, a
25 door or a background.

1 Q. Okay. Why were these photographs
2 taken?

3 A. We take a lot of photographs in plastic
4 surgery to document wounds, document postoperative
5 care and outcome.

6 Q. Are these a fair representation of
7 Rebecca's appearance at the time the photographs
8 were taken?

9 Are they accurate?

10 A. Yes.

11 Q. Were these photos taken as a part of
12 Rebecca's care at MUSC?

13 A. Yes.

14 Q. Were these photos kept in Rebecca's
15 medical chart at MUSC in the normal course of
16 business?

17 A. Yes.

18 Q. Do you know what surgeries Dr. Schimpf
19 performed on Rebecca before she became your
20 patient?

21 A. I do not.

22 Q. Dr. Herrera, can you take a look at the
23 group of photos that's been marked as Exhibit 1.

24 Can you take a look at Exhibit 1 and
25 tell the jury what Exhibit 1 shows.

1 A. Exhibit 1, there are three parts, A, B,
2 and C. They appear to show her breasts, both of
3 them. I believe the first is the right breast, the
4 second is the right breast, and the third is the
5 left breast.

6 Q. Can you tell the jury the date on those
7 photos?

8 A. It looks like November 30th, 2016.

9 Q. And were these photographs in your
10 medical chart at MUSC?

11 A. They were in the medical chart,
12 correct.

13 Q. Okay. Do you recall when your first
14 encounter was with Rebecca?

15 A. I do not recall. I would have to refer
16 to the notes.

17 Q. Okay. And I think we talked off the
18 record. You have some notes in front of you?

19 A. Correct.

20 Q. If you can flip through there and see
21 if you recognize the note that might be your first
22 visit with Rebecca.

23 MR. SMYTH: Beth, I don't have a copy
24 of what he is looking at.

25 MS. BURKE: Do you have --

1 MR. SMYTH: It's not in evidence, so...

2 MS. BURKE: It's just for him to
3 reference. But here is what he has. I'll take
4 yours. You can have Mark's copy.

5 THE WITNESS: 12/3/2016, it looks like
6 the first time she was here.

7 BY MS. BURKE:

8 Q. Do you recall anything about your first
9 encounter with Rebecca independent of your medical
10 records?

11 A. I don't understand the question.

12 Q. Oh, sorry. Never mind, then.

13 Can -- what can you tell us about
14 Rebecca's condition around the 3rd of December,
15 2016, when she became your patient?

16 A. She had some wounds or poor healing
17 areas after breast surgery.

18 Q. Are those wounds and areas of poor
19 healing depicted in the photograph in Exhibit 1?

20 A. Yes.

21 Q. Did you provide -- did you do any
22 procedures on Rebecca around that time?

23 A. Around the time, you mean within days
24 or weeks or months?

25 Q. Yes. Within -- well, when she became

1 your patient around the 3rd of December of 2016 was
2 she admitted at the Medical University of South
3 Carolina hospital?

4 A. I believe she was.

5 Q. She was inpatient, correct?

6 A. Correct.

7 Q. Okay. Did you perform a physical
8 examination of her?

9 A. I did.

10 Q. Did you perform any debridements on
11 her?

12 A. I did.

13 Q. Can you tell the jury what a
14 debridement is.

15 A. A debridement is removal of nonviable
16 tissue.

17 Q. And why was it necessary to perform
18 debridement on Rebecca at that time?

19 A. The wounds were not healing because of
20 nonviable tissue in the wound bed.

21 Q. And what does -- what does a
22 debridement accomplish?

23 A. It cleans the area to allow it to heal.

24 Q. And during the course of time that
25 Rebecca was your patient, did you perform more --

1 did you perform more than just one debridement on
2 her?

3 A. Yes.

4 Q. Okay. Do you have a rough idea of how
5 many?

6 A. I don't.

7 Q. Okay. And in performing -- is it your
8 opinion that Rebecca needed debridements?

9 A. Yes.

10 Q. And as a plastic surgeon, are you
11 trained to determine the tissues to be debrided?

12 A. Yes.

13 Q. Are you trained to tell the living
14 tissue from the nonviable tissue?

15 A. To a certain degree, yes.

16 Q. And what do you look at to make a
17 determination as to what is viable and what's
18 nonviable?

19 A. Color, vascularity. Those are probably
20 the two initial things I think about.

21 Q. And is it important to remove the
22 nonviable tissue?

23 A. Yes.

24 Q. And is it also important to leave
25 living tissue?

1 A. Yes.

2 Q. And are there -- and what is necrotic
3 tissue?

4 A. Necrotic tissue is essentially
5 nonviable tissue, tissue that's either died or
6 dying.

7 Q. So it's dead tissue?

8 A. Correct.

9 Q. Okay. And are there clinical signs of
10 tissue death or tissue necrosis?

11 A. Yes.

12 Q. What are some of those?

13 A. Color change, odor, drainage sometimes
14 can signify that.

15 Q. Are there clinical signs of fat
16 necrosis?

17 A. There are.

18 Q. What are some of those?

19 A. Usually hardness or -- fat is usually
20 bright kind of yellow or orange. So if the color
21 doesn't appear to look like that, it may signify
22 fat necrosis if you are looking directly at the
23 tissue.

24 Q. Okay. Did you see Rebecca in your
25 clinic after she was discharged from MUSC?

1 A. Yes.

2 Q. Did you perform any procedures on her
3 in the clinic setting?

4 A. I believe so.

5 Q. And what were those procedures?

6 A. Further debridements, I believe.

7 Q. And were those debridements also
8 necessary, in your opinion?

9 A. Yes.

10 Q. In the notebook in front of you, if you
11 could look at tab 5 for me.

12 A. Certainly.

13 MR. SMYTH: I'm going to object. There
14 is -- nothing in this notebook is in evidence so I
15 don't think he can look at that until it's in
16 evidence.

17 BY MS. BURKE:

18 Q. All right. We'll just go by your
19 memory, then --

20 A. Perfect.

21 Q. -- if counsel is going to object to you
22 looking at your medical records.

23 Okay. So when you --

24 MR. SMYTH: I move to strike that.

25 MS. BURKE: Okay. Sure.

1 MR. SMYTH: That's a --

2 MS. BURKE: Sure.

3 MR. SMYTH: -- proper objection.

4 MS. BURKE: Sure.

5 BY MS. BURKE:

6 Q. When you next saw Rebecca in your
7 clinic, you mentioned that you did some
8 debridements, correct?

9 A. Correct.

10 Q. And do you recall the purpose of the
11 debridements?

12 A. Just to get healthy tissue at the wound
13 bed.

14 Q. And did you perform debridements on
15 both her right and left breast?

16 A. I don't recall without looking at my
17 notes.

18 Q. Okay. Do you recall -- and the
19 pictures are in evidence. You are welcome to look
20 at those.

21 MR. SMYTH: No, they are not in
22 evidence.

23 MS. BURKE: I think I've authenticated
24 them and they are in evidence.

25 MR. SMYTH: There has been no offer of

1 the photos in evidence.

2 BY MS. BURKE:

3 Q. Okay. We're going to back up just a
4 minute, Dr. Herrera.

5 MS. BURKE: At this time I would like
6 to offer the photos in Exhibits 1 through 6 into
7 evidence.

8 MR. SMYTH: I need to know what's in
9 Exhibit 6. We haven't -- I haven't been provided
10 with what's been removed or changed from the photos
11 that we were provided, so I don't know what's --

12 MS. BURKE: Okay. We'll go off the
13 record. Here is what we took out.

14 THE VIDEOGRAPHER: Off the record at
15 2:53.

16 (A recess transpired.)

17 MR. SMYTH: I've had a chance to review
18 Exhibit 6 now, and I think we agree among counsel
19 that six photographs were taken out of the
20 plaintiff's abdomen, all from the date of July
21 24th, 2019. Is that agreed?

22 MS. BURKE: I know I removed six
23 photographs. I'm not even sure the date, either,
24 because I don't have the copies. So he has got my
25 copy.

1 MR. SMYTH: You are welcome to look at
2 mine if you want to compare them.

3 MS. BURKE: Sure.

4 MR. SMYTH: I've put an X on the bottom
5 of the page of each one you pulled out.

6 MS. BURKE: I agree that we took out
7 pictures of the abdomen. I don't think they are
8 relevant -- or not as relevant as the breast
9 pictures. There is one photograph in the stack
10 that Dr. Herrera is testifying to which are the
11 exhibits. Because the exhibits are double-sided,
12 there is one picture of the torso that is on the
13 back of a breast picture and we have left it in but
14 we did not mark it. We'll clean it up before we go
15 to trial.

16 MR. SMYTH: That's from the same date,
17 July 24th?

18 MS. BURKE: It appears to be, yeah.

19 MR. TANENBAUM: Now, let's deal with
20 the chart. Since you don't have a copy of your
21 chart present, other than what we brought...

22 MR. FAIRBAIRN: No. He has a copy of
23 all the medical records that were subpoenaed.
24 Again, I can't remember whose last subpoena came
25 in...

1 MR. TANENBAUM: For?

2 MS. FAIRBAIRN: Everything.

3 MR. TANENBAUM: For everything. Let's
4 use your chart. Okay?

5 MR. FAIRBAIRN: But that's not going to
6 be Bates stamped. It's not going to have any
7 designation on it.

8 MR. TANENBAUM: That's okay.

9 MS. BURKE: All right. Thank you.

10 MS. O'NEAL: That encompasses all
11 dates?

12 MR. SMYTH: The other thing you want to
13 make sure of that it doesn't have any reference
14 to --

15 MR. TANENBAUM: It's got to be redacted.
16 We've got a bunch of redactions to do.

17 So, here is what I'm going to suggest.
18 Let's give him the notebook that we've prepared
19 that's chronologically ordered. We'll go through
20 and either agree upon redactions or --

21 MS. BURKE: I think we let the doctor
22 testify to his chart.

23 MR. TANENBAUM: Okay.

24 MS. BURKE: I mean, he needs to be
25 comfortable at his deposition. That's who I'm

1 worried about. I'm worried about Dr. Herrera.

2 MR. FAIRBAIRN: I will just tell you,
3 like, the copy they sent him is not tabbed. It's
4 going to be difficult for him to find things, but
5 that was in response to the subpoena for the
6 deposition.

7 MS. BURKE: Okay. All right. All
8 right.

9 MR. TANENBAUM: We'll go through --

10 MS. BURKE: This is coming in as
11 evidence.

12 MR. TANENBAUM: Well, after we get
13 through redacting it. But it will be marked as an
14 exhibit today. Okay?

15 MR. SMYTH: I think we have to --
16 unless you are going to put the whole thing in. I
17 haven't had a chance to review the whole thing. So
18 I guess maybe the thing to do is to use each visit
19 that you are going to use as a separate exhibit.

20 MS. BURKE: Okay. We'll do it that
21 way.

22 MR. SMYTH: That way we can keep track
23 of what's been used since it's not Bates stamped.
24 I don't know if y'all redacted this or not. No?

25 MS. BURKE: No.

1 MR. SMYTH: So, yeah. That is my
2 hesitancy. I'd hate to get all dressed up for a
3 week-long trial and then have a mistrial because we
4 didn't --

5 MS. BURKE: And I've got to tell y'all,
6 I'm going to go back to trying not to refer him to
7 the records. I'm going to try to be very general,
8 but if I have to refer him to a record, I will take
9 it from this notebook.

10 MR. TANENBAUM: Okay.

11 MS. BURKE: But I'm going to try to go
12 back to what he knows.

13 BY MS. BURKE:

14 Q. And if you need to refer to a record,
15 ask me, and I will pull it for you.

16 A. Okay.

17 Q. Okay. All right.

18 MR. TANENBAUM: Thank you.

19 MS. BURKE: Okay. I know you want to
20 get through this. We'll get through it together.

21 THE VIDEOGRAPHER: Do you want to go
22 back on the video record?

23 MS. BURKE: We're going to go back on
24 the video record because I'm going to go back and
25 re-authenticate the photographs and then move them

1 into evidence and then I will get on with my
2 examination.

3 THE VIDEOGRAPHER: All right. On the
4 record at 3:02.

5 BY MS. BURKE:

6 Q. Hello, Dr. Herrera. Before you we have
7 marked Exhibits 1 through 6, which I believe you
8 previously reviewed.

9 A. Correct.

10 Q. I'm going to ask you a couple of
11 questions about these exhibits. Do you recognize
12 the documents found in Exhibits 1 through 6?

13 A. I do.

14 Q. What are the documents found in
15 Exhibits 1 through 6?

16 A. These are photos of Rebecca Turisk.

17 Q. And did you or someone else working at
18 MUSC take these photographs?

19 A. Yes.

20 Q. Okay. And why were these photographs
21 taken?

22 A. To document her wounds, as well as her
23 pre- and postoperative care.

24 Q. And are these photographs a fair and
25 accurate representation of Rebecca's appearance at

1 the time the photographs were taken?

2 A. I believe so.

3 Q. And were these photographs taken as
4 part of Rebecca's care at MUSC?

5 A. Yes.

6 Q. And were these photos kept in Rebecca's
7 medical chart at MUSC in the normal course of
8 business?

9 A. Yes.

10 Q. Okay. And, Dr. Herrera, I think we
11 already talked about Exhibit 1, but if you wouldn't
12 mind pulling that one out again.

13 A. Sure.

14 Q. And can you tell me what is reflected
15 in Exhibit 1?

16 A. Exhibit 1 has three photos. 1A and 1B
17 appear to be her right breast and 1C appears to be
18 her left breast.

19 Q. And what was the date those photographs
20 were taken?

21 A. November 30th, 2016.

22 Q. Okay. And we talked a couple minutes
23 ago about the fact that you saw Rebecca as an
24 inpatient at the Medical University of South
25 Carolina around the 3rd of December. Do you recall

1 that?

2 A. Yes.

3 Q. Okay. And I hate to recap everything,
4 but then we talked briefly that you saw her in your
5 clinic after she was discharged; is that correct?

6 A. Correct.

7 Q. At some point during your care and
8 treatment of Rebecca, did you determine that
9 surgery was an appropriate treatment for her?

10 A. Yes.

11 Q. And what surgery did you recommend to
12 Rebecca?

13 A. Well, she had several surgeries, but
14 initially at this time debridement of the nonviable
15 tissue.

16 Q. And we talked about debridement. So
17 you did some debridements in the clinic, correct?

18 A. Correct.

19 Q. And then did you then bring her into
20 the hospital and do a debridement in the operating
21 suite?

22 A. Yes.

23 Q. And do you remember -- do you remember
24 that surgery?

25 A. It was some time ago.

1 Q. Would your operative note assist you?

2 A. Sure.

3 Q. Okay.

4 MS. BURKE: All right, Todd. This is
5 the operative note for the February 24th, 2017
6 surgery at tab 11.

7 MR. SMYTH: Thank you.

8 MS. BURKE: I'll give you a moment just
9 to look at that.

10 I didn't do it?

11 I didn't do it.

12 All right. While he is reviewing his
13 operative note, I'm going to back up and I'm going
14 to move to admit the photographs of Exhibits 1
15 through 6 into evidence.

16 MR. SMYTH: Without objection.

17 MS. BURKE: Thank you very much. I
18 appreciate that.

19 THE WITNESS: I have reviewed those,
20 the operative report.

21 BY MS. BURKE:

22 Q. Okay. And, Dr. Herrera, I'm going to
23 let the court reporter mark that as Exhibit 7 to
24 your deposition.

25 (PLAINTIFF EXHIBIT 7, MEDICAL RECORDS,

1 BATES STAMPED TURISK-MUSC-0400-0403, was marked for
2 identification.)

3 BY MS. BURKE:

4 Q. Dr. Herrera, can you tell the jury what
5 is Exhibit 7.

6 A. This is an operative report from
7 February 24th, 2017.

8 Q. And is that an operative report that
9 was prepared by you?

10 A. Yes.

11 Q. Was it prepared in the normal course of
12 your job as a physician at MUSC?

13 A. Yes.

14 Q. Was that report kept in Rebecca's
15 medical chart at MUSC in the normal course of
16 business?

17 A. Yes.

18 MS. BURKE: At this time I would move
19 Exhibit 7 into evidence.

20 MR. SMYTH: No objection.

21 BY MS. BURKE:

22 Q. All right. Dr. Herrera, you mentioned
23 that Exhibit 7 is an operative report. What kind
24 of surgery was -- did you perform on Rebecca?

25 A. This was a surgical debridement of her

1 -- both her breasts.

2 Q. And what was the date of that surgery?

3 A. That was 2/24/2017.

4 Q. And in your operative report, did you
5 have a preoperative diagnosis?

6 A. Yes.

7 Q. And what was that?

8 A. Left breast fat necrosis and right
9 breast chronic open wound, status postremoval of
10 implants and reduction mammoplasty with nipple
11 necrosis of the right nipple.

12 Q. And did you describe the procedure you
13 performed in your operative note?

14 A. I did.

15 Q. And you called it a debridement. But
16 in your operative report, did you just -- did you
17 use a different word to describe the procedure?

18 A. I did. I called it -- it was -- I
19 guess it was more than a debridement. So this was
20 removal of the fat necrosis and nonviable tissue.
21 And for the left I believe I called it a subtotal
22 mastectomy and the right a completion mastectomy.

23 Q. Do you recall why you did a subtotal on
24 the left and a complete on the right?

25 A. The right was much worse at the

1 beginning when I met her with nipple necrosis and
2 clearly nonviable breast tissue. The left was not
3 healing well but was not complete fat necrosis.

4 Q. Was Rebecca under anesthesia for the
5 mastectomies?

6 A. Correct.

7 Q. Is it your opinion that mastectomy was
8 the appropriate treatment for Rebecca's right and
9 left breast at this time?

10 A. Yes, it was.

11 Q. What were your goals for the total
12 mastectomy on the right?

13 A. To remove all nonviable tissue.

14 Q. And what were your goals for the
15 subtotal mastectomy on the left?

16 A. The same.

17 Q. Do patients experience pain post
18 mastectomy?

19 A. Certainly.

20 Q. Did you prescribe postoperative pain
21 medications to Rebecca?

22 A. I don't have her chart, but I'm certain
23 that she was prescribed postop pain medications.

24 Q. Would it be reasonable under the
25 circumstances to prescribe postoperative

1 medications?

2 A. I don't think so.

3 Q. Okay. Let's take a look at Exhibit 2.

4 Dr. Herrera, do you recognize Exhibit 2?

5 A. I do.

6 Q. And what is Exhibit 2?

7 A. This is Rebecca Turisk. This is her --
8 both her breasts on 2A and 2B.

9 Q. Is this -- do you recall when this
10 photograph was taken?

11 A. I don't recall, but I think it was in
12 early December. It's dated up here on the top of
13 the photograph.

14 Q. Okay. Correct. Do you remember seeing
15 Rebecca in your clinic postoperatively after the
16 mastectomies?

17 A. I briefly do.

18 Q. Okay. And Exhibit 2 was prior to the
19 mastectomies, correct?

20 A. I believe so, yes.

21 Q. All right. Take a look at Exhibit 4.
22 Can you tell me the date of Exhibit 4?

23 A. It appears to be March 15th, 2017.

24 Q. And is that photograph after the
25 mastectomies in February?

1 A. It is.

2 Q. What does this photograph depict?

3 A. It shows that her wound is now closed
4 on the right breast and healing reasonably well on
5 the left.

6 Q. When you say the wound is now closed,
7 was the wound open previously?

8 A. Yes.

9 Q. Is that one of the reasons why she
10 needed the mastectomy?

11 A. I think the wound was open because it
12 wasn't healing because of the tissue that was
13 necrotic as well.

14 Q. So when you did the mastectomy, how did
15 that help with the wound healing?

16 A. Removed everything that was necrotic
17 and allowed it to heal appropriately.

18 Q. And when -- will a wound heal when it's
19 open?

20 A. It will eventually. An open wound will
21 heal as long as it's healthy.

22 Q. Were Rebecca's wounds healthy?

23 A. Not at the beginning.

24 Q. Okay. Do you remember what your next
25 procedure you performed on Rebecca was?

1 A. I don't recall offhand. I would
2 probably have to refer to my notes.

3 Q. Okay. Let me go about it this way.
4 After you performed the mastectomies on Rebecca,
5 did you perform any lipo grafting on her?

6 A. I certainly did.

7 Q. Why did Rebecca need lipo grafting?

8 A. Well, the goal was to, once the wounds
9 were healed and closed, to re-create a breast mound
10 as best we could, having had removed all the
11 necrotic breast tissue from, you know, the previous
12 surgery. So she wanted to have a better appearing
13 breast.

14 Q. And when you did the mastectomy on the
15 right, do you have an idea of what percentage of
16 her breast tissue you removed?

17 A. It's hard to say for sure, but I feel
18 the majority of it on the right side.

19 Q. Is that why you called it a total
20 mastectomy in your operative note?

21 A. Correct.

22 Q. And what about the left side?

23 A. Probably 40 percent.

24 Q. Okay. So is it your opinion to a
25 reasonable degree of medical certainty that the fat

1 grafting procedures that you performed on Rebecca
2 were medically necessary?

3 A. I think they were necessary to give her
4 an improved-appearing breast. It's hard to call it
5 medical necessity. I think the wounds were closed,
6 but they were not symmetric and a less than an
7 ideal cosmetic result.

8 Q. Did Rebecca have pain in her breast due
9 to the postoperative complications from
10 Dr. Schimpf's surgery?

11 A. I'm not certain. I think she did have
12 some pain in her breasts at some point, but I would
13 have to refer to any notes that would state that.

14 Q. Did she have pain following the
15 mastectomies?

16 A. Certainly she had some pain as she was
17 healing.

18 Q. Okay. Did you also do scar revision on
19 Rebecca's breast?

20 A. Yes.

21 Q. And what was the purpose of the scar
22 revision?

23 A. Again, trying to improve the appearance
24 of the breasts.

25 Q. Can scar tissue be painful?

1 A. It can be.

2 Q. Do you recall if any of the scar
3 revisions you did on Rebecca were to help relieve
4 her pain?

5 A. I can't recall.

6 Q. Do you recall Rebecca having a scar
7 that was tethered?

8 A. I do.

9 Q. Okay. Do you recall if you performed
10 any surgery on Rebecca to help relieve the
11 tethering?

12 A. I did.

13 Q. Okay. And do you think that relieved
14 her pain?

15 A. I don't know.

16 Q. Okay. So do you recall how many fat
17 grafting procedures you performed on Rebecca?

18 A. I believe it was four, but I'm not
19 certain without looking at my notes.

20 Q. Okay. And when you -- when you first
21 talked with Rebecca about fat grafting, did you
22 anticipate that she would need more than one
23 procedure?

24 A. Absolutely.

25 Q. Okay. And why is that?

1 A. The degree of volume loss -- we
2 certainly do one or two maybe three rounds for
3 contour deformities. I think with the volume loss
4 that she had that was going to be at least a
5 minimum of three to four.

6 Q. Okay. How -- how do you harvest the
7 fat for the fat grafting?

8 A. Standard techniques with liposuction,
9 power assisted.

10 Q. And what areas of the body do you
11 harvest fat from?

12 A. It can be anywhere. It depends what
13 the patient has available. Usually the torso, the
14 abdomen, thighs certainly, back sometimes.

15 Q. And did you harvest fat from all of
16 those areas for Rebecca?

17 A. I believe I did.

18 Q. And when you are harvesting fat for
19 liposuction for fat grafting, do you need to move
20 around to different sites to harvest fat or can you
21 just keep harvesting from the same place?

22 A. No. You need to move around. You
23 create scar. So if you are going back, you can't
24 always use the same -- can't use the site every
25 time because you may not get adequate fat.

1 Q. Okay. Do you remember where you
2 harvested first from Rebecca?

3 A. I don't remember, but I'm -- I don't
4 know.

5 Q. Are there places on the body that are
6 better for harvesting than others?

7 A. Certainly the abdomen is the first
8 choice for most people.

9 Q. Okay. And after you harvest fat from
10 the abdomen, if you have to go back and do another
11 procedure, you then look to a different location?

12 A. Occasionally.

13 Q. Okay. And when you did the fat
14 grafting on Rebecca, was she under anesthesia?

15 A. Yes.

16 Q. Is that considered a surgery?

17 A. Yes.

18 Q. Okay. What kind of anesthesia did she
19 get?

20 A. I believe it was general.

21 Q. Okay. So in other words she was under?
22 She was asleep?

23 A. Yes.

24 Q. Okay. And you mentioned that Rebecca
25 had four fat grafting procedures. Do you

1 anticipate performing more fat grafting on Rebecca
2 in the future?

3 A. Not likely.

4 Q. And why is that?

5 A. Last we spoke, I don't feel like she
6 wants to proceed with any more at this point, but I
7 haven't talked to her in a while.

8 Q. And are you also running out of areas
9 that you can harvest from for her?

10 A. That's probably true.

11 Q. Okay. And you mentioned that
12 liposuction -- did you say that liposuction causes
13 scarring?

14 A. It does some.

15 Q. Okay. All right.

16 MS. BURKE: I'm going to take a quick
17 break.

18 THE VIDEOGRAPHER: All right. Off the
19 record at 3:21.

20 (A recess transpired.)

21 THE VIDEOGRAPHER: On the record at
22 3:34.

23 MS. BURKE: Thank you.

24 (PLAINTIFF EXHIBIT 8, MEDICAL RECORDS,
25 BATES STAMPED TURISK-MUSC-0525-0527, was marked for

1 identification.)

2 BY MS. BURKE:

3 Q. Dr. Herrera, I'm going to take you back
4 a little bit. We kind of got to the end, so we
5 know where we are with Rebecca, and I want to go
6 back to the December 2016 period when she first
7 became your patient. And you have in front of you
8 Exhibit 8, correct?

9 A. Exhibit 8. Yes. Sorry. I thought you
10 said A.

11 Q. Have you had an opportunity to review
12 Exhibit 8?

13 A. Yes.

14 Q. Okay. And can you tell me what is
15 Exhibit A -- 8? I'm sorry.

16 Are they records found in Rebecca's
17 chart at MUSC?

18 A. Yes, they are.

19 Q. Okay. Were these records prepared in
20 the normal course of business?

21 A. Yes, they were.

22 Q. Were these records kept in Rebecca's
23 medical chart at MUSC in the normal course of
24 business?

25 A. Yes, they were.

1 MS. BURKE: At this time I would like
2 to move Exhibit 8 into evidence.

3 MR. SMYTH: Just so I'm clear, what are
4 the Bates stamps on it, please?

5 THE WITNESS: 0093 to --

6 BY MS. BURKE:

7 Q. They may not be --

8 A. -- in order. 9495.

9 MR. SMYTH: Let me see the exhibit.

10 BY MS. BURKE:

11 Q. Yeah. They may not be in chronological
12 order.

13 A. I think it moves around a little bit.

14 Q. It does jump around.

15 MR. TANENBAUM: Look in my notebook.
16 We'll cut this from the record. But if you can
17 look in my notebook, you'll see the numbers.

18 MR. SMYTH: Yeah. They are just
19 different numbers.

20 MS. BURKE: There are so many different
21 numbers.

22 MR. SMYTH: So that's why -- you said
23 tabs 4 and 5.

24 MS. BURKE: Yeah.

25 MR. SMYTH: Tab 5 is not -- doesn't

1 match up with what you just gave me, is what I'm
2 trying to correlate.

3 MS. BURKE: All right. Okay.

4 MR. SMYTH: May I see it one more time?

5 Thank you.

6 BY MS. BURKE:

7 Q. All right, Dr. Herrera. On page 0094
8 of Exhibit 8 --

9 Can you flip to that, please.

10 -- is this a record of a visit of yours
11 with Rebecca Turisk?

12 A. Yes.

13 Q. Okay. And at that point is Rebecca
14 hospitalized at MUSC?

15 A. I believe so.

16 Q. Can you tell from this record how many
17 days she has been in the hospital at this point?

18 A. I believe four.

19 Q. Okay. Are there -- are her date of
20 admission and her date of discharge on the record?

21 A. There are.

22 Q. Okay. And is that -- was that four
23 days total?

24 A. It appears to be.

25 Q. Okay. But at this point can you tell

1 -- did you make a note of which day of her
2 hospitalization she is in at this point?

3 A. It looks like day two.

4 Q. Okay. What was going on with Rebecca
5 day two of her hospitalization at MUSC?

6 A. I believe she was having some fevers,
7 she was getting some wound care, she was on some
8 pain medications, and she was getting some imaging,
9 it looks like.

10 Q. Okay. Was she on any medications --
11 any IV medications at that time?

12 A. I believe so.

13 Q. What was she on?

14 A. It looks like some antibiotics.

15 Q. Do you know why she was on antibiotics?

16 A. For a presumed infection.

17 Q. For a presumed infection?

18 A. Uh-huh.

19 Q. In what part of her body?

20 A. Of her breasts.

21 Q. Okay. In her right and left breast?

22 A. I think so.

23 Q. Okay. Did you describe -- did you
24 describe the appearance of her breast -- well, let
25 me back up.

1 Did you do a physical exam of
2 Ms. Turisk during this encounter with her?

3 A. Yes.

4 Q. Are your -- are the results of your
5 physical exam recorded in this note?

6 A. Yes, they are there.

7 Q. Okay. What did you find on your
8 examination of Ms. Turisk's breasts?

9 A. It was stated that she had
10 full-thickness necrosis, erythema, swelling,
11 tenderness, drainage, and dehiscence.

12 Q. And where was -- what is dehiscence?

13 A. Separation of the wound edges.

14 Q. Okay. So did that mean the wound was
15 open?

16 A. Correct.

17 Q. And where was the wound open?

18 A. Centrally, as I recall.

19 Q. And you said she had right breast full
20 tissue -- full-thickness necrosis?

21 A. Correct.

22 Q. What was the condition of her nipple on
23 the right at that time?

24 A. I believe at that time she did not have
25 one.

1 Q. Do you know why she didn't have a
2 nipple?

3 A. I don't know.

4 Q. What does full -- what is
5 full-thickness necrosis?

6 A. Complete necrosis of a layer of skin.

7 Q. Okay. What -- did you say -- do you
8 pronounce it erythema or erythema?

9 A. Erythema.

10 Q. Erythema. Okay. What is erythema?

11 A. Yeah. It's redness.

12 Q. Okay. And what does redness indicate?

13 A. Would indicate infection.

14 Q. Okay. And what about the tenderness?

15 A. Same, could possibly refer to
16 infection.

17 Q. Swelling?

18 A. Certainly you have swelling for
19 anything after surgery.

20 Q. What was the mild drainage related to?

21 A. Her open wound.

22 Q. Okay. And do you believe she had an
23 infection at that point?

24 A. The tissue did not look healthy. It's
25 hard to say without a white count. However, she

1 was also on antibiotics.

2 Q. What antibiotic was she on?

3 A. According to this note, vancomycin.

4 Q. And how was that being given to her?

5 A. IV.

6 Q. Okay. So intravenous vancomycin?

7 A. Correct.

8 Q. Okay. And that -- the date of that
9 note is what, Dr. Herrera?

10 A. I believe that note says the 6th --

11 Q. Okay.

12 A. -- of December.

13 Q. All right. In that same -- in that
14 same exhibit, is there -- is there another notation
15 of a visit for you with Rebecca or is it just the
16 7th?

17 A. I think it's the 6th and the 7th.

18 Q. Okay. So did you see Rebecca on the
19 6th?

20 A. I did.

21 Q. Okay. What can you tell me about your
22 visit with Rebecca on the 6th?

23 A. I think the 6th is what we had just
24 discussed.

25 Q. I'm sorry. Is your note for the 7th in

1 there?

2 A. Yes.

3 Q. Let's talk about the 7th. Thank you.

4 A. Okay.

5 Q. Did you perform any procedures on
6 Rebecca on the 7th?

7 A. It looks like we -- or I may have done
8 a bedside debridement --

9 Q. Okay.

10 A. -- from what I can tell there.

11 Q. And why would you have done a bedside
12 debridement on the 7th?

13 A. To remove nonviable necrotic tissue.

14 Q. Okay. Did you schedule for her to
15 follow up with you in the clinic at MUSC?

16 A. I did.

17 Q. Okay. And your recollection is that
18 she did follow up?

19 A. She did.

20 Q. Okay.

21 MS. BURKE: Todd, this is 5 from the
22 binder.

23 (PLAINTIFF EXHIBIT 9, MEDICAL RECORDS,
24 BATES STAMPED TURISK-MUSC-0526-0527, was marked for
25 identification.)

1 BY MS. BURKE:

2 Q. I'm going to hand you what we'll mark
3 as Exhibit 9.

4 Dr. Herrera, before we look at 9, would
5 you pull out Exhibit 2 for me. And how many
6 photographs are there at Exhibit 2?

7 A. It appears to be two.

8 Q. Okay. And what are the dates of those
9 photographs?

10 A. It's hard to tell. It looks like 12/4
11 and 12/6.

12 Q. Okay.

13 MS. BURKE: Do we need to hold those up
14 for you, or -- okay. We don't. Okay. Great.

15 BY MS. BURKE:

16 Q. So based on the notes that we just
17 reviewed from December 6th and December 7th, do
18 these photographs at Exhibit 2, do these -- do they
19 reflect your findings in your notes?

20 A. Correct.

21 Q. And do you think the photograph at
22 Exhibit 2, which is dated December 6th, do you know
23 if that was done before or after your bedside
24 debridement?

25 A. It looks like it was after.

1 Q. Okay. What makes you think it was
2 after?

3 A. It looks like there was some central
4 skin area from photograph on 12/4 that was
5 debrided --

6 Q. Okay.

7 A. -- the best I can tell from these
8 photos.

9 Q. And it's her -- her right nipple is
10 absent in this picture, correct?

11 A. It looks like it.

12 Q. Okay.

13 Okay. Now we'll take a look at Exhibit
14 9.

15 MR. SMYTH: Tell me what the Bates
16 stamps are for Exhibit 9, please.

17 THE WITNESS: Exhibit 9? 0525, 0526,
18 and 0527.

19 BY MS. BURKE:

20 Q. Okay. All right, Dr. Herrera. Can you
21 tell us what you have in front of you that is
22 Exhibit 9?

23 A. This appears to be her clinic followup
24 after discharge from the hospital.

25 Q. Okay. And what did -- what did you do,

1 if anything, for Ms. Turisk at this appointment?

2 I guess, did you do a debridement at
3 this appointment?

4 A. It looks like we did.

5 Q. Okay. Did you do a debridement on the
6 right and left breast?

7 A. I believe it was only the right.

8 Q. Okay. What were your findings related
9 to her breast on your physical exam?

10 A. It says fibrinous necrotic tissue at
11 the base of the wound on the right. Appear to be
12 some hypertrophic scarring on the left.

13 Q. Okay. What is granulation tissue?

14 A. Kind of healing tissue. It can be scar
15 but somewhat healthy.

16 Q. Okay. Did you note any drainage on the
17 right?

18 A. It says minimal serous drainage
19 present.

20 Q. Okay. At this point Rebecca had been
21 on IV antibiotics at MUSC, correct?

22 A. Correct.

23 Q. Okay. You note -- did you note in your
24 assessment and plan anything about the status of
25 her infection?

1 A. I'm not sure what you refer to as the
2 status.

3 Q. That's okay. Was there any evidence of
4 infection at that visit?

5 A. There was persistent necrotic tissue.

6 Q. Is persistent necrotic tissue
7 indicative of an infection?

8 A. It's hard to say.

9 Q. Okay.

10 A. It's hard to answer.

11 Q. Sure. And you mentioned earlier that
12 you did do a debridement. And you noted in your
13 record that you debrided her back to healthy
14 tissue --

15 A. Correct.

16 Q. -- is that correct?

17 Why do you debride back to the healthy
18 tissue?

19 A. To allow it to heal.

20 (PLAINTIFF EXHIBIT 10, MEDICAL RECORDS,
21 BATES STAMPED TURISK-MUSC-0529-0532, was marked for
22 identification.)

23 BY MS. BURKE:

24 Q. Okay. Okay. All right. I'm going to
25 hand you what we'll mark as Exhibit 10.

1 MS. BURKE: And, Todd, this is I hope
2 the next tab. It's mine. 19th. 19th? We're all
3 squinting.

4 MR. SMYTH: 529?

5 MS. BURKE: I have 5/19.

6 MR. SMYTH: On the very bottom of the
7 page.

8 MS. BURKE: Yes. 529. I thought you
9 were giving me a date. My apologies.

10 Okay. We'll mark this as Exhibit 10.

11 BY MS. BURKE:

12 Q. All right. Dr. Herrera, I've handed
13 you what the court reporter has marked as Exhibit
14 10. Do you recognize Exhibit 10?

15 A. These appear to be notes from her
16 chart.

17 Q. Okay. Is this -- is this a note that
18 you prepared to document your care and treatment of
19 Rebecca?

20 A. Yes.

21 Q. Is this a document that's kept in
22 Rebecca's file at MUSC in the normal course of
23 business?

24 A. Yes.

25 Q. Is this a fair and accurate record of

1 your visit on that day?

2 A. Yes.

3 MS. BURKE: Okay. I'll move Exhibit 10
4 into evidence.

5 MR. SMYTH: No objection.

6 BY MS. BURKE:

7 Q. Okay. All right. Dr. Herrera, can you
8 tell the jury what is Exhibit 10.

9 A. These are notes from her chart.

10 Q. Is it an office visit with you?

11 A. I believe so.

12 Q. Okay. And what was the date of that
13 office visit?

14 A. It appears to be 12/19/2016.

15 Q. Okay. And can you tell the jury if you
16 did a debridement on Ms. Turisk on that date?

17 A. Yes.

18 Q. And did you perform a debridement on
19 the right and the left?

20 A. I believe it was just the right.

21 Q. Okay. And do you recall why you only
22 needed to debride the right on that day?

23 A. I don't recall.

24 Q. Okay. Did you make any notation about
25 the amount of debriding that you did that day?

1 A. I think it's documented in one of the
2 pages. Open wound debridement less than 20
3 centimeters. That's the CPT code. And I don't see
4 anywhere else where it mentions the amount of
5 debridement.

6 Q. Okay. When you -- did you -- did you
7 note that you debrided the wound to petechial
8 bleeding?

9 A. I did.

10 Q. And what does that mean?

11 A. It just means bleeding from the tissue,
12 which signifies healthy alive tissue.

13 Q. Okay. So that would be tissue with a
14 blood supply, right?

15 A. Correct.

16 Q. Okay.

17 THE VIDEOGRAPHER: Would you mind
18 moving your microphone down a little bit.

19 MS. BURKE: I don't mind at all. Okay.

20 (PLAINTIFF EXHIBIT 11, MEDICAL RECORDS,
21 BATES STAMPED TURISK-MUSC-0539, 540, 0542, was
22 marked for identification.)

23 BY MS. BURKE:

24 Q. Dr. Herrera, Exhibit 11 -- are we up to
25 11?

1 A. I think so.

2 Q. I wish I could say it was lucky number
3 11 and the last one. It might not be.

4 MR. SMYTH: Do you know what that is?

5 MS. BURKE: It's the December 28th
6 visit. It should be in that pack.

7 (Off-the-record conference.)

8 BY MS. BURKE:

9 Q. All right. Take a moment to review
10 that, Dr. Herrera.

11 MR. SMYTH: Are the Bates stamps on the
12 exhibit 539 to 542?

13 MS. BURKE: I hope so. That's what I
14 have.

15 THE WITNESS: Yes.

16 BY MS. BURKE:

17 Q. I can double-check it.

18 A. This one I can't tell. It doesn't have
19 one.

20 Q. Let me see.

21 A. But the last one is --

22 Q. That one is 611. And this is actually
23 Exhibit 3. So I'll just keep -- I'll keep this,
24 but the rest should be -- it should be 539
25 through --

1 A. 539, 540, and 542.

2 Q. Yes. Okay. All right. And,
3 Dr. Herrera, if you could, just take a look at
4 Exhibit 3 as well.

5 This is what it looks like.

6 All right. Dr. Herrera, you have
7 Exhibit 11 in front of you, correct?

8 A. Correct.

9 Q. Okay. What is Exhibit 11?

10 A. It appears to be a clinic visit.

11 Q. From what date?

12 A. From 12/28/2016.

13 Q. Okay. And, Dr. Herrera, is this a note
14 that you made in the normal course of your care and
15 treatment of Rebecca Turisk?

16 A. Yes.

17 Q. And this note was made contemporaneous
18 with your treatment of Rebecca.

19 A. Yes.

20 Q. And it was kept in your file in the
21 normal course of business?

22 A. Yes.

23 MS. BURKE: Okay. I'll move Exhibit 11
24 into evidence.

25 MR. SMYTH: No objection.

1 BY MS. BURKE:

2 Q. And, Dr. Herrera, did you perform a
3 debridement on Rebecca at this December 28th, 2016
4 visit?

5 A. I don't know.

6 Q. Okay. Take a look at Exhibit 3.

7 A. Okay.

8 Q. Does Exhibit 3 refresh your
9 recollection as to whether or not you did a
10 debridement?

11 A. It does. And it looks like I did.

12 Q. Okay. And what -- Exhibit 3 is a
13 photograph, correct?

14 A. Correct.

15 Q. And what is that a photograph of?

16 A. Of Ms. Turisk's right breast.

17 Q. Okay. And why did you take that
18 photograph that day?

19 A. To document her wound.

20 Q. And what were you -- what were you
21 measuring in the photograph?

22 A. I believe just the size of the wound
23 opening.

24 Q. Okay. And that wound depicted in
25 Exhibit 3, you said that was her right breast,

1 correct?

2 A. Correct.

3 Q. Is that wound where her nipple used to
4 be?

5 A. Correct.

6 Q. Okay. And was Ms. Rebecca -- was
7 Ms. Turisk going to continue to need debridement
8 beyond this report -- I mean, this date?

9 A. Most likely, yes.

10 Q. Okay. And was she referred elsewhere
11 for her wound care?

12 A. I believe we discussed somewhere closer
13 to home or a wound care center at Trident.

14 Q. Okay.

15 A. At some point.

16 Q. Was she still on antibiotics at this
17 visit?

18 A. I believe she completed her antibiotic
19 course.

20 Q. Okay. And those were the antibiotics
21 she was taking for the infection in her breast,
22 correct?

23 A. Correct.

24 Q. Okay. All right.

25 MS. BURKE: This is tab 8, Todd.

1 BY MS. BURKE:

2 Q. All right. Dr. Herrera, I'm going to
3 hand you what the court reporter will mark as
4 Exhibit 12, and it is Bates numbered 053 (sic)
5 through 054 (sic), and it's a visit date of January
6 25th, 2017.

7 (PLAINTIFF EXHIBIT 12, MEDICAL RECORDS,
8 BATES STAMPED TURISK-MUSC-0543-0545, was marked for
9 identification.)

10 BY MS. BURKE:

11 Q. Dr. Herrera, can you tell me what
12 Exhibit 12 is?

13 A. It appears to be a clinic visit.

14 Q. Okay. And what's the date of that
15 clinic visit?

16 A. It looks like January 25th, 2017.

17 Q. At this visit, did Rebecca complain
18 about any pain in her breast?

19 A. She did.

20 Q. And what did she complain of?

21 A. Pain and discomfort in both breasts.

22 Q. Did you determine a cause for the pain
23 and discomfort?

24 A. Hard to say. I think it was presumed
25 fat necrosis.

1 Q. Okay. Did you -- did you report an
2 assessment and plan at this visit?

3 A. I did.

4 Q. Could you read your assessment and plan
5 to the jury.

6 A. Sure. Patient with significantly poor
7 postop complications from surgery at outside
8 facility. Discussed in the short term we will take
9 her to the operating room to debride the right
10 breast and close the wound if possible. In the
11 long run, she will likely need excision of fat
12 necrosis. If it does not improve with time, this
13 will likely remove most of her breast tissue.
14 Therefore, she will likely need prosthetic
15 reconstruction to improve the loss of volume. We
16 will schedule right breast debridement now and wait
17 about three to four months before performing
18 another surgery when she is ready.

19 Q. Okay. Did you also perform a physical
20 exam on that date?

21 A. I did.

22 Q. And what did you find -- what did you
23 record about your physical examination of Rebecca's
24 breast?

25 A. Loss of nipple on the right breast with

1 open wound approximately 4 centimeters in diameter
2 and 9 centimeters deep with adipose tissue visible;
3 no signs of infection; palpable surrounding fat
4 necrosis. Left breast with significant fat
5 necrosis in upper breast which encompasses nearly
6 half of her breast.

7 Q. Okay. And was this basically the
8 preoperative visit before the mastectomies you
9 performed in February of 2017?

10 A. Correct.

11 Q. Okay. Was there any significance to
12 you of the wound being -- on her right breast being
13 4 centimeters in diameter and then 9 centimeters in
14 depth?

15 A. Only I think the fact that it wasn't
16 really closing down on its own and it was fairly
17 deep, and then I didn't feel I could debride this
18 locally anymore, and that's why I felt she needed
19 to go to the operating room for a very aggressive
20 debridement.

21 Q. Can you -- can you show the jury about
22 how deep 9 centimeters is with your hand?

23 A. Sure. Probably something like that.

24 Q. Okay. All right. I want to go back to
25 the exhibit, to the 2/24/17 surgery.

1 THE VIDEOGRAPHER: Counselor, your
2 microphone is off.

3 MS. BURKE: Can you find it, Mark? I
4 can't --

5 MR. TANENBAUM: Which one?

6 MS. BURKE: The surgery note from the
7 mastectomies.

8 MR. TANENBAUM: 2/24/17.

9 MS. BURKE: I don't remember which
10 number it is. It might be seven.

11 MR. TANENBAUM: I think it's seven.
12 Yeah. Seven.

13 MS. BURKE: Seven. Okay. All right.

14 MR. TANENBAUM: Thank you.

15 BY MS. BURKE:

16 Q. Okay. Dr. Herrera, you have Exhibit 7
17 in front of you, and we had talked about Exhibit 7
18 earlier. But Exhibit 7 is your operative note from
19 your surgery on February 24th, 2017, correct?

20 A. Correct.

21 Q. And, again, that's the surgery where
22 you performed the left and right mastectomies on
23 Mrs. Turisk?

24 A. Correct.

25 Q. And that mastectomy -- those

1 mastectomies were ultimately necessary because you
2 could no longer accomplish what you needed to
3 accomplish --

4 MR. SMYTH: Objection. Leading.

5 BY MS. BURKE:

6 Q. So why were the mastectomies necessary?

7 A. Because the tissue was not healing and
8 I could no longer debride that in the clinic. It
9 was beyond what I could see within the wound bed,
10 as well as the pain she was having on the left
11 side, which was a closed wound but painful.

12 Q. Okay. Dr. Herrera, take a look at
13 Exhibit 4 again, please.

14 A. Okay.

15 Q. And what's the date of Exhibit 4?

16 A. Appears to be March 15th, 2017.

17 Q. And that's after the mastectomies you
18 performed, correct?

19 A. Correct.

20 Q. How -- how is Rebecca's healing at this
21 point?

22 A. Her wounds are nearly healed. Or
23 closed. There appears to be some scar at the
24 bottom on the right, but certainly closed.

25 Q. Okay.

1 MS. BURKE: I'm going to go off the
2 record for just a minute.

3 THE VIDEOGRAPHER: Off the record at
4 4:12.

5 (A recess transpired.)

6 THE VIDEOGRAPHER: On the record at
7 4:18.

8 BY MS. BURKE:

9 Q. Dr. Herrera, just a moment ago we were
10 talking about Exhibit 3, which I believe you
11 testified were photos after you performed the
12 mastectomies, correct?

13 A. Correct.

14 Q. Okay. So now we're looking at Exhibit
15 7, which is your operative note from February 24th
16 of 2017?

17 A. Correct.

18 Q. Okay. And did you -- did you document
19 any of your findings from your surgery on February
20 24th of 2017?

21 A. Yes.

22 Q. And what were your findings?

23 A. Specifically the findings section in my
24 note mentions a large amount of fat necrosis on
25 left upper pole of the breast and right fat

1 necrosis which was adherent to the pectoralis major
2 fascia. There were no other -- there was no other
3 evidence of any other masses or infection noted.

4 Q. Okay. The large amount of fat necrosis
5 on the left upper pole of the breast, you removed
6 that fat necrosis, correct?

7 A. Yes.

8 Q. What was the appearance of the breast
9 on the left upper pole of the breast after removing
10 that necrotic fat?

11 A. It appeared to be sunken or absent.

12 Q. Or hollow?

13 A. Or hollow.

14 Q. Okay. When you say -- what was the
15 significance of the right fat necrosis being
16 adherent to the pectoralis major fascia?

17 A. Only that it extended down to the
18 fascia of the muscle, which is essentially the rest
19 of the breast.

20 Q. Okay. And I think earlier you
21 testified that the wound on the right was 9
22 centimeters deep?

23 A. Roughly, yes.

24 Q. Roughly. So the fact that the necrosis
25 was adherent all the way down to the muscle was it

1 consistent with a deep wound?

2 A. Correct.

3 Q. Okay. And if you look in the next --
4 in the next page of your operative note, does fat
5 necrosis cause pain?

6 A. It can.

7 Q. Okay. Did you note that she was
8 experiencing any pain from fat necrosis in your
9 operative note?

10 A. Yes, I did.

11 Q. And what does your note say?

12 A. It says the fat necrosis at the
13 superior aspect of the left breast which has been
14 causing excessive amounts of pain over the last
15 couple of months.

16 MR. SMYTH: I'm sorry. What page are
17 you reading from, please?

18 THE WITNESS: 0402. That's the stamp
19 on the page.

20 BY MS. BURKE:

21 Q. When you -- before you performed this
22 surgery, did you have any concerns about the
23 viability of the left nipple?

24 A. I don't believe so at that time.

25 Q. Okay. And, again, the right nipple was

1 already gone?

2 A. Absent, yes.

3 Q. Okay. Were you -- were you able to
4 keep the left nipple intact?

5 A. I was.

6 Q. Okay. When you remove the necrotic fat
7 tissue from the breast, is that something that's
8 going to grow back?

9 A. The breast tissue itself or the
10 necrosis?

11 Q. Well, when you -- well, you tell me.
12 When you take -- in Ms. Turisk's case, when you
13 remove that -- when you removed the necrotic fat
14 from her left and right breast, did you expect her
15 breast tissue to grow back normally?

16 A. No.

17 Q. And why not?

18 A. Because it was absent at this time.

19 Q. Okay. It's not something that the body
20 will regenerate?

21 A. No.

22 Q. Okay. Do you have an opinion as to
23 whether the mastectomies you performed on February
24 24th, 2017 were related to her postsurgical
25 complications she experienced in November of 2016?

1 A. Well, it was certainly to treat the
2 status of her breast tissue at that time.

3 Q. So, then, it is your opinion that your
4 treatment in February of -- let me back up.

5 Dr. Herrera, is it your opinion that
6 your treatment of Rebecca in February of 2017, the
7 double mastectomies, were related to her
8 postsurgical complications from her surgery in
9 November of 2016?

10 A. Most likely.

11 Q. Okay. And you hold that opinion to a
12 reasonable degree of medical certainty, correct?

13 A. I do.

14 Q. Okay. Okay. I am going to -- I'm
15 going to hand you your Exhibit 6 back. I'm going
16 to go to 9. And I think we're up to Exhibit 13.

17 (PLAINTIFF EXHIBIT 13, MEDICAL RECORDS,
18 BATES STAMPED TURISK-MUSCUPDATED-0314-0319, was
19 marked for identification.)

20 BY MS. BURKE:

21 Q. All right. Dr. Herrera, I'm going to
22 hand you what the court reporter will mark as
23 Exhibit 13. And it's an office visit of yours from
24 February 13th of 2017, and the Bates numbers are
25 0348 through 0353.

1 Have you had an opportunity to review
2 Exhibit 13?

3 A. I have.

4 Q. Okay. And, Doctor, what is Exhibit 13?

5 A. It appears to be a -- it looks like an
6 ER visit. And I can't tell if it was an admission
7 to the hospital or not. I think it was.

8 Q. This is not what I meant to give you.
9 All right. Let me get you the correct record. My
10 apologies. We're skipping through a lot of stuff
11 so that should make you excited.

12 All right. Here we go. This is
13 Exhibit 13. I should have known with that unlucky
14 number. And it is Bates numbered -- the Bates
15 numbers have changed.

16 A. Okay.

17 Q. 0314 through 0319.

18 MS. BURKE: And, Todd, it's your tab
19 14.

20 BY MS. BURKE:

21 Q. This is your clinic note from 12/13/17.
22 I'm sure that was very confusing.

23 Dr. Herrera, have you had an
24 opportunity to review Exhibit 13?

25 A. I have.

1 Q. What is Exhibit 13?

2 A. It appears to be a clinic visit.

3 Q. And is this a note of a clinic visit of
4 yours with Rebecca Turisk?

5 A. It is.

6 Q. And was this note prepared in the
7 normal course of your care and treatment of
8 Rebecca?

9 A. It was.

10 Q. And was it prepared contemporaneously
11 with your care of Rebecca?

12 A. Yes.

13 Q. And has it been kept in the normal
14 course of business in the medical chart here at
15 MUSC?

16 A. Yes.

17 MS. BURKE: I move Exhibit 13 into
18 evidence, please.

19 MR. SMYTH: No objection.

20 BY MS. BURKE:

21 Q. Dr. Herrera, I believe you stated that
22 this is a clinic note. What's the date of the
23 clinic note?

24 A. It appears to be 12/13/2017.

25 Q. How far out are we from the

1 mastectomies that you performed?

2 A. It appears to be about 10 months,
3 roughly.

4 Q. How is Rebecca doing at this visit as
5 far as her healing?

6 A. From the notes it appears she is doing
7 well and has healed. I don't see a comment about
8 pain, but I also don't see if she is having any
9 pain in this note.

10 Q. Okay. Did you perform a physical exam
11 on Rebecca?

12 A. I did.

13 Q. Did you note your findings of your
14 physical exam related to her breast in your note?

15 A. I did.

16 Q. What were your findings?

17 A. Right breast with scar and tethering at
18 the inferior junction. Lack of fullness in the
19 superior pole. Left breast with contour deformity
20 in upper and lateral pole. Incisions well healed.
21 Breasts are soft bilaterally.

22 Q. Anything else?

23 A. Right reconstructed nipple in superior
24 in position to left nipple.

25 Q. And did you also note a soft tissue dog

1 ear bilaterally?

2 A. Yes.

3 Q. And what is that referring to?

4 A. That refers to excess skin, the
5 closure.

6 Q. Okay. And that's on her right or left
7 side?

8 A. It looks like the --

9 Q. Or both sides?

10 A. It's hard to tell from this note.

11 Q. Okay.

12 A. It looks like both, maybe.

13 Q. Okay. Where -- when you talk about the
14 right breast with scar and tethering of the
15 inferior T junction, what is the inferior T
16 junction?

17 A. So it's at the bottom of the breast
18 where the scar is kind of widened, and it appears
19 to look like a T, an upsidedown T. So we refer to
20 it as the T junction.

21 Q. Okay. Dr. Herrera, if you'll take a
22 look at Exhibit 6, which is in front of you, will
23 you look to see if there are any photos in Exhibit
24 6 for this visit of December 13th, 2017?

25 A. I believe there are.

1 Q. Okay. And can you -- can you identify
2 for us by exhibit number, it will be six plus a
3 letter, which photos appear to be -- appear to have
4 been taken on this December 13th, 2017 visit?

5 A. It appears to be 6D through I.

6 Q. Okay. Are you able to identify the
7 inferior T junction on any of those photographs,
8 the scarring that you referenced in your findings?

9 A. I am.

10 Q. Can you show that to me, please.

11 A. Sure. In this area where it's widened
12 and it appears to look like a T.

13 Q. Okay. That's exhibit number?

14 A. 6E.

15 Q. Okay. Are you able to discern the lack
16 of fullness in the superior pole on the right
17 breast from these photographs?

18 A. Probably 6F and 6G will show it. Also
19 6H.

20 Q. Okay. Yeah. Turn it so that the
21 camera can see. Yes. Okay.

22 A. This area here.

23 Q. Okay.

24 A. Kind of an oblique view.

25 Q. On the right side?

1 A. On the right side.

2 Q. Yeah. Okay. And is there a left
3 contour deformity in the upper and lateral pole
4 that's visible on those photos?

5 A. There doesn't appear to be a left
6 oblique view which would show it.

7 Q. Okay.

8 A. So it's hard to appreciate on these
9 views.

10 Q. Okay. And when you say the right
11 reconstructed nipple is in superior position to the
12 left nipple, what did you mean by that?

13 A. I think I was referring to the -- it
14 wasn't truly a reconstructed nipple. This was
15 where the tissue was closed at the top and the
16 excess tissue appeared to look like a nipple, but
17 by no means did we actually do a nipple
18 reconstruction. And it's higher. I think it's
19 higher, is what I was referring to. I don't
20 remember which exhibit.

21 Q. You need the operative note?

22 A. Yes. Or the clinic note, I think. I
23 think it mentioned it was higher than the left.

24 Q. It was Exhibit 7. I don't know where
25 it went. The clinic note.

1 A. Yeah.

2 MR. FAIRBAIRN: You are looking for
3 notes?

4 MS. BURKE: We are looking for Exhibit
5 13, which is his clinic note which corresponds to
6 these photographs.

7 THE WITNESS: Correct. It mentions
8 that the right appearing nipple is higher than the
9 left, just pointing out asymmetry.

10 BY MS. BURKE:

11 Q. Okay. And if you could hold up any of
12 those photographs in your opinion is a good
13 depiction of her right nipple, I want to talk a
14 little bit about the appearance of the right
15 nipple.

16 A. (Complying.)

17 Q. And you said you have not attempted any
18 reconstruction of the right nipple?

19 A. No.

20 Q. That what is there now is scar tissue?

21 A. It is scar tissue.

22 Q. Okay. At this point, have you
23 attempted any fat grafting on Rebecca?

24 A. I don't believe we have --

25 Q. Okay.

1 A. -- at this point.

2 Q. Okay. Did you discuss a plan for the
3 next steps at this visit?

4 A. I believe we did mention that at the
5 end of Exhibit 13.

6 Q. And what's the plan?

7 A. I think we discussed options for fat
8 grafting versus expander tissue expander, and she
9 voiced the opinion that she did not want implants
10 or expanders ever again, and so we chose to proceed
11 with fat grafting as an option.

12 Q. Okay. And do you think that was a
13 reasonable approach for her reconstruction?

14 A. I think it's a stretch, but a
15 reasonable option given her experience with
16 implants.

17 Q. And why do you say it's a stretch?

18 A. Because it's a large volume to replace
19 with a completely absent breast. It can be done
20 but is not commonly done alone for breast
21 reconstruction.

22 Q. Okay. Dr. Herrera, we discussed
23 earlier in the deposition that you performed
24 several fat grafts on Rebecca's breast; is that
25 correct?

1 A. Correct.

2 Q. And what was the -- what was the --
3 what was the goal for you with fat grafting?

4 A. I think our goals were the same, to
5 create a breast mound that would appear to replace
6 her absent breast.

7 Q. Okay. Were you trying to make her look
8 as natural as possible?

9 A. I was.

10 Q. Okay. And in conjunction with those
11 fat grafting procedures, you also did scar revision
12 on the breast, correct?

13 A. I believe so, yes.

14 Q. Going back to Exhibit 13, which was
15 your 12/13/17 note --

16 MR. FAIRBAIRN: 13, correct?

17 MS. BURKE: Yes. Exhibit 13.

18 BY MS. BURKE:

19 Q. I meant to ask you about the scar on
20 the right breast that you indicated was tethering
21 at the T junction. Does tethering in a scar cause
22 pain?

23 A. It can.

24 Q. Okay. And would taking out the
25 tethering in that scar relieve pain?

1 A. Sometimes.

2 Q. Okay.

3 MS. BURKE: Let's go off the record for
4 just a minute.

5 THE VIDEOGRAPHER: Off the record at
6 4:42.

7 (A recess transpired.)

8 THE VIDEOGRAPHER: On the record at
9 4:45.

10 BY MS. BURKE:

11 Q. Dr. Herrera, in your opinion, were each
12 of the surgeries we have discussed today reasonable
13 under the circumstances?

14 A. Yes, I believe they were.

15 Q. And does this include the scar revision
16 to her breast?

17 A. Yes.

18 Q. And the lipo grafting?

19 A. Yes.

20 Q. And the debridements?

21 A. Certainly.

22 Q. And the mastectomies?

23 A. Yes.

24 Q. And, in your opinion, were each of
25 these surgeries and procedures we discussed

1 medically necessary?

2 A. That's a difficult situation. I think
3 the initial debridements were. I think part of
4 plastic surgery is appearance, so I think to
5 re-create her breast you certainly could not do
6 that, but I think it's all -- was because of the
7 fat necrosis and the tissue loss.

8 Q. Okay. And, in your opinion, were each
9 of these surgeries related to her postoperative
10 complications and infection following her prior
11 breast surgery with Dr. Schimpf on November 1st,
12 2016?

13 MR. SMYTH: Objection. I don't believe
14 there is any foundation linking those two.

15 THE WITNESS: Yeah. I don't think I
16 can comment on that specifically.

17 BY MS. BURKE:

18 Q. Okay. Let me -- I'll break it down for
19 you a little bit.

20 A. Sure.

21 Q. We have looked at different pieces of
22 your chart today, correct?

23 A. Correct.

24 Q. And based upon your review of that
25 chart, did it refresh your recollection that she

1 was originally admitted to MUSC after a breast
2 surgery performed by Dr. Schimpf at an outside
3 hospital?

4 A. I believe that's true.

5 Q. Okay. So based upon that information,
6 is it your opinion that the surgeries that you
7 performed on her, the debridements and the
8 mastectomies and the lipo grafting, were related to
9 her postoperative complications following her prior
10 surgery with Dr. Schimpf?

11 MR. SMYTH: Same objection. I don't
12 believe there is any evidentiary foundation on
13 causation.

14 THE WITNESS: I don't know.

15 BY MS. BURKE:

16 Q. Okay. Let me go about it differently.
17 Well, let me go about it this way. Is your
18 understanding sitting here as Rebecca's treating
19 physician that before she became your patient she
20 had had a breast surgery at an outside hospital?

21 A. That is true.

22 Q. All right. So when she became your
23 patient in December of 2017, were you treating her
24 for postoperative complications related to a breast
25 surgery?

1 A. I believe so.

2 Q. Okay. And you noted that in your
3 notes --

4 A. Correct.

5 Q. -- on a couple of your visits --

6 A. Correct.

7 Q. -- that she had had a rough time after
8 this breast surgery, correct?

9 MR. SMYTH: Objection.

10 THE WITNESS: I was unaware of any
11 records or what surgery was done per se, but it
12 appeared she had some previous surgery.

13 BY MS. BURKE:

14 Q. Okay. Let me take a look at these
15 exhibits, the notes. 13 is there.

16 A. I think those are our notes. No.
17 Those are the notes --

18 Q. All right.

19 (Off-the-record conference.)

20 BY MS. BURKE:

21 Q. Okay. Dr. Herrera, I'm going to ask
22 you to look back at Exhibit Number 9. And you may
23 recall that we talked about this exhibit earlier.
24 Do you recall that?

25 A. I do.

1 Q. And can you take a look at this exhibit
2 and see if you note anything in your record as to
3 the reason Rebecca is following up with you?

4 A. It's noted that she is following up on
5 her nipple necrosis after bilateral breast implant
6 removal, mastopexy, and abdominoplasty done by
7 Dr. Schimpf in his office in November of 2016.

8 Q. And does your note continue to discuss
9 her course at MUSC?

10 A. It does.

11 Q. What does it say?

12 A. It mentions that she was recently
13 hospitalized and underwent serial bedside
14 debridements.

15 Q. And, again, what's the date of this
16 note?

17 A. This is December 14th, 2016.

18 Q. Okay. Was she -- does your note
19 indicate if she was followed by anyone -- any other
20 disciplines at MUSC other than plastic surgery
21 during her admission?

22 A. It looks like also infectious disease
23 was called and was following her as well.

24 Q. Do you know why?

25 A. For a presumed infection when she was

1 admitted.

2 Q. And where was the infection located?

3 A. The presumed infection was the breast
4 area.

5 Q. Okay. Okay. So, Dr. Herrera, I'm
6 going to ask you, in your opinion were each of the
7 surgeries that you performed on Rebecca related to
8 her postoperative complications and infection
9 following her prior breast implant surgery with
10 Dr. Schimpf on November 1st, 2016?

11 MR. SMYTH: Objection. No foundation
12 as to causal connection.

13 MR. TANENBAUM: I think the record is
14 clear on it. But go ahead.

15 You can answer the question.

16 MR. SMYTH: You are not allowed to
17 participate.

18 THE WITNESS: No. It clearly says she
19 had previous surgery by Dr. Schimpf. That's really
20 all I can comment on. Obviously this is a
21 complication, but I don't know anything other than
22 the surgery performed by him, you know, from that
23 standpoint.

24 BY MS. BURKE:

25 Q. And I appreciate that answer. And my

1 question is, is your care and treatment related to
2 the complication? That's my question.

3 A. I believe it is.

4 Q. Okay. I don't have any further
5 questions. I thank you so much for your time
6 today.

7 THE WITNESS: Thank you.

8 MR. SMYTH: Doctor, do you want to keep
9 going or do you want to take a break?

10 THE WITNESS: Let's keep going.

11 EXAMINATION

12 BY MR. SMYTH:

13 Q. Okay. My name is Todd Smyth, and I
14 represent Dr. Schimpf and his medical practice.

15 You've been asked a lot of questions
16 today about the care that you provided to
17 Ms. Turisk, but it's my understanding you are not
18 here to tell this jury that Dr. Schimpf did
19 anything that was below the standard of care or was
20 medically negligent in any way, are you?

21 MS. BURKE: Objection.

22 THE WITNESS: I would agree with that
23 statement.

24 BY MR. SMYTH:

25 Q. You are not here to offer any negative

1 opinions or any criticisms of any care Dr. Schimpf
2 or his staff provided, are you?

3 MS. BURKE: Objection.

4 THE WITNESS: I am not.

5 BY MR. SMYTH:

6 Q. You perform breast reduction surgeries
7 like the one Ms. Turisk got, correct?

8 A. I do.

9 Q. All right. And before you operate on a
10 patient, you tell them about the potential risks
11 and complications associated with that surgery, do
12 you not?

13 A. Absolutely.

14 Q. That's part of the informed consent
15 process that you as plastic surgeons are trained to
16 perform, correct?

17 A. Correct.

18 Q. All right. And some of those
19 complications and risks would include things like
20 infection, correct?

21 A. Correct.

22 Q. It would include fat necrosis?

23 A. Correct.

24 Q. All right. It would include nipple
25 loss?

1 A. Yes.

2 Q. All right. It would include wound
3 healing issues?

4 A. Correct.

5 Q. It would include scarring that's
6 unsightful or unsatisfactory?

7 A. Yes.

8 Q. And it would include things like
9 asymmetry, meaning one breast is a different size
10 or shape than the other?

11 A. It would.

12 Q. All right. And it would include the
13 possibility that you might need more surgery to
14 correct that as well, correct?

15 A. Correct.

16 Q. Those are all things that are
17 appropriate to tell a patient before they have this
18 kind of surgery, correct?

19 A. I would agree.

20 Q. And you warn your patients that even
21 though this risk may be rare, they do happen. They
22 are real risks, aren't they?

23 A. Correct.

24 Q. And you are familiar with the term
25 known complication, correct?

1 A. Yes.

2 Q. Do you agree that those risks and those
3 complications that we just talked about are things
4 that can and do occur even when the surgeon does
5 the surgery absolutely by the book?

6 A. That's true.

7 Q. And just because a patient experiences
8 a complication doesn't mean that the surgeon did
9 anything that was below the standard of care or
10 negligent in any way, correct?

11 A. I would agree with that.

12 Q. And you would agree that the conditions
13 that Ms. Turisk presented to you with in the end of
14 2016, those are all known complications of the
15 surgery she had, correct?

16 MS. BURKE: Objection.

17 THE WITNESS: I would say they are
18 known but to a maybe further degree than most would
19 expect.

20 BY MR. SMYTH:

21 Q. So the fat necrosis, the nipple loss,
22 the tissue loss, all those things are part of that
23 procedure, correct?

24 A. Correct.

25 Q. And you've been treating Ms. Turisk as

1 a patient I think you said since 2016, correct?

2 A. Correct.

3 Q. And you've operated on her at least
4 four or five times, as I understand it; is that
5 correct?

6 A. Yes, sir.

7 Q. Are you aware that she had a number of
8 preexisting chronic medical problems?

9 A. Correct.

10 Q. And some of those problems would
11 include fibromyalgia; is that correct?

12 A. Correct.

13 Q. She has also had multiple back
14 surgeries, correct?

15 A. Correct.

16 Q. And even required the use of a pain
17 stimulator in her spine to control that, correct?

18 A. Correct.

19 Q. So she has had cervical fusion and
20 lumbar fusion of her spine?

21 A. Correct.

22 Q. She is a patient that requires chronic
23 pain medications?

24 MS. BURKE: Objection.

25 THE WITNESS: I am not certain of that

1 but I believe she does require that. I'd have to
2 review her chart.

3 BY MR. SMYTH:

4 Q. And if you need to look at the -- your
5 chart to see what medications she is on, I'm happy
6 for you to do that.

7 MS. BURKE: And the basis for my
8 objection is relevance.

9 THE WITNESS: I probably need a note.
10 These all have different medications at different
11 times, so...

12 BY MR. SMYTH:

13 Q. All right. You brought some documents
14 with you today. Let's do that first.

15 A. There are a lot of documents.

16 Q. All right. Why don't you do this. Why
17 don't you tell us what you brought today in general
18 terms, if you can.

19 A. It looks like everything that was
20 requested by the subpoena.

21 Q. Okay. And are those records that are
22 kept on Ms. Turisk here at MUSC as part of her --
23 the normal course of business?

24 A. Yes.

25 Q. All right. I would ask you, if you

1 would, if you would look at pages 131 to 137 of the
2 documents that you brought. I think there is some
3 page numbers on the bottom right, maybe, that might
4 help, towards the very end of the stack.

5 MS. BURKE: Todd, I need to see what
6 you are referring to, please.

7 MR. SMYTH: I don't have the documents
8 he brought.

9 MS. BURKE: But you have numbers.

10 MR. SMYTH: I wrote them down when he
11 brought them.

12 MS. BURKE: Oh, okay.

13 THE WITNESS: The last page, I believe.
14 Is this the one you are referring to?

15 MS. BURKE: I need to see --

16 MR. SMYTH: 131 to 137. She's entitled
17 to see them.

18 MR. FAIRBAIRN: If you want to pull
19 them out, we'll show them to both of them.

20 THE WITNESS: I'm not sure what you are
21 looking for. It's kind of, like, pieces of notes,
22 other notes.

23 BY MR. SMYTH:

24 Q. Doctor, do you recognize the
25 information that's contained in those pages?

1 A. Somewhat.

2 Q. All right. Is that a list of
3 medications that MUSC has for Ms. Turisk as of May
4 of 2022?

5 MS. BURKE: Objection. Relevance.

6 THE WITNESS: It looks like it is.

7 BY MR. SMYTH:

8 Q. Okay. And those are records that you
9 brought with us -- you brought with you pursuant to
10 the subpoena today, correct?

11 A. Right. Correct.

12 MR. SMYTH: And at this time I would
13 move to enter those in as Defendant's Exhibit 1.

14 MS. BURKE: Same objection. Relevance.

15 MR. SMYTH: I understand your
16 objection. I'll let the judge deal with that.

17 MS. BURKE: You have to go ahead. I
18 understand.

19 MR. SMYTH: We'll proceed subject to
20 the objection.

21 MS. BURKE: Yeah. And I'll just make a
22 standing objection.

23 (DEFENDANT EXHIBIT 1, MEDICATION LIST,
24 PAGES 131-137, was marked for identification.)

25 BY MR. SMYTH:

1 Q. So Defendant's Exhibit 1 has been
2 marked, and that's pages 131 through 137 of the
3 subpoenaed records you brought with you today. Do
4 you see any medications in Ms. Turisk's current
5 list of medications that would be considered
6 chronic pain medications?

7 A. I do.

8 Q. Okay. And what would those include,
9 please?

10 A. Morphine, extended release, and
11 oxycodone.

12 Q. Is she also prescribed Narcan?

13 A. I do not see Narcan on this list.

14 Q. What is Narcan?

15 A. It's a -- I do see it. I'm sorry.
16 It's right there. Narcan. It's a medication to
17 reverse opioids.

18 Q. In case of an overdose?

19 A. Sure.

20 Q. Is she also on multiple muscle
21 relaxants?

22 A. I don't see -- I don't see multiple.

23 Q. Do you see muscle relaxants contained
24 in that list?

25 A. Maybe Ramelteon. I'm not sure what

1 that is. I don't prescribe these for her.

2 Q. How about baclofen?

3 A. Baclofen, I'm not seeing it on this
4 list.

5 Q. May I see the exhibit?

6 A. Sure. I may have -- there is a number
7 of different medications. I may have just not seen
8 it.

9 Q. Back of the first page.

10 A. Okay. I wasn't looking at the back
11 side. These are front and back. I didn't realize.
12 Yes, I see it.

13 Q. Okay. She is also on Voltaren?

14 A. She is.

15 Q. And Depakote?

16 A. I'm also not seeing Depakote on this
17 one. Can you point it out to me? I'm not seeing
18 the Depakote.

19 Q. Sure.

20 A. I don't see Depakote, but it certainly
21 could be there.

22 Q. Okay. We can move on. That may not be
23 on this particular list.

24 Is she on gabapentin?

25 A. Yes.

1 Q. Is that a nerve pain medication?

2 A. Yes. Neuropathic pain.

3 Q. So based on your review of Defendant's
4 Exhibit 1, was Ms. Turisk on -- she continued to be
5 on a number of chronic pain medications?

6 MS. BURKE: Objection. Relevance.

7 THE WITNESS: It appears so.

8 BY MR. SMYTH:

9 Q. During the time that you were caring
10 for Ms. Turisk, is it true that she had some
11 complications from some of the procedures you
12 performed as well?

13 A. She did.

14 Q. And those would include things such as
15 infection?

16 A. Correct.

17 Q. Abscesses?

18 MS. BURKE: Objection. Not in
19 evidence.

20 THE WITNESS: I don't recall abscess.
21 I know she did have an infection that needed to be
22 drained.

23 BY MR. SMYTH:

24 Q. Did she have healing issues?

25 MS. BURKE: Objection. Not in

1 evidence.

2 THE WITNESS: I would have to review my
3 notes.

4 BY MR. SMYTH:

5 Q. Okay. Did she have concerns about
6 scarring from any of the procedures you performed?

7 A. I don't believe directly related to my
8 procedures.

9 Q. Earlier you were asked about tethering
10 at the T junction. Was that the scar that you
11 created when you performed the mastectomy?

12 A. That was the procedure done for
13 previous scar fat necrosis.

14 Q. All right. But the scar itself was
15 from the surgery that you did to remove the fat
16 necrosis?

17 A. Certainly.

18 Q. And you didn't do anything below the
19 standard of care or negligent to cause any of those
20 complications, did you?

21 A. No.

22 Q. With regard to the wound care that
23 Ms. Turisk received, if she was receiving
24 antibiotics, serial debridement, and the use of wet
25 to dry dressings before she came under your care,

1 would you think that's appropriate based on her
2 condition when you saw her?

3 A. Those are certainly ways to treat
4 wounds. It may not be as aggressive as what she
5 ultimately needed.

6 Q. Right. But those are appropriate ways
7 to treat an open wound, correct?

8 A. They are.

9 Q. And, in fact, you used some of those
10 same techniques when you treated her, correct?

11 A. Yes.

12 Q. And those complied with the standard of
13 care?

14 A. Correct.

15 Q. And you don't have any criticisms of
16 anyone that would treat an open wound with
17 debridement, antibiotics, or wet to dry dressings?

18 A. Absolutely not.

19 Q. You agree that fat necrosis can be a
20 difficult problem to treat?

21 A. Yes.

22 Q. Is it difficult to reign in and get
23 ahead of sometimes?

24 A. I don't know what you are referring to
25 by that.

1 Q. Does it spread? Does the problem get
2 worse if you don't treat it?

3 A. I don't know if that's completely true.

4 Q. Okay. Is it often necessary to remove
5 a fair amount of tissue in order to appropriately
6 treat fat necrosis?

7 A. Not always.

8 Q. In some occasions is it?

9 A. Certainly.

10 Q. And in her case it was?

11 A. Certainly.

12 Q. I think you told Ms. Turisk when you
13 first saw her that she was going to need surgery to
14 address the fat necrosis and then you could restore
15 any lost volume; is that correct?

16 A. Yes.

17 Q. All right. And you agreed that's
18 appropriate medical advice?

19 A. Yes.

20 Q. There was also some questions about
21 infections. Did Ms. Turisk have a number of
22 infections during the time that you've been caring
23 for her?

24 MS. BURKE: Objection. Lack of
25 foundation.

1 THE WITNESS: I'm aware of one
2 infection that she needed a drainage for.

3 BY MR. SMYTH:

4 Q. Did she have other infections with
5 regard to any other procedures that you know of?

6 A. Not that I'm aware of specifically.

7 Q. The infection that you were asked about
8 earlier when she presented to the hospital in
9 December of 2016, were you aware that the bacteria
10 that grew out of that infection was enterococcus
11 faecalis?

12 A. I think that was reviewed in her
13 records earlier.

14 Q. Okay. Are you familiar with what that
15 strand of bacteria -- where it originates?

16 A. I think it's a GI flora.

17 Q. And the use of the Latin term faecalis,
18 is that a reference to the fact that it is often
19 found in human feces?

20 A. Possibly.

21 Q. And so the bacteria that she had in her
22 breast is one that's associated with fecal matter?

23 MS. BURKE: Objection. Leading.

24 THE WITNESS: Possibly.

25 BY MR. SMYTH:

1 Q. And is it something that's known to
2 occur that maybe when patients go to the bathroom
3 and don't use proper hygiene or wash their hands
4 appropriately you can spread that type of bacteria
5 to other areas of your body?

6 MS. BURKE: Objection. Leading.

7 THE WITNESS: I don't know.

8 BY MR. SMYTH:

9 Q. Are you aware of poor hygiene being
10 related to infection with that bacteria?

11 MS. BURKE: Objection. Leading and
12 relevance.

13 THE WITNESS: Aware, meaning? I don't
14 understand that question.

15 BY MR. SMYTH:

16 Q. All right. Are you aware of any
17 instances where there has been an association with
18 poor hygiene and an enterococcus faecalis
19 infection?

20 MS. BURKE: Objection. Relevance.

21 THE WITNESS: Not specifically, no.

22 BY MR. SMYTH:

23 Q. How else would the bacteria from the
24 gut get into a breast wound?

25 A. I don't know.

1 Q. Okay. Did you begin prescribing
2 antibiotics to Ms. Turisk before fat grafting
3 procedures because of her prior incident of
4 infection?

5 A. I -- hard to say. I tend to give
6 prophylactic antibiotics to most of my patients.

7 Q. And would that be particularly
8 important to someone that's prone to infection?

9 A. Yes.

10 MS. BURKE: Objection. Lack of
11 foundation.

12 BY MR. SMYTH:

13 Q. You are aware that Ms. Turisk also has
14 adrenal insufficiency and requires steroids for
15 that?

16 A. Correct.

17 Q. And are steroids known to suppress the
18 immune system's response to antibiotics?

19 A. I believe so.

20 Q. And that can make it harder to fight
21 infections?

22 A. Yes.

23 Q. You talked earlier about some of the
24 options that you presented Ms. Turisk with in terms
25 of restoring her breast volume, and I think you

1 said tissue expanders, implants, and fat grafting.
2 Those are the three options that you discussed; is
3 that right?

4 A. Yes.

5 Q. All right. And in your experience is
6 the most efficient way to restore breast volume
7 with an implant?

8 MS. BURKE: Objection. Relevance.

9 THE WITNESS: It's hard to answer that.
10 It depends on the patient.

11 BY MR. SMYTH:

12 Q. Is that typically a one --

13 A. No.

14 Q. -- procedure event?

15 A. No.

16 Q. What's involved with an implant to
17 restore breast volume?

18 A. It depends on why you are doing it. If
19 it's an augmentation, it's a reconstruction, they
20 are very different patients.

21 Q. Okay. In Ms. Turisk's case, would
22 restoring her breast volume with an implant be an
23 appropriate choice?

24 A. Probably not.

25 Q. And why do you say that?

1 A. Well, one, she is more of a
2 reconstructive patient at that point, and, two,
3 with a history of infection, you also have to
4 consider that, putting an implant into an area
5 that's prone to infection.

6 Q. You are saying you could not put an
7 implant there?

8 A. I'm not saying you can't. I'm saying
9 it might not be ideal.

10 Q. And I think you said the reason that
11 Ms. Turisk chose the fat grafting option is that
12 she didn't want anything else to do with
13 implants --

14 A. She did not want implants.

15 Q. Right. But by committing to the fat
16 grafting approach, she was necessarily committing
17 herself to three to four to five different
18 procedures, correct?

19 A. Most likely.

20 Q. And that was her choice?

21 A. Correct.

22 Q. And do you believe you were able to
23 restore a lot of the breast tissue that she lost?

24 A. I never met her before so I don't know
25 exactly what her body habitus and breast size ever

1 were so it's hard to say how much I reconstructed
2 or how much I gave her back.

3 Q. As of the last few visits that you had
4 with Ms. Turisk, was she generally pleased with the
5 results of the fat grafting that you had done?

6 A. I think she appeared generally pleased.

7 Q. All right. And I think your notes
8 indicate she was happy with the shape and size of
9 her breasts; is that correct?

10 A. Correct.

11 Q. All right. And as of today, you don't
12 have any plans to perform any other surgeries on
13 her as we sit here today. There is something
14 scheduled, correct?

15 A. Nothing scheduled.

16 Q. All right. You were also asked whether
17 the fat grafting was medically necessary, and I
18 think you were struggling with that particular
19 question. Is some of the fat grafting that she has
20 had done, is it also considered cosmetic in nature?

21 A. I think it would be -- it would improve
22 the appearance of her breast.

23 Q. So it's an esthetic procedure, then?

24 A. Could be.

25 MS. BURKE: Objection. Relevance.

1 BY MR. SMYTH:

2 Q. In other words, a medically necessary
3 procedure is something that you would need to
4 improve your function or ability to --

5 A. Certainly.

6 Q. -- participate in activities of daily
7 living. And that's not what we're talking about,
8 is it?

9 A. No, I don't believe so.

10 Q. And outside of the normal postoperative
11 instructions that you would give a patient, you've
12 not put any physical limitations or restrictions on
13 any of the activities of Ms. Turisk, have you?

14 A. No.

15 Q. And so she is not under any kind of
16 activity restriction as we sit here today?

17 A. I do not believe so.

18 Q. All right. I think those may be all
19 the questions I have.

20 Have the opinions that you've expressed
21 in response to my questions been held to a
22 reasonable degree of medical certainty, Doctor?

23 A. I believe so.

24 MR. SMYTH: Thank you.

25 MS. BURKE: We'll go off the record.

1 THE VIDEOGRAPHER: This is the end of
2 media unit one. We are off the record at 5:15.

3 (A recess transpired.)

4 THE VIDEOGRAPHER: This is the
5 beginning of media number 2. We are on the record
6 at 5:28.

7 (PLAINTIFF EXHIBIT 14, MEDICAL RECORDS,
8 BATES STAMPED TURISK-MUSC-0486-0491, was marked for
9 identification.)

10 EXAMINATION

11 BY MS. BURKE:

12 Q. Dr. Herrera, you have in front of you
13 what the court reporter has -- again, I apologize.
14 I'm Beth Burke. I represent your patient, Rebecca
15 Turisk. I've got a couple followup questions for
16 you.

17 And you have in your hand, I believe,
18 Exhibit 14, which has been marked by the court
19 reporter, and it's a note of your visit on March
20 15th of 2017. Have you had an opportunity to look
21 over Exhibit 14?

22 A. I have not.

23 Q. Okay. Take a quick look at that. Or
24 take as much time as you need with it. And you may
25 also want to review Exhibit 4 in conjunction with

1 Exhibit 14 because I believe that's the photograph
2 from that visit.

3 A. Okay.

4 Q. A few moments ago, counsel for
5 Dr. Schimpf asked you if Rebecca had had any
6 infections postoperatively during her treatment
7 with you. Do you recall that?

8 A. I do.

9 Q. And Exhibit 14, is that a clinic note
10 of a visit that Rebecca had with you?

11 A. Exhibit 14 I believe is an ER note.

12 Q. I'm sorry. Are you the author of the
13 note, of the Exhibit 14?

14 A. I am not.

15 Q. Let me see. I might not have given you
16 the right thing.

17 I did give you the right thing. Okay.
18 All right. Starting at the bottom of Exhibit 14
19 and then read over to the next page and then I'll
20 ask you a couple of questions.

21 And maybe I'm wrong. So is this an ER
22 visit?

23 A. This is an ER visit.

24 Q. Were you consulted?

25 A. Our team was consulted.

1 Q. Okay. All right. Why did Rebecca
2 report to the emergency room at MUSC?

3 A. It looks like she was concerned about
4 some redness and maybe an infection.

5 Q. Did -- was anything done at MUSC to
6 determine whether or not it was an infection?

7 A. I think there was, like, an area of the
8 wound was aspirated but nothing was identified.

9 Q. Okay. Was she -- was she given any
10 sort of diagnosis?

11 A. I don't see that there was a diagnosis
12 listed here on this encounter.

13 Q. Okay. Do you believe that she had a
14 postoperative infection on March 15th of 2017?

15 A. I don't believe so.

16 Q. Okay. And did you see where
17 photographs were taken at this ER visit on March
18 15th of 2017?

19 A. Yes.

20 Q. And is that photograph at Exhibit 4?

21 A. Yes.

22 Q. Okay.

23 A. I believe so.

24 Q. Okay. And how -- does she appear to
25 have an infection based on this photograph?

1 A. It's unclear.

2 Q. Okay. Does she appear to be healing?

3 A. She appears to be healing okay at the
4 incision area.

5 Q. Are her wounds open on either the right
6 or the left?

7 A. They are not.

8 Q. Okay. Counsel for Dr. Schimpf asked
9 you about a medication list, which is defense
10 Exhibit 1. He specifically asked you about Narcan,
11 morphine, and oxycodone. Can you refer to Exhibit
12 1 and tell me if that gives you any indication for
13 the refill dates for either Narcan or morphine? Or
14 the fill dates.

15 A. I'm sorry. What are you asking me
16 exactly?

17 Q. Is there any indication on that list
18 that defense gave you that's marked as Exhibit 1 as
19 to the dates of prescription or refill for either
20 Narcan or morphine?

21 A. I don't see anything listed for Narcan
22 or morphine.

23 Q. Okay. And then what about oxycodone,
24 do you see any information related to any
25 prescriptions that were written or refilled?

1 A. I only see the start date April 14th,
2 2022.

3 Q. Do you see any indication of a refill?

4 A. I do not.

5 Q. Okay. And can you tell the date of
6 that record -- the date that record was produced or
7 created?

8 A. I only see the telephone encounter of
9 May 23rd, 2022 listed on there. I don't know if
10 that's for the entire...

11 Q. So it would have been sometime after
12 May of 2022?

13 A. I believe so.

14 Q. Okay. All right. You spoke with
15 Dr. Schimpf -- I'm sorry. Okay. You spoke with
16 Dr. Schimpf -- or Dr. Schimpf's lawyer questioned
17 you earlier about fat grafting versus implant
18 tissue expanders for Rebecca's reconstruction. Do
19 you recall those questions?

20 A. I do.

21 Q. And did you discuss all of those
22 options with Rebecca?

23 A. I discussed the options as they exist
24 as a possibility but not specifically for her.

25 Q. Okay.

1 A. Those are ways to reconstruct the
2 breast.

3 Q. Okay. And you ultimately, along with
4 your patient, decided that fat grafting was the
5 best approach for reconstruction for Rebecca; is
6 that correct?

7 MR. SMYTH: Objection. Leading.

8 THE WITNESS: I would agree with that.

9 BY MS. BURKE:

10 Q. Well, let me ask it -- let me ask it in
11 the longer way. You testified that you discussed
12 fat grafting, implants, and tissue expanders
13 generally with Rebecca, correct?

14 A. Correct.

15 Q. Did you -- did you ultimately make a
16 recommendation to her one way or the other as to
17 how she should go about reconstructing her breast?

18 A. I think we kind of weighed the risks
19 and benefits. I would certainly be hesitant to put
20 a tissue expander in a previously infected area
21 ever -- ever infected, even if it's not currently
22 infected, obviously, because of the risk of failure
23 or more wound healing problems. And I certainly
24 think that fat grafting is the more prudent option
25 for her. And I think I told her that, and I think

1 that was where she already felt comfortable, so...

2 Q. And you testified earlier that the fat
3 grafting was going to hopefully give Rebecca a
4 natural appearing breast; is that correct?

5 A. Yes.

6 MR. SMYTH: Objection. Asked and
7 answered.

8 BY MS. BURKE:

9 Q. When you -- when you performed these
10 fat grafting procedures on Rebecca, did you do the
11 best you could to give her a natural looking
12 breast?

13 MR. SMYTH: Objection. Outside the
14 scope of cross. Asked and answered.

15 THE WITNESS: I did.

16 BY MS. BURKE:

17 Q. Okay. Counsel for Dr. Schimpf asked
18 you earlier about various complications related to
19 the procedures that you performed on Rebecca. Do
20 you remember that line of questioning?

21 A. I do.

22 Q. Okay. And some of those complications
23 -- do you recall what some of those complications
24 were that he listed for you?

25 A. Vaguely.

1 Q. Okay. So --

2 A. Sorry.

3 Q. Just in general, what are some of the
4 possible complications related to -- postoperative
5 complications related to a mastectomy that you
6 would have discussed with Rebecca -- or you did
7 discuss with Rebecca before you performed that
8 surgery?

9 A. Sure. For any breast surgery, there
10 are a number of complications we discuss to fully
11 inform your patient. Nipple necrosis is certainly
12 my biggest concern. Wound healing problems,
13 hematoma, seroma, asymmetry, all those are
14 something I would tell my patient are
15 possibilities, but --

16 Q. Okay.

17 A. -- not expected.

18 Q. And when a patient consents to a
19 procedure after discussing the possible
20 complications, do they consent to improper care or
21 treatment?

22 A. No.

23 Q. Okay. I'm going to hand you once again
24 defense Exhibit 1, just to try to ask you if you
25 can tell me who printed this document for you and

1 when?

2 A. It looks like it was printed by Nicole
3 Sattler on 10/6/20 something.

4 Q. Okay. And who is Nicole Sattler?

5 A. That would be my admin in my office.

6 Q. Okay. I don't think I have any further
7 questions for you, Doctor. Thank you very much for
8 your time.

9 A. Thank you.

10 MR. SMYTH: Thank you, Doctor.

11 THE WITNESS: Thank you.

12 THE VIDEOGRAPHER: All right. This
13 concludes the deposition of Fernando A. Herrera,
14 M.D. We are off the record at 5:40.

15 (The witness, after having been advised
16 of his right to read and sign this transcript, does
17 not waive that right.)

18 (The deposition concluded at 5:43 p.m.)
19
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25

CERTIFICATE OF REPORTER

I, Karen Nellius, Court Reporter and
Notary Public for the State of South Carolina at
Large, do hereby certify that the foregoing
transcript is a true, accurate, and complete
record.

I further certify that I am neither
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Witness my hand, I have hereunto
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2022 at Charleston, Berkeley County, South
Carolina.



Karen Nellius, RPR
My Commission Expires
November 14, 2024

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1 To: FERNANDO A. HERRERA, M.D.

2 Re: Signature of FERNANDO A. HERRERA, M.D.

3 Date Errata due back at our offices: 30 days

4
5 Greetings:

6 The deponent has reserved the right to read and sign.

7 Please have the deponent review the deposition

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_____, _____.

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[& - 28th]

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South Carolina Rules of Civil Procedure

Part V. Depositions and Discovery

Court Rule 30

(e) Submission to Witness; Changes; Signing.

When the testimony is fully transcribed the deposition shall be submitted to the witness for examination and shall be read to or by him unless such examination and reading are waived by the witness and by the parties. Any changes in form or substance which the witness desires to make shall be entered upon the deposition by the officer with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness, unless the parties by stipulation waive the signing or the witness is ill or cannot be found or refuses to sign. If the deposition is not signed by the witness within 30 days of its submission to him, the officer shall sign it and state on the record the fact of the waiver or of the illness or absence of the witness or the fact of the refusal to sign together with the reason, if any, given therefor; and the deposition may then be used as fully as though signed unless on a motion to suppress under Rule 32(d)(4) the court holds

that the reasons given for the refusal to sign
require rejection of the deposition in whole or in
part.

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Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
2 COUNTY OF CHARLESTON) CASE NO. 18-CP-10-2109

3
4 Rebecca Turisk,)
5 Plaintiffs,)
6 -vs) **DEPOSITION**
7 Dennis K. Schimpf, M.D.) **OF**
8 and Sweetgrass Plastic) **Jordan Harper, NP**
9 Defendants.)

10
11 DATE: Tuesday, May 28, 2019
12 TIME: 9:29 a.m.
13 LOCATION: Smyth Whitley, LLC
14 126 Seven Farms Drive
15 Suite 260
16 Charleston, SC 29492
17 REPORTER: Lisa Kerns
18 Professional Court Reporter
19

20 -----
21 **RES COURT REPORTING SERVICES**
22 **243 NELLIEFIELD CREEK DRIVE**
23 **CHARLESTON, SC 29492**
24 **(843) 818-9396**
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Charleston, SC 29492

Also present: Tye Robinson

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QUESTIONS WITNESS INSTRUCTED NOT TO ANSWER

(None)

(**Jordan Harper, NP**, having been first
duly sworn, testified as follows:)

EXAMINATION

BY MR. TANENBAUM:

Q. Good morning. We met before we began today, my name is Mark Tanenbaum this is Tye Robinson, we represent Rebecca Turisk, do you know Rebecca? Do you remember Rebecca?

A. You know, I actually didn't remember her until this was brought up.

Q. Okay.

A. I only had one encounter.

Q. One encounter with her. Yeah. So, there's

1 some rules for the Deposition which may take longer for
2 me to tell you than your Deposition will take.

3 A. Okay.

4 Q. Okay. But the rules are, and I'm required to
5 tell you this, the rules are as, as I recall, that I'll
6 ask the questions, your required to answer them unless
7 the lawyer sitting next to your right instructs you not
8 to. If there's an objection you answer any way, again
9 unless he instructs you not to. We can take a break any
10 time you want. If you don't understand a question just
11 ask me for an explanation, okay?

12 A. Okay.

13 Q. And I think that's all I'm supposed to tell
14 you, but if not I'm sure he told you ahead of time. So,
15 and your name is Jordan Harper?

16 A. Correct.

17 Q. And where do you reside Jordan?

18 A. In Charleston.

19 Q. If you would your residence address?

20 A. 1117 Ashley Avenue, Charleston, South
21 Carolina.

22 Q. Okay. And how long have you resided there?

23 A. A year.

24 Q. And will you be there for the next year as
25 well?

1 A. I will not.

2 Q. Where are you going to be living after this?

3 A. I am going to be in Augusta Georgia.

4 Q. That's right. And when do you leave for
5 Augusta?

6 A. Saturday, Saturday or Sunday.

7 Q. Okay. And what are you going to be doing in
8 Augusta?

9 A. You know, I don't know yet. My husband is
10 doing a Residency for Oral Surgery.

11 Q. Oh good. Okay. Great.

12 A. Yes.

13 Q. And how long have you been married?

14 A. Six and-a-half years.

15 Q. Where were you born and raised?

16 A. Atlanta or Roswell, Georgia.

17 Q. And when did you -- We'll, give us the benefit
18 of your educational background.

19 A. I went to Auburn University and got my
20 Bachelors in Nursing. And then I went to, I worked in
21 the ICU for about five years. Then I went, got my
22 Masters and Nurse Practitioners at UAB, University of
23 Alabama Birmingham.

24 Q. And you're a, you are a Nurse Practitioner?

25 A. Correct.

1 Q. And what do you do is a Nurse Practitioner? I
2 know you can do a lot of things that a Physician can do,
3 and a lot of things that an RN cannot do.

4 A. What do I currently do, or what --

5 Q. No, just basically what, what is the
6 difference between a Nurse Practitioner and a Nurse?

7 A. We can prescribe medication. We practiced as
8 a mid-level provider, so they are sort of the same scope
9 as a Physician's Assistant. So, it's kind of like the
10 Liaison I guess, in between a Nurse and a Physician.

11 Q. Okay. And how long have you lived here in
12 Charleston?

13 A. Six years.

14 Q. Six years. And you work for Sweet Grass now?

15 A. Correct.

16 Q. That's Dr. Schimpf?

17 A. Correct.

18 Q. And how long have you worked there?

19 A. I started working there August of 2016.

20 Q. Twenty?

21 A. 2016.

22 Q. Sixteen. And before that where did you work?

23 A. I worked at a place called Carolina Hormone
24 and Health.

25 Q. That's the woman --

1 A. It's a -- Excuse me?

2 Q. That's that Barbara?

3 A. No. It's, her name is Bernard.

4 Q. Okay. Dr. Bernard?

5 A. Uh-huh.

6 Q. And first name is?

7 A. Darleen.

8 Q. Holds hand up to ear.

9 A. Darleen.

10 Q. I'm sorry. It's either the air-conditioning
11 or my hearing is --

12 A. And I normally talk very loud, so... I'm
13 always used to like being told to be like quiet.

14 Q. That's okay. My wife, I keep saying if I ever
15 need hearing aids, and she says when.

16 So, all right, and what did you do there, were
17 you a Nurse Practitioner there?

18 A. Yes, sir.

19 Q. And you were there for three years?

20 A. No. I was there from 2015. So, I have been a
21 Nurse Practitioner since 2015. I graduated from nursing
22 school in 2010.

23 Q. Okay.

24 A. So, I worked in the ICU while I was finishing
25 my Nurse Practitioners Program.

1 Q. Here in Charleston?

2 A. Uh-huh.

3 Q. Okay. Where? What hospital?

4 A. MUSC.

5 Q. And how long have you worked for Dr. Schimpf,
6 again?

7 A. August of 2016.

8 Q. And during that period of time, what's the
9 staff turnover been like?

10 A. So when I started working there, there was
11 probably six or seven people. Honestly, they have all
12 been there, we've just added more.

13 Q. Okay.

14 A. Maybe one or two, but everyone's stayed.

15 Q. Tell us what you remember, we've discussed
16 this before, I think you had one encounter with Ms.
17 Turisk?

18 A. Uh-huh.

19 Q. Tell us what you remember about her?

20 A. I honestly only remember from what I saw from
21 my Note. So, I don't necessarily, even when I saw the
22 photo I didn't remember her face, so... But I only
23 remember what I remember from the Note.

24 Q. Okay. And you say that until this came up you
25 don't have any recollection of her; is that fair to say?

1 A. Yes.

2 Q. And who told you about the Deposition today?

3 A. Vicki.

4 Q. And who is Vicki?

5 A. She's our Office Manager.

6 Q. Okay. And what did she tell you?

7 A. That, I mean she just connected me with their
8 Paralegal. That there was Deposition, and that's all
9 she told me.

10 Q. Okay. Did she tell you what the Allegations
11 of the Complaint were?

12 A. No.

13 Q. Do you know what the Lawsuits about?

14 A. I think so.

15 Q. Tell me what you think.

16 A. Why don't you tell me?

17 Q. No. I get to ask the questions.

18 A. I think it's just the, it's just a Medical
19 Malpractice Suit, right?

20 Q. Yeah, well is that what you think?

21 A. Yeah.

22 Q. I just want to know what you think.

23 A. Yeah, that's what I think.

24 Q. Okay. And what do you think she contends,
25 Rebecca Turisk contends, that Dr. Schimpf did

1 incorrectly?

2 MR. STEWART: Object to the form.

3 THE WITNESS: I don't know what she
4 thinks.

5 BY MR. TANENBAUM:

6 Q. Sure.

7 A. I don't know what she thinks, honestly.

8 Q. Okay. You don't know?

9 A. What Rebecca thinks? How am I supposed to
10 know what she thinks?

11 Q. Okay. You don't get to ask the questions. I
12 asked you what you think --

13 A. Uh-huh.

14 Q. -- and you said you don't know.

15 A. Yeah.

16 Q. Okay. We're only as smart as we are.

17 A. Yeah.

18 Q. Right?

19 A. Yeah.

20 Q. So, we can be as smart as we want to be?

21 A. Uh-huh.

22 Q. We want to be smart.

23 A. Uh-huh.

24 Q. So, the time that you did see her after you
25 reviewed the Note, tell me what you recall now?

1 A. Can I look at my Note?

2 Q. Sure.

3 A. I do, don't know where it is.

4 Q. I think it's number 39 in, in that set of
5 materials.

6 A. Okay. So, I'm sorry can you repeat that
7 question again?

8 Q. I said tell me, you asked if you could look at
9 your note.

10 A. Uh-huh.

11 Q. Before you responded to my question about what
12 you remembered?

13 A. Uh-huh. And then...

14 Q. What do you remember?

15 A. What do I remember? Okay. I was like what
16 was I suppose to say? So, I just remember seeing her,
17 and so this was quite a while after her surgery, maybe
18 27 days it looks like. The date of surgery is 11/1.
19 And it looks like she had some fever over the weekend.
20 It doesn't appear that there was any evidence of
21 infection. Most likely, so I remember, well, I don't
22 remember, but... I prescribed her a Bactrim which is,
23 we, we'll do it for infection, but a lot of times we
24 will just do it prophylactically. So, since she had a
25 couple of fevers over the weekend, and then I took some

1 photos of her and send them to Dr. Schimpf and then that
2 way I could update him on the situation.

3 Q. Okay. And Page 39 of Exhibit 1 is your
4 Note --

5 A. Correct.

6 Q. -- from that day --

7 A. Correct.

8 Q. -- is that correct?

9 A. Correct.

10 Q. All right. Now, was Dr. Schimpf with you when
11 you saw her?

12 A. I don't think, I don't think so.

13 Q. Okay.

14 A. I'm not sure, because I said I sent the photos
15 to him. So, I'm not sure.

16 Q. All right. And tell me what you remember
17 about her incisions and about sort of the physical
18 examination. I'm sure you performed a physical
19 examination?

20 A. Correct.

21 Q. Yeah, so tell me what you recall about the
22 physical examination?

23 A. On that, I have that photo but, that I took.
24 I think we've looked at it. I think there was just, it
25 didn't appear that there was any infection, but there

1 was just some Eschar around on the Nipple Areola
2 Complex.

3 Q. Okay. So, would it be fair to say that your
4 Physical Examination Notes are the middle paragraph that
5 begin with, "abdominal incisions healing well?"

6 A. No, because it looks like I wrote above that,
7 "Erythema."

8 Q. Okay.

9 A. Yeah.

10 Q. Go ahead. Tell us what your physical
11 examination revealed, that's what I'm asking?

12 A. It looks like from the, so it looked like the
13 Erythema had resolved. That the redness had resolved.
14 And that the opening on the right side, which is the
15 breast incision, closed. And then it looked like I put,
16 "the Nipple Areola Complex with Eschar." But it looks
17 like apparent, you know from this, this appears that
18 there's no evidence of like remaining Erythema.

19 Q. Okay. So, she had two, basically two
20 procedures performed?

21 A. Uh-huh.

22 Q. Would that be fair to say?

23 A. I think she had a couple. Yeah. Sure.

24 Q. Breast removal, breast implant removal?

25 A. Uh-huh.

1 Q. Correct?

2 A. Breast reduction.

3 Q. Breast reduction. Okay. And that involved
4 removal of the implants?

5 A. Correct.

6 Q. Anything else?

7 A. It looks like Smart Lipo and then
8 Abdominoplasty.

9 Q. Okay. That's right, but I want to focus on
10 the breast first for a second. Sorry.

11 A. Oh.

12 Q. Was anything else done to her breast? Was
13 anything put back in, for example?

14 A. Not that I'm aware of.

15 Q. Okay. So, the removal of the implants, and
16 then when it says, "Erythema has closed."

17 A. I think I might have just written, like
18 accidentally said, like Erythema is closed and incision
19 is closed, I think I to me, what I'm interpreting that
20 as, is I probably should have ment resolved.

21 Q. I'm sorry. So --

22 A. Resolved. Like how it's closed, I wrote
23 Erythema is closed. Opening on the right IMF has
24 closed. Erythema, like I probably should've said like
25 resolved --

1 Q. Okay.

2 A. -- instead of closed.

3 Q. And where was the Erythema?

4 A. Around the right Inframammary incision I am
5 assuming, but I am not exactly sure.

6 Q. Okay. So, the Note doesn't really tell us
7 where it was?

8 A. Well.

9 Q. You're not sure?

10 A. Correct.

11 Q. Okay. All right. And the opening on the
12 right IMF is Intramammary --

13 A. Infra. Yeah.

14 Q. Inframammary?

15 A. Fold.

16 Q. Fold. And that's under the breast?

17 A. Correct.

18 Q. And that incision closed at that point?

19 A. Correct.

20 Q. All right. Now, the abdominal drain of course
21 refers to the, I guess you would call it a Tummy Tuck is
22 that --

23 A. Uh-huh.

24 Q. -- sort of the best way to describe it?

25 A. Uh-huh.

1 Q. Had she had an infection to your knowledge up
2 to this point?

3 A. No.

4 Q. Okay. Would you have known that?

5 A. The only way I would have known is just going
6 through the Notes.

7 Q. Did you go through the Notes before you saw
8 her?

9 A. Yes.

10 Q. Okay. Now, the, the rest of the, the physical
11 exam; well, the abdominal incision is healing well?

12 A. Uh-huh.

13 Q. That's obviously the abdomen?

14 A. Uh-huh.

15 Q. No Erythema or drainage? Abdomen, correct?

16 A. Correct.

17 Q. Mild swelling. Again, abdomen?

18 A. Uh-huh.

19 Q. No Seroma. And you need to say yes or no, not
20 uh-huh.

21 A. Oh, sorry. Yes.

22 Q. Okay. Mild swelling. No Seroma present.
23 That would also refer to the abdomen?

24 A. Correct.

25 Q. And the drainage is functioning properly,

1 output is Serosanguineous?

2 A. Uh-huh. Yes, sir.

3 Q. And Serosanguineous means what?

4 A. So, it just means the color of the drainage.

5 Q. What color is that?

6 A. It's kind of like a mix between a yellow and a
7 blood.

8 Q. Blood.

9 A. Uh-huh.

10 Q. Okay. And is that normal?

11 A. Correct. Yes.

12 Q. And then the right Nipple Areolar Complex --

13 A. Yes, sir.

14 Q. -- with Eschar formed throughout, correct?

15 A. Correct.

16 Q. What did I miss pronounce?

17 A. No, I'm laughing at myself. I just keep
18 saying, uh-huh. I'm so used to it. Sorry.

19 Q. All right. Now show us the photos that were
20 taken that day. And you can refer to them by number --

21 A. I think they are --

22 Q. -- down at the bottom right. They are the
23 ones that show the --

24 A. Yeah, 83. Is that correct?

25 Q. Yeah, 83, 84. Is that the left or right? It

1 looks like the right.

2 A. I think, I believe they are all the right.

3 Q. Okay. Now, looking at 83, that's the first
4 one. And this is, you say the incision has closed?
5 That's a photograph showing it is closed?

6 A. So, the IMF incision below?

7 Q. Uh-huh.

8 A. Yeah.

9 Q. Okay. And what is that pussy looking thing
10 above it?

11 A. It's just, it's not pus.

12 MR. STEWART: Object to the form.

13 THE WITNESS: It's just, it's just
14 tissue.

15 BY MR. TANENBAUM:

16 Q. Okay. Tissue from where?

17 A. It's just dead tissue that happens after
18 surgery.

19 Q. Not on the nipple, but I'm talking about --

20 A. Right here?

21 Q. Yeah. Circle that for me if you would, just
22 so that we know. Or draw an arrow to it.

23 A. This little guy?

24 Q. Yeah. Well, it may look little to you, but...
25 Okay. And then when you say that the incision, the

1 intramammary(sic) fold incision that's below that, we're
2 looking at that line below the tissue that you've
3 identified; is that correct?

4 A. I'm kind of; yeah. Like this area here?

5 Q. Uh-huh.

6 A. Yeah.

7 Q. You just circled it, right?

8 A. Correct.

9 Q. Okay. And then the nipple itself, tell me
10 what's going on with that?

11 A. That's called Eschar. It's just --

12 Q. Dead tissue?

13 A. -- dead tissue.

14 Q. Is that normal?

15 A. Normal? I mean...

16 Q. How many times after an implant have you seen,
17 have you seen a nipple that looked like that after an
18 implant removal?

19 A. A few.

20 Q. A few? Do you have a number? Less than five?

21 A. Yeah.

22 Q. Yeah. Less than five. Okay. And how many
23 patients with implant removal's have you, do you think
24 you've seen during your career with Dr. Schimpf?

25 A. Uh.

1 Q. A hundred or more?

2 A. Gosh, I have no idea. I feel like I would be
3 totally guessing.

4 Q. Okay. All right.

5 A. Yeah, a fair amount.

6 Q. A fair amount.

7 A. Yeah.

8 Q. So, would this, would it be fair to say that
9 this Eschar appearance as seen in Photograph 83 is rare?

10 A. In, from what I've seen?

11 Q. Yeah.

12 A. I would say it's not common.

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 Q. Uh-huh. Okay.

22 A. Again, I am not --

23 Q. And what I see around the Eschar is again what
24 appears to me to be pus. Tell me what pus is, first of
25 all? Do you know?

1 A. Pus would be, just like; you're thinking more
2 like it's an infection?

3 Q. Yeah, I --

4 A. Right, is that what?

5 Q. You aren't the one --

6 A. Oh, yeah. I forgot. I forgot. But no. When
7 I see that I don't see pus. That's not what I see. It
8 actually doesn't look like there's, to me, an infection
9 at all. That looks more, that's just like dead tissue
10 that's formed. So, if you pulled off that Eschar, you
11 would just see dead tissue.

12 Q. Underneath?

13 A. Uh-huh.

14 Q. And the tissue that's white below that, that
15 you drew an arrow to, is that dead tissue?

16 A. Correct.

17 Q. Okay. Is that also, in your mind, a lack of
18 blood flow?

19 A. No.

20 Q. What's that? What causes that? In your mind.

21 A. I know. I know. I don't want to speculate
22 from like a surgical standpoint --

23 Q. Yeah.

24 A. -- because I obviously don't do surgery --

25 Q. Right.

1 A. -- and I'm obviously not a doctor. But in my,
2 that's not from, in my opinion, that's not necessarily
3 from, that's not from blood flow at all, it's just from
4 incisions being pulled tight.

5 Q. Okay.

6 A. And that's how they should be pulled, there's
7 just, there's just tension on normal incisions.

8 Q. Okay. Over to the right in this photograph,
9 to the right of that arrow that you've drawn --

10 A. Uh-huh.

11 Q. -- there is what appears to be a black spot.

12 A. Uh-huh.

13 Q. Is that an opening?

14 A. I am not sure.

15 Q. Okay. All right. Now, was there a, a smell
16 to this, to any, any of the fluid draining from her or
17 from her breast?

18 A. I am not sure. I cannot remember.

19 Q. Okay. All right. So, if you will look at 37.
20 Let's see, your, your examination was on the afternoon
21 or sometimes on the 28th. Let's see, 4:49 is when you
22 dictated it apparently, or signed it.

23 A. Okay.

24 Q. Is that what time it was actually?

25 A. Yeah, I see -- Is that what time it was what?

1 Q. Is that time it was actually conducted, your
2 examination of her?

3 A. I doubt it.

4 Q. Okay. When, when do you think you saw her?

5 A. I have no idea. Sometime that day,
6 absolutely. I mean obviously sometime before the 4:49,
7 but I don't know what time during the day.

8 Q. Do you, do you have handwritten notes to keep
9 until you; did you dictate this or handwritten yourself?

10 A. I wrote it myself.

11 Q. With a typewriters?

12 A. With a computer.

13 Q. Yeah, right. Computer.

14 A. Yeah.

15 Q. All right. And do you have handwritten notes
16 until you get to the computer later in the day, or...

17 A. Sometimes. It just depends on the day. A lot
18 of times I will just write it on my schedule.

19 Q. Uh-huh.

20 A. But I don't keep those. I don't have those
21 notes, but I write it like as I see a patient. On my
22 schedule I just write out notes --

23 Q. I gotcha.

24 A. -- that way I can remember it.

25 Q. And you do or you do not have those original

1 notes?

2 A. No, I don't.

3 Q. Okay. All right. What do you do with those?

4 A. Shred them.

5 Q. Shred them. Okay. All right.

6 A. Because they have the patient information on
7 them.

8 Q. Yeah. Okay. Now, look at Page 37 if you
9 would on Exhibit 1. Are you familiar with this Note by
10 Dr. Schimpf?

11 A. I can be familiar with it.

12 Q. All right. I'll just have you, have you read
13 it since, since it happened before coming here today?

14 A. No.

15 Q. No?

16 A. No.

17 Q. Okay.

18 A. Would you like me to read it?

19 Q. Sure.

20 A. Okay.

21 Q. So, do you know first of all, when Dr. Schimpf
22 actually created this note?

23 A. I do not.

24 Q. Does he use the computer also at the office?

25 A. He does a couple of, I think he has a couple

1 of different ways that he charts, but yeah. He has a
2 computer as well.

3 Q. What are the different ways that he has to do
4 that he charts?

5 A. He does the dictate as well.

6 Q. Okay. And who transcribes the dictation?

7 A. I am not sure.

8 Q. Is it automatic transcription, or...

9 A. I have no idea.

10 Q. Okay.

11 A. All I know is it's not me.

12 Q. Okay. And so I guess my first question is,
13 when you saw her on the 28th, had she been to the
14 Emergency Room the night before?

15 A. I am not sure.

16 Q. Okay.

17 A. I would have to look back in the Note.

18 Q. Look back at your Note?

19 A. I mean, I know in my Note, but I'd have to
20 look back in these Notes.

21 Q. Okay. All right. And did, is it clear now
22 after reading his Note, that there was odor coming from
23 the underlying tissue under the nipple?

24 A. That's what he wrote in his Note, correct.

25 Q. You just didn't perceive it or didn't chart it

1 if it was there?

2 A. Correct.

3 Q. Okay. And he also notes that, "there is
4 colonization of bacteria under the Eschar;" is that
5 correct?

6 A. In what paragraph are you seeing that in?

7 Q. Same paragraph that is there?

8 A. Oh, "underlying tissue."

9 Q. It says, "I have discussed with her and her
10 caregiver at length today that while there is
11 colonization of bacteria --"

12 A. Oh.

13 Q. "-- present in the underlying subcutaneous
14 tissue."

15 A. Uh-huh.

16 Q. So, would that be, would it be fair to say
17 that there was in fact a bacterial infection?

18 A. I mean, again, I'm not a Surgeon but, or a
19 Doctor, but from what I understand is that whenever
20 theres an opening, like if we did a culture, you and I
21 did a culture on our skin, we're going to get bacteria,
22 because it's exposed and it's open. So that to me is
23 not you're going to always have and find a bacteria.

24 Q. Well, he gave her antibiotics for it, right?

25 A. Correct.

1 Q. So, it was something that he didn't want,
2 correct?

3 A. I'm not sure what he, if he didn't want it or
4 not.

5 Q. Okay.

6 A. But I --

7 Q. Would you want it?

8 A. Well, any time --

9 Q. Would you want it in a wound that you had?

10 A. Well, this is not even about me.

11 Q. Would you answer the question, please?

12 A. Would I want bacteria --

13 Q. In wound that you, a surgical wound that you
14 had?

15 A. Most likely, from what my understanding is, is
16 that this would be more of a prophylactic, and that's
17 why, because it's not that, any time that, you know,
18 someone cuts themselves they're going to have bacteria
19 in their skin, so you're going to have a risk of
20 bacteria going into an area, so that's why. In my
21 opinion you would be treating with an antibiotic to
22 prevent that from being an infection.

23 Q. How about the odor coming from a wound?

24 A. What would -- How about what?

25 Q. What is the significance of that to you?

1 A. Dead tissue.

2 Q. That's it?

3 A. Lots of odors can be a lots of things.

4 Q. Is that what you think this is in this wound?

5 A. Right.

6 Q. I understand odors can be lots of things?

7 A. Right.

8 Q. I'm talking about this lady, this wound --

9 A. Right.

10 Q. -- the eschar that you've photographed. So,
11 let's be real precise --

12 A. Yeah.

13 Q. Okay.

14 A. Yeah. No, I think the odor is from the
15 Eschar.

16 Q. Right. Is that a good sign?

17 A. It's what dead tissue smells like. It's not
18 good.

19 Q. It's not good?

20 A. I mean, it's not like a good smell.

21 Q. And it's not good to have it either, is it?

22 A. It's not good to have Eschar?

23 Q. The odor?

24 A. I, personally, again, from what I understand
25 about wounds, is that it, it concerns patients, the

1 smell, but a lot of times there's a lot of smells that
2 can happen post procedure that it doesn't always mean
3 that it's bad.

4 Q. Jordan, Ms. Harper, read his note. Read that
5 paragraph in full for me please, and tell me if Dr.
6 Schimpf was, if Dr. Schimpf was trying to get rid of the
7 smell? What does he encourage her to do?

8 A. The --

9 Q. Irrigated with Dakins --

10 A. Dakins.

11 Q. -- right?

12 A. Uh-huh.

13 Q. All right. What is Dakins?

14 A. It's a cleansing solution.

15 Q. All right. And he's encouraging her to
16 irrigate it, "to clean the area up," correct?

17 A. And to improve the smell. Uh-huh.

18 Q. And to clean the area up, right?

19 A. Uh-huh. It has a little bit --

20 Q. All right. And he didn't think the wound was
21 healed, did he?

22 MR. STEWART: Object to the form.

23 BY MR. TANENBAUM:

24 Q. It says here at the bottom, "our main goal at
25 this point is to get the wound healed, and once that is

1 completed" -- I'm sorry. What is your objection?

2 MR. STEWART: It was leading.

3 MR. TANENBAUM: Well, guess what? She
4 works for y'all. I get to lead her, okay?

5 MR. STEWART: Okay.

6 BY MR. TANENBAUM:

7 Q. Thank you. So, it says here, "our main goal
8 at this point is to get the wound healed, and once that
9 is completed there are various things we can do to
10 reconstruct the nipple as well as tattooing." So, is it
11 fair to say that a fair reading of that is, the wound is
12 not healed yet?

13 A. I think the main goal, meaning, yeah, meaning
14 that you, the wound, at this point the goal is to get
15 the wound healed.

16 Q. So, a fair reading is the wound was not healed
17 yet, correct?

18 A. The wound is not healed at this time when he
19 saw her? Correct.

20 Q. Thank you. Now, he also refers to the wound
21 as being "open and draining," correct?

22 A. Where are you seeing that?

23 Q. Right there in the middle of --

24 A. The third paragraph?

25 Q. -- the third paragraph, yeah.

1 A. "The wound is open and draining." That's what
2 he wrote.

3 Q. Which is contrary to what you wrote?

4 A. I don't think it's contrary, because I was
5 talking about the IMF incision.

6 Q. Okay. Which incision do you think he's
7 talking about?

8 A. The Areola Complex.

9 Q. Okay. All right. Okay. Now, do you recall
10 being present when he debrided this wound?

11 A. I don't.

12 Q. Okay.

13 A. But I just can't recall, yeah.

14 Q. Do you have any other recollection of, of this
15 young lady?

16 A. No, sir.

17 Q. Anyone associated with her?

18 A. No, sir.

19 Q. Mary Ackerman, the lady who picked her up,
20 maybe called a few times?

21 A. Uh-huh.

22 Q. No? William, her significant other, any
23 recollection of him or interacting with him?

24 A. I think I talked to him on the phone based on
25 a Note that I wrote, but I don't have like any like --

1 Q. What note is that?

2 A. Thirty-four.

3 Q. And this is November 7th, so this is six days
4 post surgery?

5 A. Correct.

6 Q. And the drainage, do you know where the
7 drainage was coming from that you are referring to
8 there?

9 A. I do not.

10 Q. Isn't that a goal of what keeping notes is
11 supposed to be, so that we can document what's happening
12 with a patient? Isn't that? That's a question.

13 A. Isn't that the what?

14 Q. The goal of keeping notes so that you can
15 document what occurred and where it was happening,
16 correct?

17 A. Correct.

18 Q. That doesn't allow you to do that, does it?

19 A. Correct.

20 Q. And she had a fever of 102 that day; is that
21 correct?

22 A. Per William, correct.

23 Q. Well, if a patient; do you know who William
24 was again?

25 A. I believe you said her caregiver.

1 Q. Well, somewhere in here it also refers to a
2 caregiver and I just didn't know whether you knew who
3 that was?

4 A. I believe it's her significant other.

5 Q. Uh-huh.

6 A. And from what I understand of this patient.

7 Q. So, is there any reason that you doubt the
8 truthfulness of this fever of 102? Are you doubting the
9 truthfulness of it?

10 A. No. No. I don't doubt the truthfulness of
11 it, but I also didn't take the temperature --

12 Q. Okay.

13 A. -- so that's why it's all, I'm just
14 documenting what he said to me.

15 Q. Right.

16 A. So I just don't know hundred percent because I
17 didn't take the temperature.

18 Q. All right. Did you have any other
19 interactions with anyone connected to this patient?

20 A. No, sir.

21 Q. Did you create any other notes in this chart?

22 A. No, sir.

23 Q. All right. Thirty minutes and I'm done. He
24 may have some questions for you.

25 MR. STEWART: I don't have anything.

1 MR. TANENBAUM: Told you. Have you
2 marked that as Exhibit 1?

3 THE COURT REPORTER: I have.

4 MR. TANENBAUM: And we'll just carry
5 that around with us, okay.

6 THE COURT REPORTER: Okay. That's fine
7 and --

8 MR. TANENBAUM: I'm sorry. For the
9 record I would like to identify these as,
10 what, Plaintiffs have marked as Turisk Sweet
11 Grass Plastic Surgery 0001 through 85.

12 (TURISK SWEET GRASS PLASTIC SURGERY
13 0001-85. MARKED PLAINTIFF'S EXHIBIT 1 FOR
14 I.D.).

15 THE COURT REPORTER: So do you want me
16 to add those to the transcript?

17 MR. TANENBAUM: No, I don't think so.

18 MR. STEWART: No, I think we referred
19 to the pretty sufficiently.

20 (Deposition concluded at 10:10 a.m.).

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13 I further certify that I am not of counsel or kin
14 to any of the parties to this cause of action, nor am I
15 interested in any manner in its outcome.

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25

Notary Public for South Carolina
My commission expires February 8, 2028

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Deposition of:
Todd Samuel Lefkowitz

November 27, 2019

In the Matter of:
Turisk, Rebecca Vs. Schimpf, Dennis

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1 STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

2 COUNTY OF CHARLESTON

3
4 REBECCA TURISK,

5 Plaintiff,

6 vs.

CASE NO. 18-CP-10-2109

7 DENNIS K. SCHIMPF, M.D. and

SWEETGRASS PLASTIC SURGERY,

8 LLC,

9 Defendants.

10
11 DEPONENT: TODD SAMUEL LEFKOWITZ, MD, MBA FACS

12 DATE: November 27, 2019

13 TIME: 12:00 p.m.

14 LOCATION: Lexington Plastic Surgery

2728 Sunset Boulevard

15 Lexington, SC

16 TAKEN BY: Counsel for the Plaintiff

17 REPORTED BY: KIMBERLY T. POWER, CR

18
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21
22 (INDEX AT REAR OF TRANSCRIPT)

1 TODD LEFKOWITZ, M.D.,
2 being first duly sworn, testified as follows:

3 EXAMINATION

4 BY MR. TANENBAUM:

5 Q. Dr. Lefkowitz, we met formally and
6 informally a minute or so before we went on the
7 record. But for purposes of the record, I'm
8 Mark Tanenbaum and I represent the plaintiff in this
9 action, a lady by the name of Turisk. Okay? Rebecca
10 Turisk. Have you ever met Rebecca?

11 A. No.

12 Q. And other than the exhibits in this case
13 or her deposition, et cetera, I assume you don't know
14 anything about her otherwise?

15 A. No, sir.

16 Q. And you're here to give expert opinions
17 today. I'm going to assume that you're qualified
18 because -- (inaudible).

19 A. Mark, you cut out a little bit. If you
20 don't mind just repeating that.

21 Q. Yeah, that's the wireless.

22 So I assume you have not met Deborah -- I
23 mean, Rebecca and that you don't know her other than
24 the exhibits; is that correct?

25 A. Correct.

1 Q. And there are certain rules that we have
2 to follow. I'm going to, first of all, assume that
3 you are an expert because you're double board in
4 general surgery and plastic surgery; is that right?

5 A. Correct.

6 Q. And there's several organizations, by the
7 way, that certify -- board certify plastic surgeons
8 or is it just one?

9 A. Just one, the American Board of Plastic
10 Surgery.

11 Q. And if I ask you a question, you will need
12 to answer with a yes or a no rather than an uh-huh or
13 huh-uh, as you know. And if Kevin objects, you're
14 required to answer it anyway unless he instructs you
15 not to.

16 A. Yes.

17 Q. And, if you would, state your full name.

18 A. Todd Samuel Lefkowitz.

19 Q. And, Dr. Lefkowitz, I read a little bit
20 about you. Were you born and raised in Lexington?

21 A. West Columbia.

22 Q. West Columbia. Okay. And what did --
23 what did your family do there?

24 A. So my father was a financial advisor. My
25 mom was actually an entrepreneur. She started a

1 cleaning service when I was fairly young. She passed
2 away when I was in college, and my dad has since gone
3 on to retire.

4 Q. Okay. And does he still live in West
5 Columbia?

6 A. He does. He technically lives in
7 Lexington now.

8 Q. And are you married?

9 A. Yes, sir.

10 Q. And have children?

11 A. No, sir.

12 Q. And how old are you?

13 A. Forty-three.

14 Q. And your educational background is
15 accurate as on the C.V., I assume?

16 A. Yes, sir.

17 Q. I see that you've done some publications.
18 Anything that relates in any way to this case?

19 A. No.

20 Q. And you've made some presentations through
21 various professional associations. Anything that
22 relates to this case?

23 A. No, sir.

24 Q. And you have testified before?

25 A. I've given depositions before, but not

1 testified in court.

2 Q. And how many times have you testified?

3 A. Zero. No times for testifying.

4 Q. I'm sorry. So this is the same -- this is
5 testifying as well, just testifying in a deposition.

6 A. This is my second deposition.

7 Q. What was the other deposition?

8 A. It was a case involving MUSC
9 approximately -- I believe it was about a year and a
10 half ago.

11 Q. And what was the issue in that case?

12 A. Delayed infection. I believe, actually,
13 Dr. Holzman was the expert for that case on the
14 plaintiff's side as well.

15 Q. And who was the plaintiff in that case?

16 A. I think it was a patient, if I remember
17 correctly, DaCosta.

18 Q. Okay. Off the record.

19 (Off the record.)

20 BY MR. TANENBAUM:

21 Q. And that case involved, as I recall, MUSC
22 and whether the infection should have been caught
23 earlier; is that correct?

24 A. That was the crux of the plaintiff's case.
25 Yes, sir.

1 Q. Okay. And in this case what do you
2 understand the issue to be as far as you're
3 concerned?

4 A. Well, based on the testimony of the
5 expert, it's an issue of blood flow in terms of the
6 choice of procedure and whether or not that was the
7 appropriate choice for that procedure.

8 Q. As far as you're concerned, what do you
9 understand the issue to be?

10 A. So when I looked at the case and had
11 thought about the case, a couple of things that came
12 to mind. Number one was that the case was indicated
13 for what she came to him to see her complaints.
14 Number two, she had a very thorough understanding of
15 the risks and benefits based on the informed consent.
16 He picked a procedure that was appropriate for what
17 she was looking for. He executed the procedure
18 appropriately and very well according to the
19 standards that we set forth, and I thought his
20 post-op care followed those standards as well.

21 Q. So break down for me, if you would, what
22 you understand Dr. Holzman's testimony to be or his
23 theory to be.

24 A. His theory, as best as I can tell, was
25 that given the previous scar from the breast

1 augmentation surgery, a different, what we call,
2 pedicle should have been chosen to carry the nipple
3 areola complex to the new position.

4 Q. Is that what your understanding is of his
5 criticism to be?

6 A. That to me was the main criticism that he
7 had within his deposition. Yes, sir.

8 Q. And that's the criticism you intend to
9 respond to; is that correct?

10 A. Correct.

11 Q. By the way -- first of all, was there any
12 issue with the -- with the procedure chosen for her?
13 Not the technique, but the procedure chosen?

14 A. No, sir.

15 Q. And in terms of the technique, do you
16 agree with me that if someone has already had breast
17 augmentation, that the nipple remains more vulnerable
18 than if one has not already had a risk -- a breast
19 augmentation procedure?

20 MR. HORTON: Object to form. You may
21 answer.

22 THE WITNESS: I don't totally agree
23 with that because I believe that it does become a
24 little bit more complex with regards to any of the
25 type of breast surgeries that we do, and I speak from

1 my experience in that I do usually about 100 to 150
2 of various breast surgeries per year, if not more.
3 So I feel comfortable in trying to expand on this.
4 But I think it's a little bit more complex with
5 regards to blood flow in the nipple areola complex
6 within the span of either reductions, mastopexies, or
7 a combination of those procedures.

8 So I think it's a difficult question
9 to answer straight -- straight from, you know, based
10 on whether or not she had a breast augmentation in
11 the past. And the way I would expand on that is that
12 one of the most common surgeries that we perform now
13 is something called a breast augmentation mastopexy
14 where we actually do breast implants at the same time
15 that we lift the breast, and we do that very
16 successfully and very safely. So I think that alone
17 would -- would argue against that statement.

18 BY MR. TANENBAUM:

19 Q. First of all, you say "we." Are you using
20 a royal "we" or --

21 A. We in a general sense for board certified
22 plastic surgeons, meaning that it's a commonly
23 performed procedure within the specialty.

24 Q. Well, let's back up for a second. With
25 Rebecca Turisk, for example, in her case the breast

1 augmentation procedure was done with an incision in
2 the inframammary -- below the inframammary gland.

3 What is it called, the inframammary fold?

4 A. No, sir. In her case she had an incision
5 at the inferior part of her areola, which is a little
6 bit different approach than at the inframammary fold.
7 So her incision was at the bottom part of her areola.
8 You certainly can put implants through an
9 inframammary fold approach, which is the more common
10 approach now, but it was very common to put it
11 through her incision that she -- that she had.

12 Q. Well, I'm under the impression that Dr. --
13 first of all, where do you get that information?
14 What's the source of that information that you have?

15 A. From -- from his operative report. His --
16 I'm sorry. Dr. Schimpf's operative report,
17 Dr. Schimpf's deposition, and Dr. Holzman's
18 deposition.

19 MR. HORTON: Mark, if I may, we might
20 be talking about two different procedures here. The
21 initial implantation versus Schimpf's procedure. I
22 just want to make sure we're talking about the same
23 procedure.

24 BY MR. TANENBAUM:

25 Q. I'm talking about the initial augmentation

1 procedure.

2 A. Yes. That was put in through what we call
3 periareolar approach, and that's through a scar at
4 the bottom of the areola.

5 Q. At the bottom of the nipple?

6 A. Correct. That's correct. That's correct.

7 Q. And you base that on -- again, on
8 Dr. Schimpf's note?

9 A. And Dr. Holzman's note, yes.

10 Q. I am not sure of that. Okay.

11 A. If -- if I may, Mark, that's different
12 than the inferior pedicle --

13 Q. I know.

14 A. -- technique.

15 Q. That's what I was asking about. In
16 Dr. Schimpf's -- in Dr. Schimpf's exhibit, he's got
17 the scar from the implant surgery drawn, I'm sorry,
18 at the bottom left of the nipple, okay, as possible
19 scar from implant surgery. All right. And then the
20 pedicle was -- for this surgery was actually where?
21 I'm looking at Exhibit 6 in his deposition. Do you
22 have that with you?

23 MR. HORTON: I'm pulling it up. Is
24 that the one drawn on the photograph?

25 MR. TANENBAUM: Yeah.

1 MR. HORTON: I'm just going to show
2 it to him on my laptop, Mark, if that works for you?

3 MR. TANENBAUM: Sure.

4 THE WITNESS: I think he also -- if I
5 may interject, I think he also -- in his deposition
6 he also drew out -- he had some drawings as well that
7 showed his approach for the reduction portion of the
8 procedure.

9 BY MR. TANENBAUM:

10 Q. Okay. And what you're saying is that
11 where he made his incisions for the reduction
12 procedure did not interfere in any way with the blood
13 supply to the nipple?

14 A. I think at the end it certainly did
15 because obviously she had a -- a pretty difficult
16 complication. My opinion, though, is that it's a
17 very commonly accepted technique, even in the
18 presence of that previous scar, for him to use and
19 that's where I differ from Dr. Holzman's testimony.

20 Q. Is there another technique that would --
21 would have been less threat to the blood supply?

22 A. That's difficult to answer. Dr. Holzman's
23 idea was to use what we call a superior pedicle or
24 tissue above that scar. However, given my experience
25 and what's based in the literature, although that's

1 another technique, what Dr. Schimpf did is actually
2 still a more preferred technique based on plastic
3 surgeon's preferences.

4 Q. Well, when you say based on plastic
5 surgeon's preferences, it's what's best for the
6 patient, correct?

7 MR. HORTON: Object to form.

8 THE WITNESS: That's correct to some
9 extent. And what I mean by that, it's a very
10 acceptable, safely performed method of performing the
11 surgery that he did.

12 BY MR. TANENBAUM:

13 Q. And the issue is whether the scar --
14 excuse me, whether the incision that was there from
15 the augmentation procedure has already disrupted the
16 blood flow coming into the areola; is that correct?

17 MR. HORTON: Object to form.

18 THE WITNESS: That is -- that is how
19 I understand Dr. Holzman's testimony.

20 MR. TANENBAUM: Hey, Kevin, off the
21 record.

22 (Off the record.)

23 BY MR. TANENBAUM:

24 Q. So as I understand it, the issue is
25 whether that blood supply to the nipple has already

1 been disrupted by the earlier procedure; is that
2 correct?

3 A. Yes, sir. As I understand it from
4 Dr. Holzman's testimony, that's -- that's his
5 opinion. Correct.

6 Q. My question to you is: Is that a correct
7 statement?

8 A. I disagree with that for several reasons,
9 but that's -- that's the crux of my argument, is that
10 I disagree with the fact that that previous scar
11 should have been what we would consider or what I
12 would consider an absolute contraindication to
13 perform that surgery in the manner that Dr. Schimpf
14 did.

15 Q. The disruption -- as far as you're
16 concerned, there had been no disruption to blood
17 supply?

18 A. Well, I think that given the results of
19 the surgery, I think there certainly was a
20 disruption. Whether that was from the previous scar
21 or not, that -- I don't think that anybody can answer
22 that definitively because you can have the same
23 complication with a breast reduction that did not
24 have a previous scar.

25 Q. I'm with you. You can trip and fall with

1 or without a banana peel on the floor, right? The
2 banana peel makes it more likely you will trip and
3 fall, correct?

4 A. Possibly. Sure.

5 Q. All right. So that's my question. Not
6 that you can have this without a prior disruption to
7 the blood supply. My question is whether or not the
8 scar itself, from an anatomical standpoint, that that
9 incision there that has already disrupted the blood
10 flow from that source of blood, correct?

11 A. Not necessarily. And the reason I say
12 that if we look at many different plastic surgical
13 procedures in different parts of the body, that will
14 give you a couple of examples, including the breast
15 procedure, that we solely rely on blood flow that
16 goes through a scar. I'll give you one example in
17 that I deal with a lot of skin cancer reconstruction
18 that is performed in stages -- multiple stages. The
19 reason that that happens like that is I might rebuild
20 a nose, which I did about two hours ago, and I used
21 cheek tissue to transfer that cheek tissue to a
22 scarred nose. Over time the blood flow from the nose
23 itself will then transfer itself to that cheek tissue
24 for which you then divide separately from the cheek.
25 So now this tissue is only getting blood flow from a

1 previous scarred area. And that's just one example
2 of many in which we use.

3 Maybe more appropriate for the breast in
4 itself is a surgery that we perform quite often, and
5 that is doing a breast lift or a breast reduction in
6 preparation for a mastectomy or a nipple-sparing
7 mastectomy, to be more accurate, for either genetics
8 or breast cancer surgery. And what happens during
9 that surgery, during the breast lift you actually cut
10 all the way around the areola. So now you have
11 created a definitive scar all the way around the
12 areola. You do a breast lift. And then six to eight
13 weeks later, you literally cut out all of the breast
14 tissue as part of the mastectomy. So now the only
15 blood flow that is getting to that nipple areola
16 complex, the only blood flow, is from skin and blood
17 flow from skin that has to cross that scar that you
18 made only six to eight weeks ago. So to me that's a
19 very convincing argument that blood flow absolutely
20 can cross scar and can get to where it needs to go.

21 Q. Well, in that case you're talking about
22 life-saving surgery, correct?

23 A. Not necessarily. We're just talking from
24 a physiological standpoint.

25 Q. I understand that there are risks to

1 certain procedures. But in the case that you've just
2 used as an example, to me it sounds like it is a
3 life-threatening disease process in which you're
4 trying to stop. I want to talk about -- I'm sorry.
5 Go ahead.

6 A. No. I'm sorry. I disagree with you.
7 This surgery is oftentimes performed in women that
8 genetically test positive for a breast cancer gene,
9 but they in no way have breast cancer at the time of
10 these procedures. And I think my main point is that
11 if the argument is that blood flow cannot cross a
12 scar, I'm giving several different examples over the
13 course of plastic surgery that we absolutely rely
14 100 percent on blood flow to cross a scar.

15 So that's my argument. In terms of while
16 I understand what Dr. Holzman is saying, my argument
17 is that in no way did Dr. Schimpf go away from the
18 standard of care using his technique despite the fact
19 that there is a scar there, and there are multiple
20 other examples of plastic surgery that we use that
21 would defend that.

22 Q. Well, what would be wrong with a superior
23 pedicle?

24 A. Absolutely nothing. Superior pedicle is a
25 wonderful way to perform that -- that surgery.

1 Q. Okay. And if the superior pedicle
2 technique had been used, then the blood supply would
3 be -- would not have been previously disrupted by the
4 earlier breast augmentation; is that correct?

5 A. Not necessarily. And what I would argue
6 is that at the end of the day, we really don't know
7 the way he did his breast augmentation in terms of
8 the tunneling. I think Dr. Holzman brought this up
9 in his deposition that if you're going to use that
10 incision around the areola, you have to tunnel
11 through the tissue to get to the area that you're
12 going to put the implant in. We have no idea or no
13 one has a definitive answer to how that tunnel was
14 created and, therefore, blood supply to a superior
15 pedicle very easily may have been disrupted through
16 the tunneling that was performed.

17 Q. And there's no way to make an examination
18 of that prior to the surgery, correct?

19 A. Unfortunately, not. I wish there was, but
20 unfortunately not. No, sir.

21 Q. Of course, a review of the earlier
22 operative record would, if it were a complete note,
23 would reveal that?

24 A. Not necessarily. It probably would not
25 have gone into that much detail because at this -- at

1 this point I think that we would be looking for
2 information that would not have been -- would not
3 have been given in terms of the angle of the tunnel
4 that that physician used to get to the pocket he
5 needed or she needed to place the implant.

6 Q. And when you perform that surgery, do you
7 not put that information in your record?

8 A. Well, commonly now we actually place
9 implants through the inframammary fold, not through
10 the periareolar technique, for various reasons, none
11 that have to do with this particular case. So my
12 note is going to be quite a bit different, like a lot
13 of plastic surgeons who place it through the
14 inframammary fold. That note is going to be a little
15 bit different, and that would not -- for whatever
16 it's worth, my note would not give that information
17 for somebody coming back to perform a breast
18 reduction surgery.

19 Q. When you did the procedure or used the
20 technique with the incision at the nipple -- forgive
21 me for not going into the technical stuff because I
22 won't remember that. But when you did it that way --
23 did you ever do it that way?

24 A. I've done it very rarely. I think maybe
25 two or three times in my -- in my career.

1 Q. Okay. Did you note then where you made
2 your tunnel?

3 A. No. It's difficult to know. I would
4 argue that I probably did it three times and made
5 three different angled tunnels. That can be possibly
6 my technique, but it was different each time.

7 Q. Did you note that in your operative
8 record?

9 A. I don't remember, but I would -- I
10 would -- I would argue probably not.

11 Q. I don't want to argue. I just want to
12 know. Arguing would be speculation.

13 A. No, I don't.

14 Q. Certainly we will never know whether it
15 was noted with Rebecca's prior surgery because
16 Dr. Schimpf did not ask for those records, correct?

17 A. I'm not aware. I don't know.

18 Q. In his deposition, I think we discussed
19 that.

20 MR. HORTON: Object to form.

21 BY MR. TANENBAUM:

22 Q. But it's not in his chart, correct?

23 A. Not that I saw. No, sir.

24 Q. In fact, it was so unclear to him that he
25 wrote here on the exhibit, Exhibit 6, possible scar

1 from implant surgery because he wasn't aware of where
2 that incision was, correct?

3 MR. HORTON: Objection.

4 THE WITNESS: Again, this is pure
5 speculation. It could have been -- a lot of times
6 when we see patients that many years out, the scar
7 has healed so well, it's sometimes difficult to tell
8 whether or not that was an actual scar from that
9 particular surgery.

10 BY MR. TANENBAUM:

11 Q. Okay. Now, the other -- what other
12 criticism do you understand Dr. Holzman had?

13 A. Per his deposition, that was his -- and I
14 believe he reiterated that that was his main
15 criticism, was the choice of pedicle that Dr. Schimpf
16 utilized based on the presumed previous scar.

17 Q. Do you think that the patient did anything
18 to cause or contribute to the outcome she's had?

19 A. Nothing that I saw or would be concerned
20 about.

21 Q. So, for example, I think Dr. Schimpf had
22 some question about whether she should have come back
23 in the day of the surgery or the day after the
24 surgery, that sort of thing. She didn't feel well
25 enough to go in. That made no difference in the

1 outcome, did it?

2 MR. HORTON: Objection.

3 THE WITNESS: I don't believe so. I
4 commend him for offering to the patient to come in to
5 be evaluated. But at the end of the day, that can be
6 the patient's choice.

7 BY MR. TANENBAUM:

8 Q. But it also did nothing to contribute to
9 or cause the loss of as much tissue as experienced?

10 A. No, sir. I do not believe so.

11 Q. You believe that my statement is correct?
12 Just so the record is clear, you don't believe that
13 her failure to come in that day --

14 A. Correct.

15 Q. -- had any --

16 A. Correct. Yes, I agree.

17 Q. And was there any other way in which she
18 failed to do anything that Dr. Schimpf advised her to
19 do that contributed in any way to the outcome?

20 A. Not to my knowledge.

21 Q. Or any other person?

22 A. Not to my knowledge.

23 Q. How do you -- do you know Dr. Schimpf?

24 A. I do not. I have talked to him twice many
25 years ago. Once when I was interviewing for MUSC, he

1 was one of the faculty interviewers. I believe we
2 may have spoken for five minutes. That was in 2007.
3 And then once very briefly about the Darla Moore
4 School of Business. This was many years ago. At no
5 point was any discussion based around clinical
6 findings. It was simply he had done an MBA program
7 prior to me, so we spoke for about five minutes on
8 that.

9 Q. And how did you come to be involved in
10 this case?

11 A. I was asked to review the chart by the
12 defendant's law team, and that's how I got involved.

13 Q. Who did you know on the law team?

14 A. No one.

15 Q. And who made the initial contact?

16 A. They did.

17 Q. "They" meaning?

18 A. I believe it was Kevin, if I remember
19 correctly.

20 Q. Do you have a relationship with the
21 defendant's insurer, for example, JUA or whoever
22 the -- I forget who the insurer is here. But whoever
23 it is, do you have a relationship with them?

24 A. Not to my knowledge. My insurance is
25 through Lexington Medical Center. I don't know

1 exactly what relationship they have, but I am not
2 personally insured or have any relationship with
3 them. No.

4 Q. And is your name on a list of folks who
5 are willing to testify for insurers or physicians?

6 A. No, sir, I am not.

7 Q. Have you ever reviewed a chart for a
8 plaintiff, a patient?

9 A. No.

10 Q. And is this the first or second time that
11 you've been involved in a case?

12 A. Yes. Second time I've been involved in a
13 case. There's a third ongoing. I have not yet been
14 asked to give a deposition in that case.

15 Q. And is that case in suit?

16 A. Yes.

17 Q. And what are the issues in that case?

18 A. It is also a breast reduction case. I
19 just am getting to know that case. That's about all
20 I know of it and that's out of Sumter, South
21 Carolina.

22 Q. And how did you become involved in that
23 case?

24 A. Same. Defendant's lawyers asked me to
25 review it along with several other plastic surgeons.

1 Q. Any lawyers involved in this case?

2 A. Yes. But for the life of me, I don't
3 remember his name off the top of my head.

4 Q. Is the lawyer in that case also involved
5 in this case?

6 A. No.

7 Q. Okay. I think we've agreed that the blood
8 supply, unfortunately, was -- had been disrupted by
9 the incision in the breast from the breast
10 augmentation procedure. Do you agree with that?

11 MR. HORTON: Objection.

12 THE WITNESS: No, sir. I cannot
13 agree with that. I agree that blood flow was
14 disrupted at some point during the surgery, but I
15 certainly can't assume that it was directly related
16 to the previous breast augmentation surgery.

17 BY MR. TANENBAUM:

18 Q. But it was disrupted as a result of this
19 surgery, correct?

20 A. It was resulted at some point during
21 the -- during the surgery.

22 Q. During this surgery, Dr. Schimpf's
23 surgery?

24 A. Yes, that's correct.

25 Q. And what do you think caused it to be

1 disrupted?

2 A. I don't know.

3 Q. The only blood supply that would have been
4 left to the nipple would have been from the pedicle,
5 is that correct, the inferior pedicle?

6 A. The inferior pedicle. Correct. Yes.

7 Q. All right. And assuming that the
8 scaffold, the knife, was nowhere near the -- other
9 than the margins that were made for the incision,
10 it's almost like a T-hole. It just comes up, goes
11 around; is that correct?

12 A. For the pedicle itself? Is that what
13 you're asking?

14 Q. Yes.

15 A. I might be able to draw it out for you.
16 It's going to look a lot like Dr. Schimpf's drawing.
17 Is it okay if I draw it out for you?

18 Q. Please.

19 (Off the record.)

20 THE WITNESS: Basically if you're
21 looking straight on at the breast, okay, so this is
22 the top. This is down. So this is your nipple
23 areola complex. This gets carried to a different
24 position on this pedicle and this would be your
25 inferior pedicle that starts here and goes up and

1 just above the nipple areola complex and this pedicle
2 is attached all the way down as far as it can attach,
3 whether it's to the chest wall or to the muscle,
4 depending on where that implant was -- is placed.

5 BY MR. TANENBAUM:

6 Q. Okay. And so the -- as I understand it,
7 I'm going to call it the foot of the pedicle.

8 A. Okay.

9 Q. Remains attached throughout, I mean, it's
10 not disrupted at all that way, correct?

11 A. Correct. In fact, this entire area that
12 is within this area is not disrupted in any way. So
13 what is disrupted is on the outside here, and the
14 tissue that is removed is excess tissue that is above
15 here. And so that's what carries that nipple areola
16 complex up.

17 Q. I am curious. Does that not leave the
18 nipple much higher than it would be normally?

19 A. So this actually doesn't have to stretch
20 very much because what happens is actually the breast
21 surrounding it will get brought down and reshaped
22 around this -- around this pedicle, if that makes --
23 if that makes sense.

24 Q. And is the nipple -- does the nipple
25 remain in the center almost of the breast or where it

1 would naturally be?

2 A. So depending on -- that's where you would
3 like it at the end of the surgery. Oftentimes women
4 that need this surgery, the nipple areola complexes
5 are pointing down or they are towards -- you know,
6 they're facing downward. So you're trying to lift
7 the nipple areola complex to a certain height and
8 then shape the breast around it.

9 Q. What gets stretched with time would be
10 what's above the nipple areola complex?

11 A. No. All the forces get transmitted across
12 the entire pedicle here. I don't want to suggest
13 that this is under any tension, because it's not,
14 because most of the tension is on the breast tissue
15 that you shape around the -- around the pedicle.

16 Q. And with Rebecca Turisk -- thank you very
17 much. We'll mark that as one.

18 (PLF. EXHIBIT 1, Drawing, was marked
19 for identification.)

20 BY MR. TANENBAUM:

21 Q. In terms of millimeters, centimeters of
22 tissue above and around the areola complex, how much
23 tissue is left above it and on either side?

24 A. There's not a right or wrong. I typically
25 will leave approximately one to two centimeters.

1 Q. And Dr. Schimpf, do you recall how much he
2 left?

3 A. That I do not know. Typically that is not
4 something I would typically put in my operative
5 report. That's lesser of value for the surgeon and
6 for the patient. Much more important value is the
7 width of the pedicle. If you don't mind, I'll show
8 you this again. So in this type of surgery, the
9 width of this pedicle is of utmost importance. And,
10 you know, when I was going through training and in
11 practice, I typically use a six to eight centimeter
12 width pedicle. In his operative note, he used a ten
13 centimeter pedicle. So what that told me right off
14 the top was that he was very cognizant and aware of
15 blood flow and maintaining a longer pedicle width to
16 maintain blood flow.

17 Q. Okay. When the pedicle width --
18 regardless of its width, that is where the blood
19 supply is coming out, correct?

20 A. It's coming from several areas. Number
21 one, it's coming from that bottom -- it's coming from
22 that bottom area. There is oftentimes, but not
23 always, a vessel that comes up through this tissue.
24 And so it's not always there. So then you have to
25 ask yourself, well, why would this pedicle survive if

1 that vessel is not always there? And the answer is
2 that because this pedicle is receiving blood flow not
3 just from this one vessel or couple vessels that are
4 coming through here, but also the depth of the
5 vessels that are coming through the tissue. You have
6 to think about it in three dimensions, that this
7 is -- that this has a depth to it and you have
8 vasculature that's coming up through it from
9 various -- from various standpoints and from the
10 bottom. That's why that width is important because
11 the wider it is, the more vessels that you're able to
12 capture coming from that base, if that makes sense.

13 Q. Yeah. So the base itself --

14 MR. TANENBAUM: The material that you
15 see in Exhibit 9 to Dr. Schimpf's deposition, do you
16 have that there, Kevin?

17 MR. HORTON: Yes.

18 THE WITNESS: Yes, sir. Go ahead.

19 BY MR. TANENBAUM:

20 Q. If we look back at your exhibit, where
21 does that tissue come from?

22 A. So that was the tissue that I was alluding
23 to that comes from out here. Right there.

24 Q. Is there any tissue that's removed from
25 below the -- below the pedicle?

1 A. No. No, sir. That would be called
2 undermining and that's not done because this pedicle
3 receives blood flow from deep. And if you -- if you
4 undermine it the whole way, then you -- then you can
5 disrupt vasculature in that way.

6 Q. Okay. And is there a way to know where
7 the blood -- where arteries and veins -- you've got
8 to have one -- at least one of each to supply an
9 area, correct?

10 A. Yes and no. Typically an area might get
11 many vessels, some that you can see, some that are
12 very small that you can't see that can supply -- that
13 can supply an area.

14 Q. The arteries take it to an area and the
15 veins bring it back, correct?

16 A. Correct.

17 Q. So I'm looking at the redness of the
18 tissue. Which breast was it that was so badly --
19 that she lost the most tissue on?

20 A. I believe that was the right breast.

21 Q. And was that also the breast that was --
22 become so badly -- where she lost the nipple?

23 A. Yes, sir.

24 Q. And so when we look at the right breast
25 here in Exhibit 9 --

1 A. Mark, let me just -- let me just double
2 check that for you. I just want to make sure that
3 I've got that correct here. If you can bear with me
4 for one second. Yes, that's correct. It's the right
5 breast.

6 Q. So what causes the amount of redness you
7 see in Exhibit 9?

8 A. That's difficult to say. I think in part
9 that's actually from the actual picture itself.
10 That's not necessarily the true color of the tissue.

11 Q. Okay. What's the true color of the
12 tissue?

13 A. True color of the tissue can range from
14 yellow to white. Yellow is typically more fatty in
15 nature, white would be more fibrous in nature, and
16 then you have the overlying skin.

17 Q. Normally it's not bloody looking like
18 this, correct?

19 A. It certainly can be if there was some
20 blood staining on that tissue, which is very common
21 as well.

22 Q. Blood staining from what?

23 A. When -- when you're performing the
24 surgery, obviously you're going to create some --
25 some amount of bleeding and that blood can stain

1 the -- stain the tissue that you can -- you can see,
2 especially if it's -- if it's like this, in this
3 case, a picture that's taken right after that tissue
4 was taken out.

5 Q. Okay. When you do the procedure, what you
6 expect to see is yellowish or whitish?

7 A. You expect to see normal breast tissue.
8 The only thing that typically would concern me in a
9 case like this is a mass or a lesion that would be
10 more representative of a cancer, which doesn't
11 necessarily have a different color. So coloration is
12 -- is not something that is of great concern to me.

13 Q. And the implants when they're put in can
14 also act to inhibit blood flow?

15 A. I disagree with that. I don't believe
16 that implants do inhibit blood flow because they're
17 not -- they're not disrupting that blood flow in any
18 way. I'm not aware of any study or any literature
19 out there that suggests that the implants slow blood
20 flow down or disrupt blood flow to any amount of
21 tissue that they're interacting with.

22 In fact, just to expand on that a little
23 bit, whenever we put an implant in, there's something
24 called a capsule that forms around an implant. Just
25 like any foreign body, your body will wall off that

1 foreign object and a breast implant is no different.
2 And so when we look at -- or when I go back in and
3 see a capsule that forms around the implant, that
4 capsule is the closest tissue to that implant. And,
5 in fact, that capsule which has been shown has more
6 blood flow or stronger blood flow than just about any
7 tissue that surrounds it. I don't know of any
8 scientific reasons of why that occurs, and I don't
9 know of any studies that are out there of why that
10 occurs. But it does go to show that the tissue
11 that's closest to the implant has a very high level
12 of vascularity.

13 Q. I was just asking. I wasn't arguing.

14 A. That's fine. I'm just trying to think of
15 examples for you.

16 Q. Any other opinions in this case?

17 A. No, sir. Other than, you know, just to
18 kind of reiterate, I felt that -- and the reason I
19 chose to take on the case is I felt that Dr. Schimpf
20 performed very easily at the level that would be
21 standard of care throughout the entire -- throughout
22 the entire process. I certainly don't think anything
23 the patient did was detrimental in her own outcome.
24 I feel that she's had appropriate care even after she
25 transferred her care from Dr. Schimpf.

1 Q. And would you agree with me that had he
2 chosen a superior pedicle instead of an inferior
3 pedicle, that there was less chance that the blood
4 flow would have been disrupted?

5 A. I don't know. I cannot -- I can't answer
6 that. I don't know. That would be pure speculation.

7 MR. TANENBAUM: Okay. That's all the
8 questions I have.

9 MR. HORTON: I don't have any
10 questions.

11 (The witness, after having been
12 advised of his right to read and sign this
13 transcript, waives that right.)

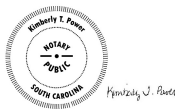
14 (The deposition was adjourned at 1:05 p.m.)
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CERTIFICATE OF REPORTER

I, Kimberly T. Power, Court Reporter
and Notary Public for the State of South Carolina at
Large, do hereby certify that the foregoing
transcript is a true, accurate, and complete record.

I further certify that I am neither
related to nor counsel for any party to the cause
pending or interested in the events thereof.

Witness my hand, I have hereunto
affixed by official seal this 13th day of December,
2019, at Lexington, Lexington County, South Carolina.



Kimberly T. Power, Court Reporter
My Commission Expires: 4/24/2025

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[k - okay]

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[old - reduction]

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South Carolina Rules of Civil Procedure

Part V. Depositions and Discovery

Court Rule 30

(e) Submission to Witness; Changes; Signing.

When the testimony is fully transcribed the deposition shall be submitted to the witness for examination and shall be read to or by him unless such examination and reading are waived by the witness and by the parties. Any changes in form or substance which the witness desires to make shall be entered upon the deposition by the officer with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness, unless the parties by stipulation waive the signing or the witness is ill or cannot be found or refuses to sign. If the deposition is not signed by the witness within 30 days of its submission to him, the officer shall sign it and state on the record the fact of the waiver or of the illness or absence of the witness or the fact of the refusal to sign together with the reason, if any, given therefor; and the deposition may then be used as fully as though signed unless on a motion to suppress under Rule 32(d)(4) the court holds

that the reasons given for the refusal to sign
require rejection of the deposition in whole or in
part.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES
ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.
THE ABOVE RULES ARE CURRENT AS OF APRIL 1,
2019. PLEASE REFER TO THE APPLICABLE STATE RULES
OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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3



11/12/2016

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2/3/2017
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2/6/2017
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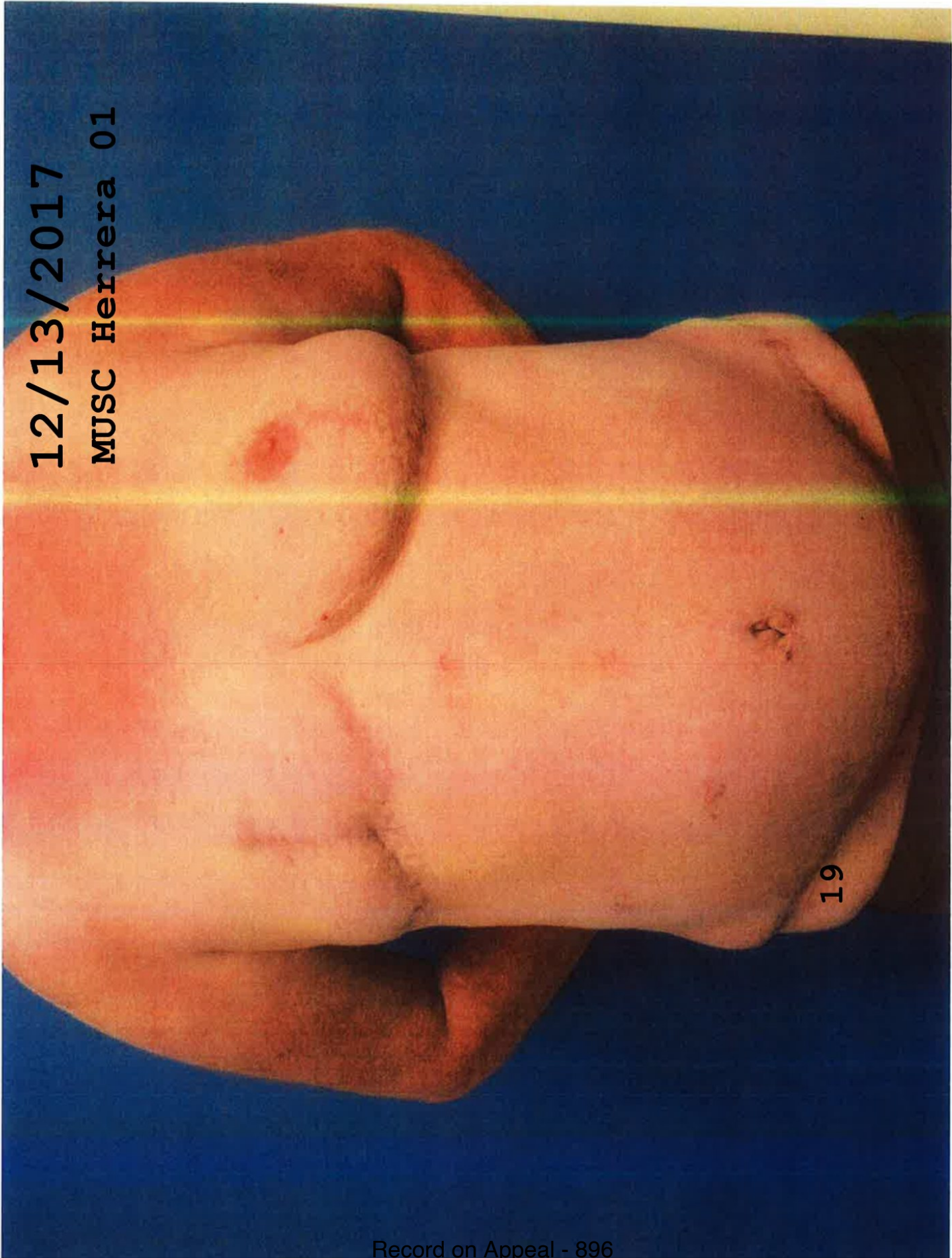


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12/13/2017

MUSC Herrera 01



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March 2021
PHOTOSUPDATED-0001



11/12/2022
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Rebecca Turisk				
Provider	Dates of Service	Bates # on billing	Note	Amount
Health First	11/28/2016	HealthFirst 0017	Breast pain and open breast wound	\$187.00
Health First	12/3/2016	HealthFirst 0017	Breast pain, swelling, and redness	\$144.00
Health First	3/15/2017	HealthFirst 0018	Post-Op mastectomy and breast redness	\$200.00
MUSC Medical Center	12/3/2016 -12/07/2016	MUSC 0560-0563	Post-Op infection of breasts	\$24,274.03
MUSC Medical Center	12/19/2016	MUSC 0572	Breast wound debridement	\$95.00
MUSC Medical Center	12/22/2016	MUSC 0574	Breast ultrasound and drain removal	\$546.00
MUSC Medical Center	12/26/2016	MUSC 0576-0577	Breast wound assessment and check	\$2,364.00
MUSC Medical Center	2/13/2017 - 2/14/2017	MUSC 0581-0582	Plastic surgery consult and wound check for breasts	\$4,784.00
MUSC Medical Center	2/15/2017	MUSC 0585	Consult for debridement of breasts	\$100.00
MUSC Medical Center	2/24/2017	MUSC 0586-0588	Double mastectomy	\$33,846.00
MUSC Medical Center	3/1/2017	MUSC 0592	Plastic surgery follow-up after double mastectomy	\$100.00
MUSC Medical Center	3/15/2017	MUSC 0593-0594	Breast pain. Plastic surgery follow-up.	\$3,781.00
MUSC Medical Center	9/8/17-9/10/17	MUSC 1578-1580	Burning chest pain at double mastectomy site	\$12,098.50
MUSC Medical Center	3/22/2018	MUSC 1592-1593	Breast reconstructive surgery	\$42,438.00
MUSC Medical Center	3/23/2018	MUSC 1597-1598	Acute Post-op pain after breast reconstructive surgery	\$4,852.10
MUSC Medical Center	3/27/18-3/28/18	MUSC 1600-1601	Admission for observation and pain control post-op breast reconstruction surgery	\$6,856.10
MUSC Medical Center	4/6/18-4/8/18	MUSC 1605-1607	Breast pain, swelling, and redness. Admitted to plastics	\$9,462.60
MUSC Medical Center	4/11/18-4/13/18	MUSC 1611-1612	Follow-up of L&D of right breast abscess. Admitted to plastics	\$4,246.00

REBECCA TURISK V. DENNIS SCHIMPF, MD SWEETGRASS PLASTIC SURGERY, LLC

MUSC Medical Center	8/16/18-8/17/18	MUSC 1625-1626	Breast Pain	\$2,382.00
MUSC Medical Center	9/13/2019	MUSC 1772-1773	Breast reconstructive surgery	\$42,338.01
MUSC Medical Center	12/18/2019	MUSC 0964	Follow-up to discuss breast reconstruction	\$120.00
MUSC Medical Center	12/27/2019	MUSC 0964-0967	Breast reconstructive surgery	\$31,400.01
MUSC Medical Center	3/26/2021	MUSC 5420-5422	Breast reconstructive surgery	\$43,829.01
MUSC Medical Center	2/14/2022	MUSC 5427-5428	Breast reconstructive surgery	\$51,415.01
MUSC Physicians-Borg,Keith	11/30/2016	MUSC 0559	Breast infection	\$638.00
MUSC Physicians - Various Providers	12/03/2016 -12/07/2016	MUSC 0564-0565	Post-Op infection of breasts	\$2,810.00
MUSC Physicians- Ravenel, James G.	12/4/2016	MUSC 0566	Post-Op infection of breasts	\$132.00
MUSC Physicians- Ravenel, James G.	12/4/2016	MUSC 0567	Post-Op infection of breasts	\$407.00
MUSC Physicians-Gladin, III, Collier Branan	12/5/2016	MUSC 0568	Post-Op infection of breasts	\$640.00
MUSC Physicians-Gladin, III, Collier Branan	12/5/2016	MUSC 0569	Post-Op infection of breasts	\$132.00
MUSC Physicians-Herrera,Fernando A	12/14/2016	MUSC 0570	Breast debridement	\$371.00
MUSC Physicians-Meissner,Eric Gerhard	12/19/2016	MUSC 0571	Breast wound debridement	\$150.00
MUSC Physicians-Herrera,Fernando A	12/19/2016	MUSC 0573	Breast wound debridement	\$371.00
MUSC Physicians- Irshad,Abid	12/22/2016	MUSC 0575	Breast ultrasound and drain removal	\$132.00
MUSC Physicians-Larson,Eric J	12/26/2016	MUSC 0578	Breast wound assessment and check	\$428.00
MUSC Physicians-Herrera,Fernando A	12/28/2016	MUSC 0579	Wound debridement	\$150.00
MUSC Physicians-Herrera,Fernando A	1/25/2017	MUSC 0580	Breast assessment. Scheduled debridement	\$150.00
MUSC Physicians-McGary,William Brett	2/13/2017	MUSC 0583	Plastic surgery consult and wound check for breasts	\$638.00
MUSC Physicians-Herrera,Fernando A	2/15/2017	MUSC 0584	Consult for debridement of breasts	\$95.00
MUSC Physicians-Various Providers	2/24/2017	MUSC 0589	Double mastectomy	\$3,346.00
MUSC Physicians-Various Providers	2/24/2017	MUSC 0590	Double mastectomy	\$8,224.00
MUSC Physicians - Yared,Maria	2/24/2017	MUSC 0591	Double mastectomy	\$1,336.00

REBECCA TURISK V. DENNIS SCHIMPF, MD SWEETGRASS PLASTIC SURGERY, LLC

MUSC Physicians-Jennings, Lindsey Kathleen	3/15/2017	MUSC 0595	Breast pain. Plastic surgery follow-up.	\$428.00
MUSC Physicians-Ackerman, Susan J.	3/15/2017	MUSC 0596	Breast pain. Plastic surgery follow-up.	\$132.00
MUSC Physician-Armstrong, Gold, Hrywko, Blecher	9/8/17-9/10/17	MUSC 1581	Burning chest pain at double mastectomy site	\$1,508.00
MUSC Physician Cluver, Abbie Rae	9/8/2017	MUSC 1582	Burning chest pain at double mastectomy site	\$407.00
MUSC Physician Ravenel, James	9/8/2017	MUSC 1583	Burning chest pain at double mastectomy site	\$46.00
MUSC Physicians-Herrera, Fernando A	12/13/2017	MUSC 1591	Plastic surgery follow-up	\$150.00
MUSC Physician- Finley, Brister	3/22/2018	MUSC 1594	Breast reconstructive surgery	\$4,671.00
MUSC Physicians-Herrera, Fernando A	3/22/2018	MUSC 1595	Breast reconstructive surgery	\$25,080.00
MUSC Physician- Saef, Steven	3/23/2018	MUSC 1599	Acute Post-Op pain	\$638.00
MUSC Physician-Suranyi, Pal	3/27/2018	MUSC 1602	Admission for observation and pain control post-op breast	\$46.00
MUSC Physician-Costello, Phillip	3/27/2018	MUSC 1603	Admission for observation and pain control post-op breast	\$407.00
MUSC Physicians Todoran, Jennings	3/27/18-3/28/18	MUSC 1604	Admission for observation and pain control post-op breast	\$711.00
MUSC Physician Conway, William	4/6/2018	MUSC 1608	Breast pain, swelling, and redness. Admitted to	\$54.00
MUSC Physician-Jennings, Lindsey	4/6/18-4/8/18	MUSC 1609	Breast pain, swelling, and redness. Admitted to	\$638.00
MUSC Physicians-Tibbetts, Jill	4/11/2018	MUSC 1610	Follow-up of L&D of right breast abscess. Admitted to plastics	\$180.00
MUSC Physician-Winterfield, Laura	4/13/2018	MUSC 1613	Follow-up of L&D of right breast abscess. Admitted	\$173.00
MUSC Physician-Nance John	4/12/2018	MUSC 1614	Follow-up of L&D of right breast abscess. Admitted	\$54.00
MUSC Physician-Wing, Ashley	4/23/2018	MUSC 1615	Follow-up right breast	\$180.00
MUSC Physician Huber,	8/16/2018	MUSC 1624	Breast Pain	\$150.00
MUSC Physician Krywko,	8/16/2018	MUSC 1627	Breast Pain	\$428.00
MUSC Physician Suranyi, Pal	8/16/2018	MUSC 1628	Breast Pain	\$54.00
MUSC Physician Herrera, Fernando	11/28/2018	MUSC 1641	Follow-up right breast scars	\$150.00
MUSC Physicians-Herrera, Fernando A	7/24/2019	MUSC 1770	Follow-up breast infections	\$150.00

REBECCA TURISK V. DENNIS SCHIMPF, MD SWEETGRASS PLASTIC SURGERY, LLC

MUSC Physician-Bigelow, William R.	7/24/2019	MUSC 3647	Follow-up breast infections	\$185.00
MUSC Physician-McDonald John W.	7/24/2019	MUSC 1769	Follow-up breast infections	\$150.00
MUSC Physicians-Herrera, Fernando A	8/21/2019	MUSC 1771	Follow-up breast revision	\$150.00
MUSC Physician Gutman, David	9/13/2019	MUSC 1774	Breast reconstructive surgery	\$4,432.00
MUSC Physicians-Herrera, Fernando A	9/13/2019	MUSC 1775	Breast reconstructive surgery	\$20,259.00
MUSC Physicians-Herrera, Fernando A	12/18/2019	MUSC 0963	Follow-up to discuss breast reconstruction	\$150.00
MUSC Physicians-Klein, Andrew and McKinney, Regan	12/27/2019	MUSC 0968	Breast reconstructive surgery	\$3,237.00
MUSC Physicians-Krywko, Diann Marie	12/27/2019	MUSC 0969	Breast reconstructive surgery	\$428.00
MUSC Physicians-Herrera, Fernando A	12/27/2019	MUSC 0970	Breast reconstructive surgery	\$17,818.00
MUSC Physicians-Herrera, Fernando A	2/24/2021	MUSC 5417	Follow-up to discuss breast reconstruction	\$155.00
MUSC Physicians Wilson Sylvia, Bierling-Slowly, Karin	3/26/2021	MUSC 5423	Breast reconstructive surgery	\$4,070.00
MUSC Physicians-Herrera, Fernando A	3/26/2021	MUSC 5424	Breast reconstructive surgery	\$10,640.00
MUSC Physicians-Herrera, Fernando A	12/22/2021	MUSC 5425	Plastic surgery follow-up	\$163.00
MUSC Pharmacy	2/14/2022	MUSC 5426	Breast reconstructive surgery	\$125.41
MUSC Physician Steinberg, Holum, Herrera	2/14/2022	MUSC 5429	Breast reconstructive surgery	\$15,278.00
Summerville Medical Center	2/7/2017	SMC 1208-1212	Breast wound	\$16,163.00
Summerville Medical Center	2/6/17-2/16/17	SMC 1213-1216	Right breast wound	\$3,396.00
Summerville Medical Center	1/31/17-2/5/17	SMC 1217-1227	Breast wound	\$84,820.00
Summerville Medical Center	1/10/17-1/31/17	SMC 1228-1232	Breast wound	\$8,095.00
Summerville Medical Center	11/29/2016	SMC 1233-1236	Breast pain, swelling,	\$5,353.00
Summerville Medical Center	3/22/18-3/23/18	SMC Updated Billing0014-	Post-Op pain	\$6,167.00
		Total		\$579,677.78



MEDICAL RECORDS
169 Ashley Ave Suite H102
MSC 250
Charleston SC 29425-3490
Inpatient Record

TURISK, REBECCA A
MRN: 001134417
DOB: [REDACTED] Sex: F
Acct #: 511733189
Adm: 2/24/2017, D/C: 2/24/2017

Brief Op Note - Encounter Notes (continued)

Brief Op Note by Fernando A Herrera, MD at 2/24/2017 3:44 PM (continued)

Drains and Retained Items (Surgical):

Drain/Device Site 02/24/17 1430 Left chest 15 Fr. Blake (Active)

Insertion Site clean and dry; dressing intact 2/24/2017 3:24 PM

Drainage Characteristics/Odor serosanguineous 2/24/2017 3:24 PM

Drain/Device Site 02/24/17 1445 Right chest 15 Fr. Blake (Active)

Insertion Site dressing intact; clean and dry 2/24/2017 3:24 PM

Drainage Characteristics/Odor serosanguineous 2/24/2017 3:24 PM

Surgeon Evaluation of Wound Class: III: Contaminated: Open, fresh, accidental wounds and Major break in sterile technique or Gross Spillage from GI tract or Acute nonpurulent inflammation

Complications: None

Findings: subtotal subcutaneous mastectomy of left breast for removal of fat necrosis through a peri-areolar incision, subtotal completion mastectomy of the right breast with debridement of skin and layered closure of 10 cm wound. Viable left nipple at completion

Expected Return to OR: No

Attestations: I was present for the entire procedure.

Signed:

Fernando A Herrera, Jr

2/24/2017

3:44 PM

Electronically Signed by Fernando A Herrera MD on 2/24/2017 3:46 PM

Op Note - Encounter Notes

Op Note signed by Fernando A Herrera, MD at 3/1/2017 11:58 AM

Author: Fernando A Herrera, MD

Rev: 3/1/2017 11:58 AM

Editor: Fernando A Herrera, MD (Physician)

Related Notes:

Trans ID: 73265234920170225091403

Trans Time:

Service: SUR-PLASTIC SURGERY

Note Time: 2/24/2017 12:00 AM

Original Note by Robinder Singh, MD (Resident) filed at 2/27/2017 7:49 AM

Trans Status: Available

Trans Doc Type: Operative Note

Author Type: Physician

Status: Signed

Dictation Time:

PATIENT NAME: TURISK, REBECCA A

MRN: 001134417

CSN: 1086557014

DATE OF SURGERY: 02/24/2017

SERVICE: Plastic Surgery

Printed on 5/5/2017 4:03 PM

HIM ROI IP Encounter Report

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ROI# 50213450 PAGE 390 OF 585
Turisk-MUSC-0400



Record on Appeal - 903

Turisk-MUSC-0400
CONFIDENTIAL MEDICAL RECORDS



MEDICAL RECORDS
169 Ashley Ave Suite H102
MSC 250
Charleston SC 29425-3490
Inpatient Record

TURISK, REBECCA A
MRN: 001134417
DOB: [REDACTED] Sex: F
Acct #: 511733189
Adm: 2/24/2017, D/C: 2/24/2017

Op Note - Encounter Notes (continued)

Op Note signed by Fernando A Herrera, MD at 3/1/2017 11:58 AM (continued)

SURGEON: Fernando Herrera, MD

ASSISTANTS: Robinder Singh, MD

PREOPERATIVE DIAGNOSES: Left breast fat necrosis and right breast chronic open wound, status post removal of implants and reduction mammoplasty with nipple necrosis of the right nipple at an outside facility.

PROCEDURE PERFORMED:

1. subcutaneous mastectomy of left breast for severe fat necrosis
2. Completion mastectomy of right breast for fat necrosis and excision of scar and intermediate closure of wound measuring 10 cm

POSTOPERATIVE DIAGNOSES: Left breast fat necrosis and right breast chronic open wound, status post removal of implants and reduction mammoplasty with nipple necrosis of the right nipple at an outside facility.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: 75 cc.

IV FLUIDS: 1.2 L of crystalloid.

SPECIMENS: Fat necrosis of the left breast and right breast sent for routine pathology.

DRAINS: Two #15 drains placed in both pockets bilaterally.

FINDINGS: Large amount of fat necrosis on the left upper pole of the breast and right fat necrosis which was adherent to the pectoralis major fascia. There was no other evidence of any other masses or infection noted.

COMPLICATIONS: None.

DISPOSITION: The patient was stable, extubated, and transferred to the PACU without any complications.

HISTORY OF PRESENT ILLNESS: This is a patient who is known to the Plastic Surgery Service. At an outside hospital, the patient ended up



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MRN: 001134417
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Acct #: 511733189
Adm: 2/24/2017, D/C: 2/24/2017

Op Note - Encounter Notes (continued)

Op Note signed by Fernando A Herrera, MD at 3/1/2017 11:58 AM (continued)

having removal of implants with a reduction mammoplasty and ended up having a right necrotic nipple. She underwent multiple debridements and she has been infected multiple times and she now presents with a chronic open wound of the right breast which has been healing well without any signs of infection. She also has a large area of fat necrosis at the superior aspect of the left breast which has been causing excessive amounts of pain over the last couple months. The patient understood the risks, benefits, and alternatives of undergoing removal of fat necrosis on the left and excision of the chronic wound in the right breast with closure. Consent was obtained, and the patient underwent this procedure on 02/24/2017.

PROCEDURE IN DETAIL: Prior to being brought into the operating room, the patient underwent bilateral pectoralis blocks by Anesthesia. She was now brought to the operating room and placed in a supine position. General endotracheal tube intubation was performed and general anesthesia was induced, and the patient tolerated these portions of the procedure well. Preoperative antibiotics were given. SCDs were placed. A time-out was then performed to confirm the patient's identity and the procedure that was being performed. The breast and the chest were prepped and draped out in sterile fashion bilaterally. We then started by making a supra-periareolar incision on the left breast. The area of fat necrosis involved the entire upper and mid portion of the breast. We dissected down to the area of fat necrosis with the Bovie electrocautery. We identified a plane leaving the skin flaps well perfused. Retractors were used to dissect around the fat necrosis superiorly and towards the axillary wall and medially down to the chest wall. The fat necrosis was clearly adherent to the pectoralis muscle fascia and the muscle. A lighted retractor was then used to aid in dissection of the lateral border of the fat necrosis. The area of the fat necrosis was then removed off the pectoralis fascia in one entire piece through the incision and sent for routine pathology. A subcutaneous mastectomy was completed on the left breast leaving the skin flaps well perfused. The wound was copiously irrigated. About 25 minutes was used to obtain hemostasis with Bovie electrocautery. After hemostasis was obtained, a 15 Blake drain was placed through the incision and brought out laterally. After this was done, 5000 units of thrombin was sprayed into the pocket. The deep subcutaneous layer of tissue was closed using interrupted 2-0 Vicryl sutures. The deep dermal layer was then closed and approximated using 3-0 Monocryl sutures and the intracuticular layer on the nipple was closed using a running 4-0 Monocryl suture. The superior portion of the



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Acct #: 511733189
Adm: 2/24/2017, D/C: 2/24/2017

Op Note - Encounter Notes (continued)

Op Note signed by Fernando A Herrera, MD at 3/1/2017 11:58 AM (continued)

nipple appeared to be perfused. We then placed the bacitracin and Xeroform on this portion of the nipple, and prior to closing this site, the final lap count, instrument count, and needle count were correct. There were no missing items.

We then paid attention to the right open chronic wound. The edges of the chronic wound were excised and the rind was removed. There was excess amount of fat necrosis which was also on the base of this wound and adherent to the pectoralis fascia. The entire rind was re-excised leaving well perfused skin flaps and the tissue was removed medially and laterally and down to the pectoralis fascia. After this area of fat necrosis was removed, there was some bleeding from the lateral portion of the pocket which was irrigated and hemostasis was then obtained using Bovie electrocautery. After this was done, a 15 Blake drain was brought through the wound and out laterally and secured using a 2-0 nylon suture. The wound was irrigated copiously. Once hemostasis was complete, 5000 units of thrombin was applied to this pocket. The wound was closed with deep subcutaneous stitches approximating these layers with 2-0 Vicryl suture in an interrupted fashion. The vertical wound of the right breast measured 10 cm in length. The deep dermal layer was then closed using interrupted 3-0 Monocryl suture and the intracuticular layer was closed using a running 3-0 Monocryl suture. Prior to closing the right side, the final lap count, instrument count, and needle count were correct and no missing items. Both specimens were sent for routine pathology. The drains were then placed to suction with adequate drainage and bacitracin ointment and Xeroform were placed on top of the wounds along with fluffs and a bra. The patient tolerated the procedure well and was then extubated and transferred to the PACU without any complications. Dr. Herrera was scrubbed in during the entire case from start to finish.

Dictated by: Robinder Singh, MD

Robinder Singh, MD

Fernando Herrera, MD
Surgeon



Sweetgrass
PLASTIC SURGERY

Discharge Instructions

YOU ARE URGED TO CAREFULLY FOLLOW THESE INSTRUCTIONS!

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

The pain medicines and anesthetics you received during your stay at the facility will continue to have some effect on you for 24 hours.

Therefore, during the 24 hours after your procedure for your safety and the safety of others:

DO NOT STAY ALONE. You may feel sleepy, lightheaded or dizzy at times. We strongly recommend that a responsible adult be with you for the rest of the day of surgery and also during the night for your protection and safety.

- **DO NOT DRIVE A MOTOR VEHICLE** or operate power tools. Teenagers are not to engage in athletic sports.
- **DO NOT MAKE MAJOR DECISIONS** or sign important papers.
- **DO NOT DRINK BEER, WINE OR OTHER ALCOHOLIC BEVERAGES for 48 hours.**
- **DO NOT TAKE SEDATIVES OR TRANQUILIZERS** or any non-prescribed medication unless otherwise instructed by your surgeon.

1. Rest at home with activity as tolerated.
 - ☐ Restrict your activities & rest for a day. Resume light to normal activity tomorrow
 - ☐ No lifting greater than 10 pounds.
2. You may have pain for the first day after surgery. Pain medicine prescribed by your doctor should be taken as directed. It may make you sleepy and less alert than you normally are. **DO NOT USE OR RESUME USING BLOOD THINNERS, ASPIRINS, IBUPROFEN OR ASPIRIN-LIKE ANTI-INFLAMMATORY DRUGS FOR 10 DAYS.** Written medication instructions have been reviewed and a copy provided for you to take home.
3. If you take blood thinners regularly, be sure to check with your physician before resuming their use.
4. You may eat what you like unless otherwise instructed by your doctor. Begin with clear liquids, then progress to soft foods as tolerated.
5. Anesthetics and pain medicines may cause constipation in some individuals. Use of over the counter stool softeners is encouraged. Use as directed by manufacturer
6. Anesthetics and pain medicines may cause nausea and vomiting in some individuals. If nausea or vomiting becomes a problem at home, call your doctor.
7. Dressing care.
 - ☐ Keep clean and dry ☐ Wear garment or bra as much as possible.
 - ☐ You may **NOT** shower for 48 hours after you leave the facility, and replace dressing as needed.
8. You are scheduled for a follow-up appointment with your physician on _____.
9. If you should experience any of the following, please call your physician's office during office hours at 843.471.1135 or Dr. Schimpf on his cell phone after hours and during the weekend at 843.367.2258.
 - a. difficulty breathing
 - b. bleeding that you feel is excessive
 - c. persistent nausea or vomiting
 - d. pain that is greater than explained to me in this teaching
 - e. increased redness, warmth, swelling, hardness around operative area
 - f. Oral temperature greater than 101.5
 - g. Increasing & progressive drainage from surgical area
 - h. calf pain or swelling

If you feel this is an emergency, call 911

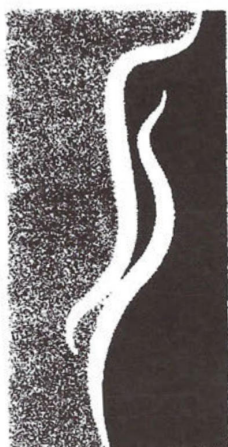
OTHER INSTRUCTIONS:

By signing this form I am acknowledging that I understand the instructions given and medication prescribed to me.

Patient/ Responsible Party: Mary E. Oakes Date: 11/1/14 Time: 1330

RN/ PA signature: Jessica J. R. RN Date: 11/1/14 Time: 1330

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf



Sweetgrass

PLASTIC SURGERY

COSMETIC SURGERY OF THE FACE & BODY

REDUCTION MAMMOPLASTY

(Breast Reduction) 2 Implant Removal Rt

Breast reduction is usually performed to relieve back, neck and shoulder pain, and skin irritation that women with large breasts sometimes experience, rather than to enhance the appearance of the breast. The best candidates for this procedure are those who are mature enough to understand and have realistic expectations about the results.

Patient's
Initials

- Rt The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- Rt Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- Rt I understand and accept that the most likely material risks and complications of a reduction mammooplasty have been discussed with me and may include but are not limited to:
- asymmetry
 - bleeding
 - change in nipple and skin sensation
 - delayed healing
 - different size than expected
 - discoloration/swelling
 - discomfort (pain/sensitivity)
 - failure to improve symptoms
 - infection
 - nipple retraction/poor contour
 - restricted activity
 - skin, nipple, flap loss
 - ~~wound~~ separation
 - unsatisfactory results
- Rt I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- Rt I understand and accept the risks of blood transfusion(s) that may be necessary.
- Rt I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its

TURISK_00017

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

RT ultimate appearance.
RT I am aware that smoking during the pre- and postoperative periods could increase chances of complications. I am also aware I may be tested for tobacco use the day of the procedure.
RT I have informed the doctor of all my known allergies.
RT I have informed the doctor of all medications that I am currently taking, including prescriptions, OTC remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
RT I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
RT I am aware and accept that no guarantees about the results of the procedure have been made.
RT I have been advised of the probable consequences of declining recommended or alternative therapies.
RT I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
RT I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
RT The doctor has answered all of my questions regarding this procedure.
I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct Dennis Schimpf, M.D., with associates or assistants of his or her choice, to perform breast reduction mammoplasty at Sweetgrass Plastic Surgery on my:

Right Breast

Left Breast

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

[Signature] 10-27 3:17
Patient or Legal Representative Signature/Date/Time

[Signature]
Relationship to Patient

Rebecca Turisk
Print Patient or Legal Representative Name

[Signature]
Witness Signature/Date/Time
Jessica [Signature] RN 11/1/16 0750

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

[Signature] 11/1/16 0750
Physician Signature/Date/Time

TURISK_00018



Sweetgrass

PLASTIC SURGERY

COSMETIC SURGERY OF THE FACE & BODY

102 West 8th North Street
Suite B
Summerville, SC 29483
843-471-1135 (O)
800-919-5720 (F)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Rebecca Turisk Date of Birth: [REDACTED]
Previous Name: _____ Social Security #: _____

I request and authorize Sweetgrass Plastic Surgery to release
healthcare information of the patient named above to:

Name: Fernando A. Herrera Jr. MD
Address: 96 Jonathan Lucas St. MSC 613
City: Charleston State: SC Zip Code: 29425

FAX: 843-792-5346

This request and authorization applies to: Dr. Herrera

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☒ All healthcare information

☐ Other: _____

Patient Signature: [Signature] Date Signed: 12-20-16

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

TURISK 00001

12/22/2016

Encounter - Office Visit Date of service: 07/08/16 Patient: Rebecca Turisk DOB: [REDACTED] PRN: TR166012

PATIENT
Rebecca Turisk
DOB [REDACTED]
AGE 50 yrs
SEX Female
PRN TR166012

FACILITY
Sweetgrass Plastic Surgery
T (843) 471-1135
F (800) 919-5720
 102 West 8th North Street
 B
 Summerville, SC 29483

ENCOUNTER
NOTE TYPE SOAP Note
SEEN BY Dennis Schimpf MD
DATE 07/08/2016
AGE AT DOS 50 yrs
Not signed

Patient Identifying details and demographics

FIRST NAME	Rebecca	SEX	Female	ETHNICITY	
MIDDLE NAME	-	DATE OF BIRTH	[REDACTED]	PREF. LANGUAGE	
LAST NAME	Turisk	DATE OF DEATH	-	RACE	
SSN	-	PRN	TR166012	STATUS	Active patient

CONTACT INFORMATION

ADDRESS LINE 1	535 College Park Road	CONTACT BY	-
ADDRESS LINE 2	-	EMAIL	rebeccaturisk@gmail.com
CITY	Ladson	HOME PHONE	-
STATE	SC	MOBILE PHONE	843-532-9304
ZIP CODE	29456	OFFICE PHONE	(843) 797-7757
		OFFICE EXTENSION	-

FAMILY INFORMATION

NEXT OF KIN		PATIENT'S MOTHER'S
RELATION TO PATIENT		MAIDEN NAME
PHONE		
ADDRESS		

Subjective

Patient presents today as a new consult to discuss macromastia. Patient reports long standing neck and upper back pain, which has been unrelieved by multiple over the counter anti-inflammatories and pain relievers. Her breasts impede her ability to perform physical activity. She also has moisture, rash and irritation in infra-mammary folds. Has used creams, salves and powder with little improvement. She has no significant breast history personally or in her family history. Past medical history: fibromyalgia, Degenerative disc disease. Allergies: NKDA. Social h/c: non-smoker. Past surgical history: BBA, cervical spine, lumbar spine, shoulder, ankle.

Objective

Height: 64 in, Weight: 167 lbs. Well appearing, well nourished. AAOx3, Head: NCAT. Very large heavy breasts that are pendulous and fibrous. Nipple to clavicular length, R 30 cm, L 28cm. Ptosis grade 3. Infra-mammary folds are moist with chronic skin changes from inflammation. No mass palpated, No evidence of skin dimpling or retraction. Small implants palpated. Nipples everted with normal sensation. Shoulder strap grooves noted. No lymphadenopathy. Resp: clear. Abdomen: soft, non-tender, non-distended. Extremities: warm, dry, without edema.

Assessment

Hypertrophy of breast, ICD 10 N62. Neck pain, ICD 10 M54.2. Thoracic back pain, ICD 10 M54.9.
 Bilateral Breast Reduction, CPT code: 19318-50.

Plan

A very pleasant female with significant neck and back pain, which is directly related to her large pendulous breasts. I recommend bilateral breast reduction and anticipate a resection weight of 500 grams at a minimum from each breast. I discussed with her wound healing, wound opening, draining, infection, and possible revision. Patient understands and answered all her questions. She

<https://static.practicefusion.com/apps/ehr/?c=1385407302&PF/charts/patients/65e433eb-3cod-48e7-bd5c-376c70022c93/encounter/7a176b1b-9eb2-4d7d-bda2-d...> 1/2

TURISK_00002

1/22/2016

Encounter - Office Visit Date of service: 07/08/16 Patient: Rebecca Turisk DOB: 05/27/1966 PRN: TR166012
would like to proceed with bilateral breast reduction.

 practice fusion
Free cloud based EHR

<https://static.practicefusion.com/app/ehr/?c=1385407302#PF/chart/patients/85e433eb-3ccd-48e7-bd5c-376c70022c93/encounter/7a176b1b-9eb2-4d7d-bda2-d...> 2/2

TURISK_00003

REBECCA TURISK
11/01/2016

OPERATIVE REPORT

SURGEON: DENNIS SCHIMPF, M.D.
ASSISTANT: NONE
PREOPERATIVE DIAGNOSIS: 1. MACROMASTIA, NECK AND BACK PAIN.
2. MOISTURE AND RASH ALONG THE
INFRAMAMMARY FOLD.
3. LIPODYSTROPHY OF THE ABDOMEN.
POSTOPERATIVE DIAGNOSIS: SAME.
PROCEDURE: 1. INFERIOR WISE BREAST REDUCTION
TECHNIQUE WITH REMOVAL OF BREAST
IMPLANTS.
2. ABDOMINOPLASTY.
ESTIMATED BLOOD LOSS: MINIMAL.
COMPLICATIONS: NONE.

Instrument and sponge count correct at the conclusion of the procedure per the operating room staff.

Attending surgeon, Dennis Schimpf, scrub and present for the duration of the procedure.

DETAILS:

The patient was evaluated in the preoperative holding area. Verbal confirmation was obtained with the patient of the procedures which she was scheduled to undergo, specifically removal of breast implants with a breast reduction, a reduction mammoplasty and an abdominoplasty. Marks were then made consistent with these procedures. Inferior pedicle Wise reduction technique was designed with the nipple/areolar complex placed at 19 cm and an inferior pedicle diameter of 10 cm. Abdominal marks were consistent with a lower abdominal incision for an abdominoplasty. Details of the procedure were discussed with the patient. All questions were answered at this point. The risk of the procedure and informed consent had been obtained. Risks were explained to the patient, that included wound healing, need for revisional surgery specific to breast, nipple loss, alteration in sensation or poor painful unsightly scarring, which may need revision, as well as fluid collection such as a seroma or hematoma possibly postoperatively. The patient verbalized her understanding to this procedure. In addition, we discussed an abdominoplasty, specifically wound separation or dehiscence, need for revisional surgery, hematoma or seroma formation and overall unsightly painful or thickened widened scarring, which may need additional revisional surgery. The patient verbalized her

TURISK_00004

REBECCA TURISK
PAGE TWO
11/01/2016

understanding to these risks. As inherent to any surgery, there are risks of anesthesia, as well as general overall health. Once consent was verified, the patient was brought to our operating room and placed in a supine position under IV sedation. I turned my attention first to the breasts. A 38 mm cookie cutter was used to outline the nipple/areolar complex bilaterally. A 10 cm inferior pedicle was deepithelialized. Creation of the pedicle was then performed in the standard fashion in the medial, central and lateral compartment to the level of the implant, which was encountered in the upper outer aspect. The capsule was entered and the implant was easily removed from the right side. A 15 round Blake drain was then left in this pocket and tailor-tacking was performed of the marks of the breast reduction. Inspection revealed that these marks were adequate and there was no undo tension. As a result, the marks which had been placed were then incised in the medial, central and lateral compartment in the skin, as well as a very small amount of redundant breast tissue was excised in these three compartments. The breast tissue was then wrapped over the inferior pedicle. The inferior T was reapproximated with a U-shaped 0 PDS suture, following which multiple 2-0 PDS interrupted sutures were placed along the inframammary fold, followed by 2-0 Vicryl and 3-0 Monocryl intracuticular sutures. The inferior T was then reapproximated with 2-0 PDS and 3-0 Monocryl. I turned my attention to the contralateral breast and the same procedure was performed. The implant was removed in the same manner intact. Excision of medial, central and lateral breast tissue was performed, as well as closure of the wound over a 15 round Blake drain, and closure of the skin incisions. At this point, the patient was sat up on the operating table. Four and a half cm above the inframammary fold nipple/areolar complex marks were made again using a 38 mm cookie cutter 9 cm from the midline to the most medial aspect of the areolar complex. These marks seemed appropriate and symmetrical. A #10 scalpel was used to incise the skin markings. Electrocautery was used to carry the dissection through the subcutaneous tissue on both sides. I turned my attention to the right side of the nipple/areolar complex. This was easily transposed into its new location. The nipple/areolar complex appeared to be have good capillary refill and was viable at this point. There was no evidence of congestion or ischemia. It was then inset with interrupted 2-0 Vicryl and 4-0 intracuticular Monocryl sutures. I turned my attention to the contralateral breast and performed the same incision and transposition, as well as inseting of the nipple/areolar complex. At the conclusion, the nipple/areolar complex appeared intact and viable. I turned

TURISK_00005

REBECCA TURISK
PAGE THREE
11/01/2016

my attention now at this point to the abdomen. A #10 scalpel was used to incise the lower mark of the abdomen. Electrocautery was used to carry the dissection through the subcutaneous tissue to the level of the anterior abdominal wall. Elevation was performed to the level of the umbilicus. At this level, the skin was incised and released in the periumbilical region. Elevation continued to the level of the lower thoracic cage. At this point, the patient was sat up on the table, approximately 25 to 30N in a reflexed position. 0 PDS suture was used to reapproximate the rectus muscle in the midline in a running fashion. Redundant skin and tissue was redraped over the abdomen. The redundancy was excised after markings were made. At this point, the superficial fascial system was closed with 0 PDS followed by 2-0 Vicryl and finally 3-0 intracuticular Monocryl suture. The umbilicus had been marked at the skin level. A #10 scalpel was used to incise this mark and the umbilicus was transposed and inset into its new location with 2-0 Vicryl and 3-0 Monocryl suture in an intracuticular fashion. A 15 round Blake drain that had been left in the abdomen and this was sutured in place with a 2-0 nylon suture, as had the breast drains. The patient had Steri-Strips placed over the incisions, was placed in a surgical bra, as well as an abdominal binder, and was stable throughout the case. She was awoken from anesthesia in stable condition.

DKS/del

TURISK_00006



Rebecca Turisk
DOB: XXXXXXXXXX
DOS: 11/01/2016
Dennis Schimpf

Physician's Immediate Post Operative Report

Post Op Diagnosis:	S/P BBR; Abdominoplasty; Smart lipo Bra line
Procedure:	Bilateral Breast Reduction; ~~Implant Removal~~ Abdominoplasty; smart lipo Bra line
Surgeon:	Dennis Schimpf, MD
Assistant:	Meghan Smith, CST
Anesthesia:	Mike Denovan, CRNA
EBL:	75cc
Fluid:	2000mL LR; 800mL Timentel
Drainage:	minimal
Complication:	none
Specimen Gross:	Medial Abdomen - 70g R Abdomen - 920g L Abdomen - 920g R Breast - 740g L Breast - 700g
Findings:	intact implants weighing 400g per side
Implants:	
Discharge Patient per PACU protocol	✓

Physician Signature

11/1/16
Time/Date



Sweetgrass
PLASTIC SURGERY

HISTORY & PHYSICAL

Rebecca Turisk
DOB:
DOS: 11/01/2016
Dennis Schimpf

Diagnosis/History of Present Problem: <u>Desire for procedure</u>	
Allergies: <u>NKA</u>	
Current Medications: <u>See med list</u>	
PAST HISTORY	NEG Comment, if Positive
CARDIAC: Infarction, failure, arrhythmia, palpitations, hypertension, angina	☒
PULMONARY: Bronchitis, emphysema, asthma, pneumonia, sputum, TB	☒
CNS: Seizures, stroke, migraine, MS	☒
KIDNEY: Infections, failure	☒
ENDOCRINE: Diabetes, thyroid, adrenal	☒
LIVER: Hepatitis, failure	☒
GI: Hiatal hernia, colitis, Crohn's	☒
GYN/GU	☒
BONE/JOINT: arthritis	☒
ENT: Nosebleeds, croup, upper airway	☒
EYE: Glaucoma	☒
FAMILY HISTORY OF BLEEDING TENDENCY	☒
PAST SURGERY:	☒
PHYSICAL EXAMINATION HCG <u>(-)</u> TOBACCO <u>(-)</u>	
BP <u>144/93</u> Pulse <u>118</u> RR <u>13</u> Temp <u>100.7</u> Weight <u>172</u> Height <u>5'3"</u> O2 <u>96</u>	
General Appearance:	
Skin:	☒
HEENT: Eyes	☒
Ears, nose	☒
Mouth, throat	☒
Neck	☒
CHEST: Respiratory	☒
Heart	☒
Breasts ☐ Deferred	☒
ABDOMEN	☒
PELVIC: Rectal ☒ Deferred	☒
EXTREMITIES	☒
NEUROLOGICAL	☒
MUSCULOSKELETAL	☒
Cleared for Surgery? ☒ Yes ☐ No	
Photos Taken: ☒ Yes ☐ No	
PATIENT PLAN OF CARE	
Impressions:	
Recommendations: GA/TIVA for surgery	

COMMENTS

11/1/16 Date

Physician



Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

Post-op Phone Call

Patient Phone Number #: _____

Procedure: _____

PATIENT CONTACTED (date/time): 1st attempt _____ 2nd attempt _____ 3rd attempt _____

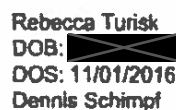
Spoke With: NO answer : 1m

1. DID YOU HAVE DIFFICULTY RESUMING NORMAL ACTIVITY? ☐ No ☐ Yes _____
2. DID YOU HAVE ANY TROUBLE WITH NAUSEA OR VOMITING? ☐ No ☐ Yes _____
3. DID YOU HAVE A SORE THROAT? ☐ No ☐ Yes _____
4. DID YOU HAVE DIFFICULTY RESUMING YOUR DIET? ☐ No ☐ Yes _____
5. DO YOU HAVE ANY CALF PAIN? ☐ No ☐ Yes _____
6. DO YOU HAVE EXCESSIVE PAIN OR SWELLING? ☐ No ☐ Yes _____
7. DO YOU HAVE PAIN OR SWELLING AT THE IV SITE? ☐ No ☐ Yes _____
8. DO YOU HAVE CONCERNS ABOUT YOUR WOUND OR WOUND CARE? ☐ No ☐ Yes _____
9. DO YOU HAVE ANY NUMBNESS OR TINGLING IN THE AFFECTED LIMB? ☐ No ☐ Yes _____
10. HAVE YOU HAD TO CONTACT YOUR PHYSICIAN FOR ANY PROBLEMS? ☐ No ☐ Yes _____
11. HAVE YOU HAD A FEVER? ☐ No ☐ Yes _____
12. WERE YOUR POST PROCEDURE INSTRUCTION REVIEWED? ☐ No ☐ Yes _____
13. DO YOU KNOW YOUR FOLLOW-UP APPOINTMENT TIME? ☐ No ☐ Yes _____
14. COULD WE HAVE DONE ANYTHING BETTER: ☐ No ☐ Yes _____
15. DO YOU HAVE ADDITIONAL QUESTIONS? ☐ No ☐ Yes _____

Comments: _____

Justina J. [Signature]
Signature

11/2/14
Time/Date

☐ No Medications

Allergies: ☒ NKA Allergies:

Medications on Discharge

[illegible]

☒ No changes in Home Medication required. Continue taking Home Medications as previously directed by your other physicians.

☐ Make the following changes to your Home Medications. Continue all other medications as previously directed by your physician:

Additional Written Instruction:

☒ Norco 7.5/325 1 tablet every 6 hours as needed for pain	☐ Bactrim DS 1 tablet every 12 hours
☐ Percocet 7.5/325 1 tablet every 6 hours as needed for pain	☐ Keflex 750mg 1 tablet every 8 hours
☒ Phenergan 25mg 1 tablet every 4 hours as needed for nausea	☐ Doxycycline 100mg 1 tablet every 12 hours
☐ Robaxin 500mg 1 tablet every 6 hours as needed spasms	

Other:

Physician Signature:

Date: 11/11/12

Source of Medicine List: Check All That Apply	
Patient Medication List	
Patient/Family Recall	✓
Pharmacy	
Primary Care Physician	
Surgeon	
Meds brought in	
Other	

I understand that I am to take the medications listed above upon my discharge from the center. I acknowledge that I have been told to contact the physicians who ordered any medications that I was taking before coming to the center to confirm if I should remain on those medications. The medication list has been reviewed with, and a copy given, to me or my representative.

Patient Signature:

Date: 11/1/14

**RNPA
Signature:**

Date: 10/11/00

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

"Count On Us"

Cymbalta 120mg (Oct 26)
Celebrex 200mg (last taken 10-26)
Oxycodone 5mg this morning 4:00
testosterone 3mg 10-31 last taken
progesterone 10-31 " "
estradiol 10-31 " "
multi-vitamin 10-31 last taken
levothyroid 120 this morning

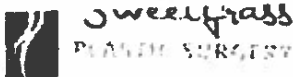
Mary Ackerman ^{cell} 703-629-7738

843-297-8626

Driver

OS 2517

TURISK_00011



Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

Discharge Instructions

YOU ARE URGED TO CAREFULLY FOLLOW THESE INSTRUCTIONS!

The pain medicines and anesthetics you received during your stay at the facility will continue to have some effect on you for 24 hours.

Therefore, during the 24 hours after your procedure for your safety and the safety of others:

DO NOT STAY ALONE. You may feel sleepy, lightheaded or dizzy at times. We strongly recommend that a responsible adult be with you for the rest of the day of surgery and also during the night for your protection and safety.

- **DO NOT DRIVE A MOTOR VEHICLE** or operate power tools. Teenagers are not to engage in athletic sports.
- **DO NOT MAKE MAJOR DECISIONS** or sign important papers
- **DO NOT DRINK BEER, WINE OR OTHER ALCOHOLIC BEVERAGES for 48 hours.**
- **DO NOT TAKE SEDATIVES OR TRANQUILIZERS** or any non-prescribed medication unless otherwise instructed by your surgeon.

1. Rest at home with activity as tolerated.

- ☐ Restrict your activities & rest for a day. Resume light to normal activity tomorrow
- ☐ No lifting greater than 10 pounds.

2. You may have pain for the first day after surgery. Pain medicine prescribed by your doctor should be taken as directed. It may make you sleepy and less alert than you normally are. **DO NOT USE OR RESUME USING BLOOD THINNERS, ASPIRINS, IBUPROFEN OR ASPIRIN-LIKE ANTI-INFLAMMATORY DRUGS FOR 10 DAYS.** Written medication instructions have been reviewed and a copy provided for you to take home.

3. If you take blood thinners regularly, be sure to check with your physician before resuming their use.

4. You may eat what you like unless otherwise instructed by your doctor. Begin with clear liquids, then progress to soft foods as tolerated.

5. Anesthetics and pain medicines may cause constipation in some individuals. Use of over the counter stool softeners is encouraged. Use as directed by manufacturer

6. Anesthetics and pain medicines may cause nausea and vomiting in some individuals. If nausea or vomiting becomes a problem at home, call your doctor.

7. Dressing care.

- ☐ Keep clean and dry ☐ Wear garment or bra as much as possible.

- ☐ You may NOT shower for 48 hours after you leave the facility, and replace dressing as needed.

8. You are scheduled for a follow-up appointment with your physician on _____

9. If you should experience any of the following, please call your physician's office during office hours at 843.471.1135 or Dr. Schimpf on his cell phone after hours and during the weekend at 843.387.2258.

- a. difficulty breathing
- b. bleeding that you feel is excessive
- c. persistent nausea or vomiting
- d. pain that is greater than explained to me in this teaching
- e. increased redness, warmth, swelling, hardness around operative area
- f. Oral temperature greater than 101.5
- g. Increasing & progressive drainage from surgical area
- h. calf pain or swelling

If you feel this is an emergency, call 911

OTHER INSTRUCTIONS:

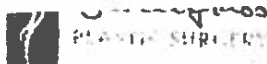
By signing this form I am acknowledging that I understand the instructions given and medication prescribed to me.

Patient/ Responsible Party: Mary E. Schimpf Date: 11/1/14 Time: 1330

RN/ PA signature: Jessica Julia R. R. Date: 11/1/14 Time: 1330

8

TURISK_00012



PACU Nursing Notes

Rebecca Turisk

DOB: [REDACTED]

DOS: 11/01/2016

Dennis Schimpf

Time	B/P	P	R	Temp	O ₂ %	O ₂ /M	Pain 0-10	10-wors	NURSES NOTES	Initials
1300	92/50	87	14			48				JS
1315	100/88	88	13			99				JS
1330	105/64	88	13			99				JS
									Doing well; Denies pain/nausea	
									Minimal tightness in Robaxin	
									given PO to water and crackers;	
									Drain care/post op care	
									reviewed; EIV as scheduled	

Blood Glucose:

Aldrete Scale

#	Activity	Score	Score			
			Pre op	Adm Rpt	30	60
2	Moves all 4 extremities		2	2	2	2
1	Moves 2 extremities					
0	Moves 0 extremities					
2	Able to deep breathe and cough		2	2	2	2
1	Dyspnea, shallow or limited breathing					
0	Apnea					
2	Systolic BP $\pm$ 20 mm of preadmission levels		2	2	2	2
1	Systolic BP $\pm$ 20-50 mm of preadmission level					
0	Systolic BP $\pm$ 50 mm of preadmission level					
2	Fully awake		2	1	2	2
1	Patient arousable by verbal stimuli					
0	Not responsive					
2	Normal		2	2	2	2
1	Pale, dusky, blotchy, other					
0	Cyanotic					
10			10	9	10	10

Patient must have score of 9 for discharge

Discharge Criteria/Evaluation

	Yes	No
al Signs Stable	✓	
nt / oriented	✓	
in Controlled & Education Provided	✓	
ntrolled nausea / no vomiting	✓	
sence of respiratory distress	✓	
sence of significant bleeding / drainage	✓	
luids tolerated	✓	
ulates with minimal assist / not dizzy	✓	
ity to void if applicable	✓	
ossible adult escort	✓	
score of 9 or = to pre procedure	✓	
criptions given to patient / family/ Education on Use	✓	
arnings returned to patient	✓	
arge instructions given:	✓	
al, written & return demo if applicable	✓	
nt / family verbalizes understanding	✓	

PACU Initial Assessment

Neurological: ☒ Awake ☒ Alert ☒ Oriented ☐ Drowsy/Arousable ☐ MAE

Respiratory:

Airway adjunct: ☒ None ☐ Nasal Cannula ☐ Mask O₂ ___ l/min

O₂ discontinued at ___

☒ Breath Sounds Clear/Equal ☐ Productive Cough

☐ Non-Productive Cough

☐ Rales ☐ R ☐ L ☐ Rhonchi ☐ R ☐ L

☐ Congested ☐ Wheezes

Intake: IV Fluids: Fluid ☒ 500ML ☒ 1000ML ☐ NS.9 ☐ LR

Location: ☒ PACU

Removed: Total infused: 2000 cc

Tolerating IV Fluids? ☒ Yes ☐ No

Surgical Dressing: ☐ N/A ☐ Wound clean and dry

☒ Dry and intact ☒ Minimal drainage ☐ Wet and spreading

Dressing reinforced: ☐ Yes ☐ No ☐ N/A

Drain: ☒ Jackson Pratt X 3 (Each breast and Abdomen)

Color: Adm ___ / OC ___

☒ CMS within normal limits ☐ Adequate Capillary Refill:

☐ Ice

Output: ☐ Able to void spontaneously

Emesis: ☒ N/A Amt: ___ Total: ___

Medications

Time	Med	Int
1330	Robaxin 500mg PO	JS

Signature

meets discharge criteria

Discharged @

1330

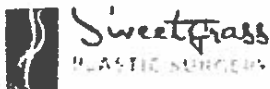
with

friend

Mode: ☐ Amb ☒ Wheelchair ☐ Walker ☐ Stretcher

10

TURISK_00013



Intra-Operative Phase

Rebecca Turisk

DOB: XXXXXXXXXX

DOS: 11/01/2016

Dennis Schimpf

Times
In OR: 0830
Time Out: 0857
Abx: OSA5
Start: 0858
End: 1250
To PACU: 1200

Procedure: Bilateral Breast Reduction & Implant Removal
Pre-Op Dx: Abdominoplasty; Liposuction for procedure
Wound Class: I (II) III IV

Surgeon: Dennis Schimpf
CRNA: Mina Denovan
Circulator: Jessica Pulce
Assistant: Megan Smith

- ☒ CORRECT Patient/Procedure/Site - ALL Staff involved and verified Time Out
 - ☒ Anesthesia Type: TIVA
 - ☒ Bilateral SCDs applied prior to induction
 - ☒ Pt warming
 - ☒ Pt. Positioned with all pressure points padded and protected (supine, LR lateral)
 - ☒ Skin Prep: Chlorhexidine
 - ☒ Specimens: 2 pillow under knees
 - ☒ Drains: X 3 JP (Bilateral Breast and Abdomen)
 - ☒ Implants: R Breast - 740g
L Breast - 700g
R Abdomen - 420g
L Abdomen - 400g + 20g = 420g
Medial Abdomen - 70g
- SmartSkin Joules: R Bra Line - 250cc
L Bra Line - 250cc
Abdominoplasty/Breast Reduction Weight: _____
- ESU#: 1 Cut 25 COAG: 60 80 (Brow) PAD Site: Anterior Skin intact: yes/no
- Measurements: ACE Steri-strips BRA Binder ABDs
- Intra Op Add: INITIAL COUNT: Sponge 5 Blades 1 Needles 7; 1 hypo; 1 Bovie
FINAL COUNT: Sponge 10 Blades 1 Needles 18; 1 hypo; 1 Bovie
- ap: 5
- ✓ Circulator/Assistant Agree

TRA-OP MEDICATION:

Med	Dose	Site	Amount	Signature
Mareaine	0.25% 10cc + 10cc + 30cc = 50cc			Jessica Pulce, RN
Tumescence	1.1 (50cc lidocaine, 5cc Biotin, 1cc epinephrine)			Jessica Pulce, RN

Report Given to PACU RN

Jessica Pulce, RN
RN/PA Signature11/1/14
DATE/TIME



Sweetgrass
PLASTIC SURGERY

Universal Protocol Checklist

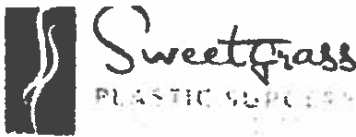
Rebecca Turisk
DOB: XXXXXXXXXX
DOS: 11/01/2016
Dennis Schimpf

Safety Goals

☒	Patient identification is verified by two methods, the patient's name, date of birth
☒	When applicable containers used for specimens are labeled in patient's presence.
☒	Medications are labeled that are not immediately administered to patient. Two individuals qualified to participate in the procedure verify medications both verbally & visually.
☒	Patient's current medications and known allergies are documented in the patient's medical record.

Patient chart contains

☒	Completed History & Physical
☒	Signed Informed Consent in chart
☒	Pre-procedure Nursing Assessment
☒	Pre-procedure Anesthesia Assessment
☒	Labeled Diagnostic and Radiology Test results are properly displayed if needed
☒	Required implants, devices, special equipment/trays are available
☒	The procedure site is marked by a licensed independent practitioner, who will be present when the procedure is performed, with the patient involved in the process
☒	A timeout is performed before the procedure including the following: Surgeon, Circulator, Anesthesia Provider, Scrub Technician and any other active participants in the procedure.
☒	Correct patient identity
☒	Correct site of procedure
☒	Procedure to be performed



Rebecca Turisk
 DOB: XXXXXXXXXX
 DOS: 11/01/2016
 Dennis Schimpf

Pre-Surgical Nursing Phone Instructions

0830

	Completed	Comments
1. Confirm date, arrival time and patient's phone #. Explain the hour difference between arrival and OR time.	☒	
2. Remind patient of need to have someone drive him/her home (that procedure WILL NOT be done if no one available) and length of stay. Driver Name: <u>MARY</u> Relationship: <u>Friend</u> Driver Location: _____ Driver's Phone: _____	☒	
3. All patients are to bring complete list of their medication, dosages and frequency. (Include herbs and Vitamins), wear all cotton underwear and sports bra and no jewelry.	☒	
4. Are you on a blood thinner (Coumadin, ASA, Plavix etc.) and if so confirm stop for 2 weeks? Last dose?	☒	
5. Remind patient to take heart and blood pressure meds with small sip of water the morning of the procedure. PLEASE do bring inhalers to the center with them.	☒	
6. Remind patient not to eat or drink past 12 midnight, unless directed otherwise by their physician. No smoking for 2 weeks prior and 2 weeks after the day of surgery. No alcohol for 48 hours prior to surgery.	☒	
7. Patients with Sleep Apnea should bring their CPAP machine.	☒	
8. Does the patient have allergies? Are you allergic/sensitivity to latex, sulfites, soy, peanuts, or eggs?	☒	
9. Does patient have an Internal Defibrillator- If so needs to be rescheduled to hospital setting.	☒	
10. Has the patient traveled outside the country in the last 30 days, or been exposed to anyone whom has? If yes, where? (review signs and symptoms EBOLA / TB)	☒	
Patient Contacted: ☒ Yes ☐ No ☐ Left Message	☐	
Spoke with: ☒ Patient ☐ Other _____	☐	
Verbalized understanding of instruction	☒	*pt has adrenal fatigue*
Staff: <u>Meghan Smith</u>	Date: <u>10/31/16</u>	Time: <u>4:37pm</u>
First Attempt: Date/Time: <u>10/31/16 @ 1245</u>	Left Message with: <u>pt</u>	RN: <u>Good</u>
Second Attempt: Date/Time: _____	Left Message with: _____	RN: _____
Third Attempt: Date/Time: _____	Left Message with: _____	RN: _____

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf



Sweetgrass

PLASTIC SURGERY

COSMETIC SURGERY OF THE FACE & BODY

REDUCTION MAMMOPLASTY

(Breast Reduction) RT Implant Removal

Breast reduction is usually performed to relieve back, neck and shoulder pain, and skin irritation that women with large breasts sometimes experience, rather than to enhance the appearance of the breast. The best candidates for this procedure are those who are mature enough to understand and have realistic expectations about the results.

Patient's
Initials

- RT The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- RT Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- RT I understand and accept that the most likely material risks and complications of a reduction mammoplasty have been discussed with me and may include but are not limited to:
- asymmetry
 - bleeding
 - change in nipple and skin sensation
 - delayed healing
 - different size than expected
 - discoloration/swelling
 - discomfort (pain/sensitivity)
 - failure to improve symptoms
 - infection
 - nipple retraction/poor contour
 - restricted activity
 - skin, nipple, flap loss
 - would separation
 - unsatisfactory results
- RT I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- RT I understand and accept the risks of blood transfusion(s) that may be necessary.
- RT I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its

TURISK_00017

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2018
Dennis Schimpf

RI ultimate appearance.
RI I am aware that smoking during the pre- and postoperative periods could increase chances of complications. I am also aware I may be tested for tobacco use the day of the procedure.
RI I have informed the doctor of all my known allergies.
RI I have informed the doctor of all medications that I am currently taking, including prescriptions, OTC remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
RI I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
RI I am aware and accept that no guarantees about the results of the procedure have been made.
RI I have been advised of the probable consequences of declining recommended or alternative therapies.
RI I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
RI I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
RI The doctor has answered all of my questions regarding this procedure.
I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct Dennis Schimpf, M.D., with associates or assistants of his or her choice, to perform breast reduction mammoplasty at Sweetgrass Plastic Surgery on my:

RI Right Breast

RI Left Breast

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

RI 10-27-17
Patient or Legal Representative Signature/Date/Time

RI
Relationship to Patient

Rebecca Turisk
Print Patient or Legal Representative Name

Dennis Schimpf
Witness Signature/Date/Time
11/1/18 0750

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

[Signature]
11/1/18 0750
Physician Signature/Date/Time

TURISK_00018

ABDOMINOPLASTY

Rebecca Turisk
DOB: XXXXXXXXXX
DOS: 11/01/2016
Dennis Schimpf

Abdominoplasty, or "tummy tuck," is a major surgical procedure designed to tighten the lower abdomen and may involve tightening of muscles of the belly wall. This procedure inevitably involves large and sometimes unsightly scars. These are inevitable and their final appearance depends on your own genetic healing characteristics that have little to do with the surgery. Occasionally, other complications may also occur.

Patient's
Initials

RT

The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

RT

Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

RT

I understand and accept that the most likely material risks and complications of abdominoplasty have been discussed with me and may include but are not limited to:

- allergic reactions
- asymmetries of contour
- bleeding
- change in sensation or numbness of abdominal skin
- changes in shape or appearance of pubic hair
- delayed healing
- disappointment
- "dog ears" (skin excess at scar end)
- extended hospital stay
- failure to alleviate symptoms of rash and back pain
- genital region numbness
- hematoma (blood clots under skin)
- infection
- loss of skin from insufficient circulation (requiring further surgery and skin graft)
- loss of umbilicus (belly button) or displacement to the side
- need for more surgery for secondary surgical corrections
- pain (may be prolonged)
- permanent scars that may be unsightly
- pulmonary embolism (blood clots in the lung)
- seroma (fluid collection under the skin)

RT

I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

RT

I understand and accept the risks of blood transfusion(s) that may be necessary.

RT

I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.

RT

I understand that skin and tissue relaxation may follow plastic surgery after weight loss. This natural loosening or stretching of skin after surgery is unpredictable, and may require additional surgery.

RT

I am aware that smoking during the three to four week pre- and postoperative periods is prohibited as smoking could dramatically increase chances of complications.

RT

I have informed the doctor of all my known allergies.

RT

I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

RT

I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

RT

I am aware and accept that no guarantees about the results of the procedure have been made or implied. Additionally, I understand that abdominoplasty (panniculectomy) done to relieve symptoms of skin irritation and/or back pain is not a cosmetic operation.

RT

I have been advised of the probable consequences of declining recommended or alternative therapies.

3114
Revised 9/05 12/05 1/06, 6/07

(Continued)

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice setting, CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).

TURISK_00019

- Rt I have been informed of what to expect postoperatively, including but not limited to:
Rt estimated recovery time, anticipated activity level, and the possibility of additional procedures.
Rt I understand that any tissue/specimen removed during the surgery may be sent to pathology
 for evaluation.
Rt The doctor has answered all of my questions regarding this procedure.

This will certify that I have read this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct Dennis Schimpf, M.D., with associates or assistants of his or her choice, to perform abdominoplasty on November 1, 2016 at Sweetgrass Plastic Surgery.

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

[Signature] 11.27.16
 Patient or Legal Representative Signature/Date/Time

[Signature]
 Relationship to Patient

Rebecca Turisk
 Print Patient or Legal Representative Name

[Signature] 11.27.16
 Witness Signature/Date/Time
Jessica Juler RN 11/1/16 0750

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the proposed treatment and the risks and consequences of not proceeding, have offered to answer any questions and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

[Signature] 11/1/16
0750
 Physician Signature/Date/Time

initial copy given to patient

initial ☒ original placed in chart

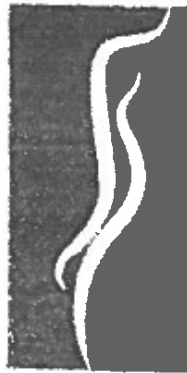
Rebecca Turisk
 DOB: [Redacted]
 DOS: 11/01/2016
 Dennis Schimpf

104
 6/1/2016 12:05:10 PM 6.10

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice state(s), C.A.S. and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).

TURISK_00020

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf



Sweetgrass
PLASTIC SURGERY
COSMETIC SURGERY OF THE FACE & BODY
843-471-1135

Frequently Asked Questions for Smartlipo, Precision, and Cellulaze

1. **What is Smartlipo?** Smartlipo is a laser lipolysis technology which uses heat to melt unwanted fat as well as heat the under surface of the dermis causing skin tightening. Smartlipo is a commercial brand form of laser lipolysis created by Cynosure. Precision and Cellulaze are procedures which use different hand pieces and fibers in comparison to Smartlipo, but all three procedures are based on the same laser lipolysis technology and performed with the same main laser unit.
2. **What areas of my body can I have treated?** Laser lipolysis can be performed on virtually any area of the body including, neck, arms, male chest, bra strap, lower back, abdomen, abdominal flanks, outer thighs, inner thighs, anterior and posterior upper legs, knee area, and lower legs.
3. **Do I need Anesthesia?** The vast majority of patients have the procedure **WITHOUT** IV sedation or general anesthesia. Local anesthetic is used to make small 3 mm incisions through which Tumescant fluid is injected under the skin numbing the treatment areas in approximately 15 minutes. However, we do offer IV sedation for patients, especially for those patients who have had a previous procedure on that area being treated. There tends to be scar tissue present in such areas and makes it more difficult to achieve adequate anesthesia with the tumescant fluid.
4. **Will I bruise?** Most patients experience mild bruising. The flanks tend to have the most bruising due to the fibrous nature of the fat in that area. The neck tends to bruise the least amount.
5. **How much down time will I need?** Most patients return to their normal level of activity within 48 hours. This can include work as well as exercise.

TURISK_00021

6. **Will the procedure tighten the skin?** The use of heat via the laser on the under surface of the dermis has been shown to both tighten the skin as well as help thicken the skin. However, many factor affect the overall skin tightening including, genetics, skin tone and history of skin trauma dermal tears (stretch marks)
7. **Will I be able to drive after the procedure?** Patients may drive after the procedure if they do NOT take oral medicine a head of the procedure. If the patient has a ride then we will often give them both valium as well as pain medicine to be taken 90 minutes before the procedure.
8. **Do I have to wear a special garment after the procedure?** We usually wrap the areas which are treated with ACE wraps or jaw bra. We ask that the patient wear some form of compression (ACE wraps, dri-fit compression or spunks) as much as possible for up to 6 weeks.
9. **Will I be swollen after the procedure?** Yes. The initial swelling can last approximately 6 weeks. This is the reason we ask that the patient use compression during this time period.
10. **How many treatments will I need?** Over 90% of the patients achieve their desired results with one session or treatment of the given area. In approximately 10% of the patients we do perform a "touch up" or revision of the area after the 6 month post procedure period.
11. **How long will it take to see results?** Most patients begin to see minor improvements within 6-8 weeks as the initial swelling begins to subside. **HOWEVER**, the area which was treated will continue to improve for up to 6 months. Its take a full 6 months for the skin and tissue to reach its ultimate result. As a result any touch up or revisional procedures will usually not be performed during the initial 6 month post-operative period.

Patient Signature: _____

Date: 11/1/16

Witness: _____

Date: 11/1/16

Rebecca Turisk
DOB: 
DOS: 11/01/2016
Dennis Schimpf

TURISK_00022



Sweetgrass
PLASTIC SURGERY

Rebecca Turisk
DOB: ~~XXXXXX~~
DOS: 11/01/2016
Dennis Schimpf

I request and authorize Dr. Dennis Schimpf, and his colleagues, to perform a procedure on me known as: _____
using the SmartlipoTriPlex system.

The nature and effects of the procedure, the risks, ramifications, complications involved, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that imperfections might result and that the operative result may not reach my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. I understand that in the unlikely case where an imperfection results, the patient and doctor may determine the necessity of a secondary procedure and such revisions are not included in the initial surgical facility or anesthesia fee, but they will be billed at a lesser rate.

I understand that I may be required to wear the garment continuously for the number of days determined by the surgeon; removal is only permitted to wash and apply sterile dressing to the treatment area or take a shower.

I understand that possible adverse effects may include bleeding, infection, scarring, skin contour irregularities, asymmetry, surgical shock, pulmonary complications, skin loss, seroma, allergic reactions, and anesthesia related complications. These may occur and have been discussed and understood. I understand the importance of pretreatment and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I recognize that during the course of the operation unforeseen conditions may necessitate additional or different procedures other than those above. I therefore further authorize and request that the above named surgeon perform the procedures that are, in his professional judgment, necessary, and desirable.

I understand that local and/or tumescent anesthesia is normally required when liposuction is performed. I consent.

Photographs will be taken of the region of the treatment. I give permission for these photographs to be used for the purposes of professional publications, training, educational, or sales purposes. If I do not agree to being photographed, it will in no way affect my present or future care. I agree to have photographs taken as part of this study as described in this form ☒ Yes ☐ No.

I certify that I have read the above authorization, that the explanations referred to therein were made to my satisfaction, and that I fully understand such explanations and the above authorization.

Signed: [Signature] Date: 11/1/16
(Patient or person authorized to consent for the patient)

Witness: Jessica J. [Signature] Date: 11/1/16

TURISK_00023

Rebecca Turisk
DOB: ~~XXXXXX~~
DOS: 11/01/2016
Dennis Schimpf



Authorization For The Use of Photographs

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. Your surgery has been photographically documented before, possibly during and now after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, Dennis K. Schimpf, MD, MBA, FACS is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well. Please consider the following circumstances and either authorize or deny use of your photos for each situation.

Patient Name: Rebecca Turisk

Procedures that you are having done:

1. Breast reduction & Implant Removal
2. Smart lipo Bra line
3. Abdominoplasty

I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. I authorize the anonymous use of my photographs for this purpose by Dennis K. Schimpf, MD, MBA, FACS.

Procedure 1: ☒ YES ☐ NO

Procedure 2: ☒ YES ☐ NO

Procedure 3: ☒ YES ☐ NO

I authorize the anonymous use of my photographs by Dennis K. Schimpf, MD, MBA, FACS in the seminars, health fairs and conferences for interested and/or prospective patients.

Procedure 1: ☒ YES ☐ NO

Procedure 2: ☒ YES ☐ NO

Procedure 3: ☒ YES ☐ NO

TURISK_00024

I authorize the anonymous use of my photographs in the articles written by Dennis K. Schimpf, MD, MBA, FACS for publication in medical journals so long as I am notified in writing prior to publication.

Procedure 1: ☒ YES NO

Procedure 2: ☒ YES NO

Procedure 3: ☒ YES NO

I authorize the anonymous use of my photographs in articles written by Dennis K. Schimpf, MD, MBA, FACS for publications in magazines and newspapers so long as I am notified in writing of such use prior to publication

Procedure 1: ☒ YES NO

Procedure 2: ☒ YES NO

Procedure 3: ☒ YES NO

I authorize the anonymous use of my photographs in television interviews of Dennis K. Schimpf, MD, MBA, FACS or programs produced for cable TV so long as I am notified in writing of such use prior to production.

Procedure 1: ☒ YES NO

Procedure 2: ☒ YES NO

Procedure 3: ☒ YES NO

I understand that every attempt will be made to represent me and Dennis K. Schimpf, MD, MBA, FACS accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature 

Date: 11-11-16

Rebecca Turisk
DOB: 
DOS: 11/01/2016
Dennis Schimpf

TURISK_00025



Sweetgrass
PLASTIC SURGERY

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

Financial Policy Regarding Revision

Plastic and reconstructive surgery may require additional revisional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). It is our policy as a predetermined courtesy to our patients not to charge a surgeon's fee for revisional surgery for approximately 12 months from the original date of surgery. We do, however, expect the patient to pay whatever other expenses arise as a result of treatment in the hospital or outpatient setting. If the revisional surgery occurs in our office facility, the patient is responsible for the expense of the facility and anesthesia revisions. It depends upon the individual policy

for procedures, specifically Smartlipo, that the physician feels does not have a desirable outcome and requires an additional surgical procedure, a maximum of 75% of the physician's fee will be credited towards the new procedure.

We hope that no problem arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to their patients. It is important for patients undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

My signature below, indicates that I understand and agree to the above policy.

Signature [Signature] Date 10-27-16

Witness [Signature]
Jessie Duke RN

102 West 8th North Street, Summerville SC 29483
843.471.1135 Office 800.919.5720 Fax
Sweetgrassplasticsurgery.com

TURISK_00026



Sweetgrass

PLASTIC SURGERY

Rebecca Turisk
DOB: [REDACTED]
DOS: 11/01/2016
Dennis Schimpf

I was given information describing Sweetgrass Plastic Surgery's policies on:

1. Rights and Responsibilities
2. Policy on Advance Directives
3. Disclosure of Ownership
4. Privacy Policy

I authorize the following people to receive information about my health status:

Rebecca Turisk
Name

self
Relationship

[Signature]
Patient signature

11/1/16
Date

TURISK_00029

PREANESTHESIA EVALUATION		Age	Sex	Height	Weight
Proposed Procedure Mastopexy / Augment / SL		50	M	5'5"	175
Previous Anesthesia / Operations PONV		Pre-Procedure Vital Signs B/P 123/78 P 99 R 14 T			
Family History of Anesthesia Complications		Current Medications List Noted			
AIRWAY / TEETH / HEAD & NECK - AOD - From		Allergies None			
TEETH		MALLAMPATI			
☒ Good/Intact		☒ I			
☐ Poor		☒ II			
☐ Dentures		☐ III			
☐ Upper Partial		☐ IV			
☐ Lower Partial		NECK ROM			
		☒ Good			
		☐ Limited			
		History From:			
		☒ Patient			
		☐ Significant Other			
		☐ Parent/Guardian			
		☐ CHART			
		☐ Communication/Language Problems			
		☐ Poor Historian			
SYSTEM	WNL	COMMENTS	DIAGNOSTIC STUDIES		
RESPIRATORY Asthma Bronchitis COPD Dyspnea Unilateral Chest Pain Cough Recent URI SOB Tuberculosis Pneumonia	☒	Tobacco Use: ☐ Yes ☒ No _____ Packs / Day for _____ Years	EKG Chest X-Ray NSR/ST		
CARDIOVASCULAR Abnormal EKG Angina ASHD CHF Dysrhythmia Fever/Tachycardia Vascular Disease	☒	Ethanol Use: ☐ Yes ☒ No _____ Frequency "Street Drug" Use: ☐ Yes ☒ No _____ Frequency	Pulmonary Studies CPA CNA		
HEPATO/GASTROINTESTINAL Liver Obstruction Cirrhosis Hepatitis / Jaundice Gallstones / Reflux Nausea / Vomiting Diarrhea	☒		Other		
NEURO / MUSCULOSKELETAL Anesthesia Back Problems CVA / Stroke / TIA DJD Headaches Loss of Consciousness Seizures	☐	Chronic Pain - Oxy OD - Fibromyalgia	High / Med / CBC > - <		
RENAL / ENDOCRINE Diabetes Renal Failure / Dialysis Thyroid disease Urinary Retention Urinary Tract Infection Weight Loss / Gain	☐		Electrolytes +++ Urea Nitrogen C HAZARD		
OTHER Anemia Bleeding Tendencies Cancer Chemotherapy Dehydration Hemorrhoids		Abnormal Fungus	Other		
Pre-operative / Diagnosis DSS-RES PROC.		POSTANESTHESIA NOTE			
Planned Anesthesia / Special Monitors B-GA (ET) (MA) Awake / Intubation ☐ Central Line ☐ Arterial Line ☐ PA Cath ☐ Epidural ☐ TIVA ☐ Other		1. ☒ No Anesthesia Complications 2. O ₂ Sat 98 % 3. Post-Op Hydration Adequate ☒ Yes ☐ No 4. Respiratory, Cardiovascular, Mental Status Acceptable ☒ YES ☐ NO 5. Notes:			
Pre-Anesthesia Medications Ordered / Given ☐ Ativan 4mg ☐ Xanax 1mg ☐ Robax 20mg ☐ Zofran 4mg ☐ Reglan 10mg ☐ Baclofen 30cc ☐ Brethine 0.25mg ☐ Accu Check		Anesthesia Signature Darwin, CNA Date 11-1-16 Time 1340			
Surgeon and Anesthetist have discussed the anesthetic plan and surgeon agrees with the proposed anesthetic. ☒ Yes ☐ No		PATIENT IDENTIFICATION REBECCA TURSK			
Evaluator Signature Darwin, CNA Date 11-1-16 Time 830					

Revised 04/24/14

TURISK_00030

ANESTHESIA CONSENT FORM

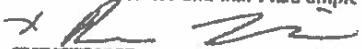
I acknowledge that my doctor has explained to me that I will have an operation or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that ALL forms of anesthesia involve some RISKS and no guarantees or promises can be made concerning the results of my procedure. Although rare, unexpected SEVERE COMPLICATIONS with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and the additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service listed below could be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

General Anesthesia Or Total Intravenous General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks	Mouth or throat pain, hoarseness, injury to the mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
Spinal or Epidural Anesthesia / Anesthesia With Sedation Without Sedation	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of body.
	Technique	Drug injected through a needle/catheter placed into the spinal canal or immediately outside the spinal canal.
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, total spinal.
Major/Minor Nerve Block With Sedation Without Sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of operation.
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
Monitored Anesthesia Care (with sedation)	Expected Results	Measurement of vital signs, Anesthesia staff available.
	Technique	Drug injected into bloodstream.
	Risks	Increased awareness, anxiety and/or discomfort.
Monitored Anesthesia Care (without sedation)	Expected Results	Measurement of vital signs, Anesthesia staff available.
	Technique	None.
	Risks	Increased awareness, anxiety and/or discomfort.

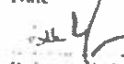
I hereby consent to the anesthesia services listed above and authorize that it be administered by Mike Donovan, CRNA or their associates, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following consideration to be observed, if applicable:

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of anesthesia service and that I had ample time to ask questions and to consider my decision.


Patient's Signature

Date 11/1/16 Time 8:30

Substitute's Signature


Relationship to Pat

Witness

Rebecca Turisk
DOB XXXXXXXXXX
DOS: 11/01/2016
Dennis Schimpf

TURISK_00031

REBECCA TURISK
11/02/2016

TELEPHONE CALL AND TEXT MESSAGING

In follow up today, throughout the course of the day, I have had the opportunity to talk with both folks who are at Ms. Turisk's helping her postoperatively. Overall, she is doing okay. She has had some episodes of light-headedness and dizziness. Her blood pressure right now is running approximately 105/60 and she remains slightly tachycardic at 110 to 130.

I discussed with the caregiver the possibility of IV fluid at an outpatient setting or in our office. At this point, they feel that she does not want to go to an Urgent Care Center or be seen, and that she will continue to increase her PO intake. I have asked them to continue to monitor her blood pressure and pulse every few hours to ensure that there is no dramatic change and if things do worsen to let me know immediately. I discussed this in detail with them and at present they have no further questions. We will continue to monitor the situation.

DKS/del

REBECCA TURISK
11/03/2016

TELEPHONE AND TEXT MESSAGING

Today, she was found to be doing better. She is ambulating without difficulty. She continues to increase her PO intake and, overall, feeling better than she has. Her blood pressure and pulse have been stable. They have taken down the dressings and she is beginning to bathe with a sponge.

Overall, the incisions are clean, dry and intact, per the family, and she is doing well. I have instructed them to contact me if she has any additional difficulties or problems.

DKS/del

12/22/2016

Patient Chart Note

Telephone Call

Rebecca Turisk (DOB: [REDACTED] Age: 50, Account: #12482)

11/07/2016

Spoke with William. Reports drainage output is dark red which is a change from the serousanguinous appearance previously. Also, patient has developed fever of 102 today. Has not taken any pain meds, tylenol, or ibuprofen since yesterday. Discussed taking pain medication or ibuprofen if fever persists. Patient to be seen in the office tomorrow.

Note created by Jordan Harper on 11/07/2016 01:52:34PM

12/22/2016

Patient Chart Note

Follow-up

Rebecca Turisk [REDACTED], Age: 50, Account: #12482)

11/08/2016

1 week post op from BBR, implant removal, smartlipo and abdominoplasty. Patient is improving, was in quite a bit of discomfort and fatigued (has adrenal fatigue). Breast drains have been <20 for over 2 days. Abdomen drain >50 still.

Abdomen incision is healing well, intact, no erythema/drainage. Very bruised on flanks and down lateral thighs. Moderate swelling but no seroma. Drain is functioning properly.

Bilateral breast incisions are intact, healing well. No erythema/drainage. Breasts with mild/mod swelling. No seroma. Bilateral drains functioning properly. Right nipple/areola complex is very bruised.

Removed bil breast drains. FU Friday for Drain removal (call Thurs to cancel if not ready)

This document has been electronically signed by Rebecca Zerwick Johnson, PA on 11/08/2016 12:09:16 PM

12/22/2016

Patient Chart Note

Follow-up

Rebecca Turisk ([REDACTED]), Age: 50, Account: #12482)

11/15/2016

FU from implant removal/BBR, abdominoplasty and smartlipo.

Patient is doing better daily.

Right areola nipple complex is very bruise and eschar formed.

All incisions are clean, intact w/o erythema/warmth/discharge. No seroma palpated to breasts or abdomen

FU 2 weeks.

DKS did see as well.

This document has been electronically signed by Rebecca Zerwick Johnson, PA on 11/21/2016 03:00:47 PM

REBECCA TURISK
11/28/2016

THIS IS AN ADDITION TO THE NOTE PERFORMED BY JORDAN HARPER, WHOM IS MY NURSE PRACTITIONER AND WHOM I SAW THE PATIENT WITH:

Last night I was contacted by the emergency room at the Summerville Medical Center. I had the opportunity to discuss the patient with the emergency room physician. We discussed that she had an opening of the right side and some eschar present on the right nipple/areolar complex. Her white count was normal and vital signs were stable. She was afebrile in the emergency room.

Blood cultures were performed, which we subsequently followed and were negative for any significant culture growth. In this phone conversation, I had the opportunity to discuss wound care with the emergency room physician, including wet-to-dry dressing changes and offered to see the patient the following morning at the office to provide both an evaluation, as well as any debridement which may be needed. She was given antibiotics in the emergency room IV and was discharged home with follow up instructions for the following day, 11/28/2016.

On 11/28/2016, I had the opportunity to discuss her care with her and her caregiver. She does have dry eschar present on the right nipple/areolar complex. Today, I sharply debrided that tissue. She had odor coming from the surrounding underlying tissue, which is open and draining. There is no overlying cellulitis, induration or evidence of subcutaneous spread of infection. Cultures were obtained in the emergency room and appropriate antibiotic treatment has been prescribed. I have discussed with her and her caregiver at length today that while there is colonization of bacteria present on the underlying subcutaneous tissue, the wound is open and draining. I would like to avoid any sharp dissection at this point further, as I have explained often times the body does a better job of demarcating tissue and in that way we are able to preserve tissue when allowing to heal by secondary intention. I have given them a prescription for Dakin's solution, which will dramatically improve the smell and hopefully clean up this region. I have asked them to try this for 48 hours and we will see them back in the office on 11/30/2016. Again, they have my phone number and I have talked and text with them multiple times. I have instructed them to contact me if they have any additional concerns or problems. The patient today had questions about her nipple and about the wound. I explained to her that our main goal at this point is to get the wound healed and once that is completed, there are various things that we can do to reconstruct the nipple, as well as tattooing

REBECCA TURISK
PAGE TWO
11/28/2016

3-D versions, which will dramatically improve her outcome. She states today that she is not overly concerned about the presence of a nipple and that overall her neck and back feel better and she has had less migraines. I will see her back in 48 hours for continued evaluation.

DKS/del

Follow-Up

Rebecca Turisk (DOB: [REDACTED] Age: 50, Account: #12482)

11/28/2016

DOS 11.1.16 from BBR, implant removal, smartlipo, and abdominoplasty. The patient is doing well. Pain controlled. Patient reports vaseline was irritating incision sites. She has been putting normal saline on gauze to breast incision sites. Erythema has closed and opening on right IMF incision has closed. Abominal drain < 20 cc/day x 2 days. Reporting "fevers" over the weekend.

Abominal incisions healing well. No erythema or drainage. Mild swelling, no seroma present. Drain is functioning properly, output is serosanguinous.

Right nipple-areolar complex with eschar formed throughout. Photos taken.

Medications: Written Bactrim.

Follow-up: Return to clinic in 1 week.

Photos sent to DKS. F/u with patient within a week to treat right nipple-areolar complex. Bactrim DS PO BID x 7 days #14.

This document has been electronically signed by Jordan Harper, NP on 11/28/2016 04:49:51 PM

12/22/2016

Patient Chart Note

Prescription Note

Rebecca Turisk (DOB: [REDACTED], Age: 50, Account: #12482)
11/28/2016

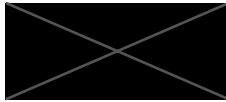
R_x

Bactrim

Physician: Dennis, Schimpf

NPI:

DEA:



Prepared by: Dennis, Schimpf

12/22/2016

Patient Chart Note

Prescription Note

Rebecca Turisk (DOB: [REDACTED], Age: 50, Account: #12482)
11/30/2016

R_x

Dakin's Solution 0.25%

Physician: Dennis, Schimpf

NPI: [REDACTED]

DEA: [REDACTED]

Prepared by: Dennis, Schimpf

Follow-Up

Rebecca Turisk (DOB: [REDACTED] Age: 50, Account: #12482)

11/30/2016

DOS 11.1.16 from Abdominoplasty (Tummy Tuck); Breast Reduction; Smartlipo of Bra Line. Patient went to ED yesterday, was concerned about right nipple-areolar complex. Was told she had "a staph infection" and was prescribed Keflex. Has been taking Bactrim since Monday.

Eschar throughout right nipple-areolar complex with dehiscence. Malodorous. Debrided the area. Packed with gauze. Dressed with ABD.

Medications: Written Dakin's Solution 0.25% 1.4 ozAAA TID.

Follow-up: Return to clinic in 2 - 3 days.

f/u appt friday. Dakin's solution 0.25% to affected area TID.

This document has been electronically signed by Dennis Schimpf, MD on 11/30/2016 12:27:29 PM

12/22/2016

Patient Chart Note

Telephone Call

Rebecca Turisk (DOB: [REDACTED] Age: 50, Account: #12482)

12/08/2016

12/1/2016--Dr. Schimpf received a phone call last night that patient was seen in the ER. I called the patient to see if she would like to come in and be seen by Dr. Schimpf. Bill answered and said that she was resting and he would ask her and if she did want to be seen he would give us a call back. Pt or care taker did not call back.

12/2/2016--Called and left a voicemail to check on patient and see how she was feeling. Patient did not return call.

12/5/2016--Patients friend and business partner (Nisreen Sad) came by the Summerville office to ask for a refund for her procedure. Ms. Turisk had paid the deposit for her procedure but she had decided that she no longer wanted to proceed. While in the office she informed us that Ms. Turisk was at MUSC. I spoke with Dr. Schimpf regarding the refund and made him aware that Ms. Turisk was in the hospital. He advised to issue a refund and call and check on patient. Called and left a voicemail for patient but she did not return call.

12/8/2016--Nisreen Sad called the office to check on status of refund. Since Ms. Turisk had not returned call (wanted to see if patient wanted check written or credit card refunded) her credit card was refunded. Called patient to let her know about refund. Bill answered and said that patient was sleeping. She was released from the hospital yesterday. Bill stated that she was on some strong antibiotics and that she was having a rough time. Advised Bill to please keep us updated with how patient was feeling and also let him know about the refund to patients credit card.

VT

Dennis Schimpf, MD

Note created by Vicky Tolbert on 12/08/2016 04:32:26:PM

Wound Evaluation

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 11/29/16 18:57 Author POSTON, MARVIN R Status Entered Source HCA:SCA:COCTR

Wound Site #1: Breast, Right
Is This a Wound Re-Check: No
Date of Injury: //
Time of Injury:
Mechanism of Injury: POST OP

Wound Type #1: INFECTION

Description of Wound 1:

Foreign Body Involvement

No

What

Size of Wound (CM X CM):

Removed Prior To Arrival

Evidence Of Infection #1: Yes

Foreign Body Presence Discernible

Signs of Infection:

Active Bleeding Location #1: No

Drainage

Amount & Description of Bleeding #1:

Controlled with Bandage/Pressure 1:

Sensation Distal to Injury:

Pulse Distal to Injury:

Capillary Refill Distal to Injury:

Movement Distal to Injury:

Tetanus received within last 5 yrs

Received Tetanus Vaccine in Year:

Any Other Wounds:

Additional Findings:

patientkeeper

Printed: 3/23/17 12:52

By: Schimpf, Dennis K MD

Wound Evaluation

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (643)532-9304 CELL

Date/Time 11/29/16 19:57 Author POSTON, MARVIN R Status Entered Source HCA:SCA:COCTR

Date of Initial Injury/Wound: //
Original Mechanism of Injury:

Any Residual Associated Signs & Symptoms:

Original Wound Type:

Description of Wound Re-Check:

Size of Wound (CM X CM):

Assessment of Wound:

Wound Site #2:

Wound Type #2:

Description of Wound 2:

Size of Wound (CM X CM) #2:

Amount & Description of Bleeding #2:

Active Bleeding Location #2:

Controlled with Bandage/Pressure 2:

Evidence Of Infection #2:

Wound Site #3:

Wound Type #3:

Description of Wound 3:

Size of Wound (CM X CM) #3:

Amount & Description of Bleeding #3:

Active Bleeding Location #3:

Controlled with Bandage/Pressure 3:

Evidence Of Infection #3:

Wound Site #4:

Wound Type #4:

Description of Wound 4:

Size of Wound (CM X CM) #4:

Amount & Description of Bleeding #4:

patientkeeper

Printed: 3/23/17 12:52

By: Schimpf, Dennis K MD

Wound Evaluation

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 11/29/16 19:57 Author POSTON, MARVIN R Status Entered Source HCA:SCA:COCTR

Active Bleeding Location #4:

Controlled with Bandage/Pressure 4:

Evidence Of Infection #4:

Author: POSTON, MARVIN R

Wound Evaluation

Teaching Education

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 19:58 Author POSTON,MARVIN R Status Entered Source HCA:SCA:COCTR

Learner: Patient

Readiness to Learn: Cooperative

Barriers to Learning: None

Patient Rating of Current Knowledge Level:

Teaching method: Verbal

Name of interpreter:

Language line personnel/number used:

See next page

Patient/Family education subject items: Medications

Safety

Procedures

Pain management

NPO status

Learner(s) verbalized understanding and/or return demonstration of items: Y
Items Not Understood By Learner:

Pt/Family encouraged verbalize anxieties and reassurance given: N

Pt/Family/Significant other informed of condition and treatment plan: Y

Pt/Family/Significant other encouraged give input and participate in tx: Y

Comments:

Last page

Author: POSTON,MARVIN R

Teaching Education

Pain Assessment/Reassessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: 0000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 19:50 Author JENKINS, LUCINDA S Status Entered Source HCA:SCA:COCTR

- - PAIN ASSESSMENT - -

Pain scale utilized: Verbal numeric

Pain intensity: 7

Pain location: Breast left

Breast right

Pain radiation:

Pain description: Aching

Comfort considerations/Alleviating factors:

If other, describe:

(End)

Numeric pain scale: Severe pain-7

Wong-Baker pain scale:

Is the patient extubated and unable to communicate:

Facial expression:

Body movements:

Ventilator compliance:

Vocalization (extubated patients):

Muscle tension:

CPOT total score:

Face:

Legs:

Activity:

Cry:

Consolability:

FLACC total score:

Facial expression:

Cry:

Breathing patterns:

Arms:

Legs:

State of arousal:

NIPS total score greater than 3 indicates pain:

Author: JENKINS, LUCINDA S

patientkeeper

Printed: 3/23/17 12:51

By: Schimpf, Dennis K MD

Pain Assessment/Reassessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 19:50 Author JENKINS, LUCINDA S Status Entered Source HCA:SCA:COCTR

Pain Assessment/Reassessment

Medication History

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 19:49 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

Takes Daily Medications, Vitamins, Herbal or OTC Medications Yes

Attention Required: No

Home Medications:

CELECOXIB (CeleBREX) 200 MG

200 MG PO DAILY

DULoxetine (CYMBALTA) 60 MG

60 MG PO BID

MULTIVITAMIN W-MINERALS (DAILY MULTIVITAMIN-MINERALS) 1 EACH

1 TAB PO BID

oxycODONE (ROXICODONE) 15 MG

5 MG PO Q4H PRN

HYDROCORTISONE (CORTEF) 5 MG

5 MG PO DAILY

LIOTHYRONINE (CYTOMEL) 25 MCG

CEPHALEXIN (KEFLEX) 500 MG

500 MG PO Q8H

SULFAMETHOXAZOLE/TRIMETHOPRIM 800/160 MG (BACTRIM DS) 1 EACH

PROGESTERONE, MICRONIZED (PROMETRIUM) 200 MG

TESTOSTERONE

1 MG

Author: JENKINS,LUCINDA S

Medication History

patientkeeper

Printed: 3/23/17 12:49

By: Schimpf, Dennis K MD

EDM NOTE

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 12/04/16 07:50 Author GASKINS,AMANDA B Status ENTERED Source HCA:SCA:COCTR

CULTURE RESULTS RECEIVED. POSITIVE FOR STAPH AUREUS ENTEROCOCCUS.
IS SENSITIVE TO TREATMENT PROVIDED. NO CHANGES INDICATED PER DR KRAMER

** BELOW MANDATORY FOR GC / CH / HERPES / STREP / C.DIFF**

PATIENT WAS NOTIFIED ON N/A.

Author: GASKINS,AMANDA B

EDM NOTE

Detailed Assessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: [REDACTED] MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 18:47 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

Suicide screening: N

Evidence of physical and/or psychological abuse: N

Are you frequently being bullied:

Do you currently think your safety is being threatened by anyone you know: N

Comments:

See next page

Previous Medical History: Y Surgical History BACK

Breast Augmentation

Medications and Treatments Prior to Arrival: Other treatment:

Tetanus received within last 5 yrs

Received Tetanus Vaccine in Year:

See next page

Nutritional Assessment WDP? Y Explain Variance:

Detailed Assessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 11/28/16 19:47 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

Functional Assessment WDP? Y Explain Variance:

Living arrangements: Lives with others

Other living arrangement:

See next page

Tobacco history: N Describe tobacco use:

Alcohol history: N Describe alcohol use:

Drug use history: N Describe drug use history:

See next page

Are there cultural, religious, language, developmental or behavioral factors to consider in planning care: N Describe:

Any barriers to learning identified: N Barriers to learning:

Readiness to learn:
Cooperative
Interest shown

Preferred method of learning:
Discussion

Detailed Assessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: 0000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 19:47 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

See next page

OB/GYN History: (if noted below)

LMP: HYSTERECTOMY

Gravida: Para:

Pregnant: Unable to Assess

Estimated Delivery Date: //

Number of Weeks Pregnant:

Weeks Gestation:

Any Problems with this CURRENT Pregnancy:

Contractions:

Are you leaking any fluids:

Vaginal Bleeding:

See next page

6 Weeks/42 days or less Post Partum:

Date of Delivery: //

Number of days Post Partum:

Type of Delivery:

Did you have any problems with recent pregnancy:

Do you feel a sense of hopelessness or helplessness that affects the care of you or your baby:

See next page

Detailed Assessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 11/29/16 19:47 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

Primary Caregiver:

Primary Caregiver has appropriate documentation:
Social Services/Agency contacted:

Body Mass Index (BMI): 28.7 : HIGH

Development Within Normal Range for Age:

Fontanelles (Age < 2):

See next page

Immunizations Current: Recent Immunizations:

Influenza Immunization Given Within Last 7 Days:

Exposure To Communicable Diseases:

See next page

ED plan of care

Chief Complaint: WOUNDEVAL; WOUNDEVAL

Expected outcome of chief complaint: Stabilized/Maintained

Additional findings:

Detailed Assessment

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: XXXXXXXXXX MRN: D000484121 Phone: (643)532-9304 CELL

Date/Time 11/29/16 19:47 Author JENKINS,LUCINDA S Status Entered Source HCA:SCA:COCTR

Are you here because you tried to hurt yourself:

Last page

In the past few days have you been having thoughts or making plans about hurting yourself:

See next page

I want to ask you if your child attempted suicide in the past year:

In the past week have you been having thoughts or making plans about hurting yourself:

See next page

Have you tried to hurt or kill yourself in the past year:

New Behavior of Child:

See next page

Comment:

See next page

Patient is at Risk for Suicide:

Respiratory: N

Heart: N:

GI: N

Neurological: Y: Migraines

Mental health: N:

Cancer: N:

Chronic/other: Y: Arthritis
Back pain/chronic

Risk factors: Y: Hyper/Hypothyroidism

Comments: THROID HYPORADRENAL DEPRESSION CHRONIC BACK

Last page

Author: JENKINS,LUCINDA S
Detailed Assessment

This report is compliant with the requirements of the College of American Pathologists.

Panel - CBC W/AUTO DIFFERENTIAL

SU:HCA:SCA:COCTR - SUMMERVILLE L39851140
M39851245 295 MIDLAND PARKWAY, SUMMERVILLE, SC
29485Collected Date/Time: 11/29/16 19:55 Resulted Date/Time: 11/29/16 20:46
Ordering Physician: Brian L MD Leal

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000494121 Phone: (843)532-8304 CELLCollected Date/Time: 11/29/16 19:55 Resulted Date/Time: 11/29/16 20:46
Ordering Physician: Brian L MD Leal

Value	Units	Norm	Normal Range	Performing Lab	Comment
WBC 9.6	k/mm3		4.0-10.9 k/mm3	SU:HCA:SCA:COC TR	
RBC 3.27	M/mm3	L	3.70-5.00 M/mm3	SU:HCA:SCA:COC TR	
HGB 8.8	g/dL	L	11.5-14.5 g/dL	SU:HCA:SCA:COC TR	
HCT 28.1	%	L	34.0-43.0 %	SU:HCA:SCA:COC TR	
MCV 89.0	fL		80.0-95.0 fL	SU:HCA:SCA:COC TR	
MCH 28.3	Pg		26.0-32.0 Pg	SU:HCA:SCA:COC TR	
MCH C 29.6	g/dl	L	32.0-35.0 g/dl	SU:HCA:SCA:COC TR	
RDW 52.1	fL	H	35-46 fL	SU:HCA:SCA:COC TR	
RDW CV 16.3	%	H	11.5-15.0 %	SU:HCA:SCA:COC TR	
PLT 649	K/mm3	H	135-350 K/mm3	SU:HCA:SCA:COC TR	
MPV 8.3	fL	L	9.0-12.4 fL	SU:HCA:SCA:COC TR	
NEU T % 70.1	%		40.1-76.4 %	SU:HCA:SCA:COC TR	
LYM PH % 18.8	%		14.8-45.8 %	SU:HCA:SCA:COC TR	
MON O % 9.9	%		4.0-12.7 %	SU:HCA:SCA:COC TR	
EOS % 0.6	%		0.0-5.4 %	SU:HCA:SCA:COC TR	
BAS O % 0.4	%		0.0-1.2 %	SU:HCA:SCA:COC TR	
IG% 0.2	%		0.1-0.3 %	SU:HCA:SCA:COC TR	
NEU T # 6.7	K/mm3		1.3-8.4 K/mm3	SU:HCA:SCA:COC TR	
LYM PH # 1.8	K/mm3		0.5-5.0 K/mm3	SU:HCA:SCA:COC TR	
MON O # 1.0	K/mm3		0.1-1.3 K/mm3	SU:HCA:SCA:COC TR	
EOS # 0.1	K/mm3		0.0-0.6 K/mm3	SU:HCA:SCA:COC TR	
BAS O # 0.0	K/mm3		0.0-0.1 K/mm3	SU:HCA:SCA:COC TR	
IG# 0.02	K/mm3		0.01-0.03 K/mm3	SU:HCA:SCA:COC TR	

Any laboratory data incorporated into this document may not be complete as this is not the official patient record.
The original full report is available in Meditech.

This report is compliant with the requirements of the College of American Pathologists

Panel - COMPREHENSIVE METABOLIC
PANELSU:HCA:SCA:COCTR - SUMMERVILLE L39851140
M39851245 295 MIDLAND PARKWAY, SUMMERVILLE, SC
29485

Collected Date/Time: 11/29/16 19:55

Resulted Date/Time: 11/29/16 20:53

Ordering Physician: Brian L MD Leal

TURISK, REBECCA C.

Age: 60Y Gender: F DOB: XXXXXXXXXX MRN: D000484121 Phone: (843)532-9304 CELL

Collected Date/Time: 11/29/16 19:55

Resulted Date/Time: 11/29/16 20:53

Ordering Physician: Brian L MD Leal

	Value	Units	Norm	Normal Range	Performing Lab	Comment
NA	143	mEq/L		136-145 mEq/L	SU:HCA:SCA:C OCTR	
K	4.4	mEq/L		3.6-5.1 mEq/L	SU:HCA:SCA:C OCTR	
CL	102	mEq/L		101-111 mEq/L	SU:HCA:SCA:C OCTR	
CO2	28	mEq/L		22-32 mEq/L	SU:HCA:SCA:C OCTR	
ANI ON GAP	13.0			3-13	SU:HCA:SCA:C OCTR	
GLU	106	mg/dL	H	70-100 mg/dL	SU:HCA:SCA:C OCTR	
BUN	23	mg/dL	H	6-20 mg/dL	SU:HCA:SCA:C OCTR	
CRE ATIN INE	0.9	mg/dL		0.4-1.0 mg/dL	SU:HCA:SCA:C OCTR	
GFR BY MDR D	> 60			>=60	SU:HCA:SCA:COCTR	
****REFERENCE RANGE: >=60 mL/min/1.73m2****						
*****A GFR of <60.0 mL/min/1.73m2 indicates CKD*****						
EST CRC L CG/ BW	64.6	mL/min		>60 mL/min	SU:HCA:SCA:C OCTR	
EST CRC L CG/ ABW	89.4	mL/min		>60 mL/min	SU:HCA:SCA:C OCTR	****Estimated CRCL used in adjusting medication dosages.****
TOT AL PRO TEIN	7.6	gm/dL		6.1-8.0 gm/dL	SU:HCA:SCA:C OCTR	
ALB UMI N	3.5	gm/dL		3.4-4.8 gm/dL	SU:HCA:SCA:C OCTR	
CAL CIU M	9.6	mg/dL		8.9-10.3 mg/dL	SU:HCA:SCA:C OCTR	
TOT AL BILI RUB IN	0.3	mg/dL		<1.0 mg/dL	SU:HCA:SCA:C OCTR	SAMPLES FROM PATIENTS TAKING NAPROXEN MAY EXHIBIT FALSELY ELEVATED RESULTS FOR TOTAL BILIRUBIN.
AST	24	Units/L		<35 Units/L	SU:HCA:SCA:C OCTR	
ALT	21	Units/L		10-63 Units/L	SU:HCA:SCA:C OCTR	
ALK	127	Units/L	H	32-101	SU:HCA:SCA:C	

Any laboratory data incorporated into this document may not be complete as this is not the official patient record.
The original full report is available in Meditech.

patientkeeper

CAP LABORATORY REPORT

Date: 03/23/17 12:47

By: Schimpf, Dennis K
MD

This report is compliant with the requirements of the College of American Pathologists.

Panel - COMPREHENSIVE METABOLIC
PANEL

SU/HCA/SCA/COCTR - SUMMERVILLE L39851140
M39851245 295 MIDLAND PARKWAY, SUMMERVILLE, SC
29485

Collected Date/Time: 11/29/16 19:55 Resulted Date/Time: 11/29/16 20:53
Ordering Physician: Brian L. MD Leal

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843) 532-8304 CELL

Value	Units	Norm	Normal Range	Performing Lab	Comment
PHO			Units/L	OCTR	
S					
TOT					
AL					

Any laboratory data incorporated into this document may not be complete as this is not the official patient record.
The original full report is available in Meditech.

Page 2 of 2

TURISK_00059

This report is compliant with the requirements of the College of American Pathologists.

Panel - URINALYSIS COMPLETE

SU:HCA:SCA:COCTR - SUMMERVILLE L39851140
M39851245 295 MIDLAND PARKWAY, SUMMERVILLE, SC
29485

Collected Date/Time: 11/29/16 19:55 Resulted Date/Time: 11/29/16 21:09
Ordering Physician: Brian L MD Leal

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)632-9304 CELL

Collected Date/Time: 11/29/16 19:55 Resulted Date/Time: 11/29/16 21:09
Ordering Physician: Brian L MD Leal

	Value	Units	Norm	Normal Range	Performing Lab	Comment
COL OR	YELLOW			YELLOW	SU:HCA:SCA:COC TR	
APPE ARA NCE	HAZY			CLEAR	SU:HCA:SCA:COC TR	
GLU	NEGATIVE	mg/dL		NEGATIVE mg/dL	SU:HCA:SCA:COC TR	
BILIR UBIN	NEGATIVE			NEGATIVE	SU:HCA:SCA:COC TR	
KET ONE	25	mg/dL		NEGATIVE mg/dL	SU:HCA:SCA:COC TR	
SPE C GRA V	1.007			1.003-1.030	SU:HCA:SCA:COC TR	
BLO OD	NEGATIVE			NEGATIVE	SU:HCA:SCA:COC TR	
PH	7.0			5.0-7.0	SU:HCA:SCA:COC TR	
PRO TEIN	NEGATIVE	mg/dL		NEGATIVE mg/dL	SU:HCA:SCA:COC TR	
URO BIL	NORMAL	mg/dL		< 2.0 mg/dL	SU:HCA:SCA:COC TR	
NITRI TE	NEGATIVE			NEGATIVE	SU:HCA:SCA:COC TR	
LEUK ESTE R	NEGATIVE	Leu/uL		NEGATIVE Leu/uL	SU:HCA:SCA:COC TR	
RBC	0-2	#/hpf		0-2 #/hpf	SU:HCA:SCA:COC TR	
WBC	0-2	#/hpf		0-2 #/hpf	SU:HCA:SCA:COC TR	
SQU AM EPI CELL S	3-5	#/hpf		0-5 #/hpf	SU:HCA:SCA:COC TR	
BACT	MODERATE	#/hpf	*	RARE #/hpf	SU:HCA:SCA:COC TR	

Any laboratory data incorporated into this document may not be complete as this is not the official patient record.
The original full report is available in Meditech.

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TURISK_00060

patientkeeper

Printed: 03/23/17 12:45

By: Schimpf, Dennis K MD

BLOOD CULTURE

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: 0000484121 Phone: (243)532-9304 CELL

Date/Time 11/29/16 20:00 Status Completed Source HCA:SCA:COCTR

BLOOD CULTURE

Procedure: BLOOD CULTURE

Final

Ver Time: Dec 5, 2016 6:33am DLAB.JWT1

Res Time: Dec 5, 2016 6:33am DLAB.JWT1

SPECIAL RESULT:

NO GROWTH AFTER 5 DAYS INCUBATION

BLOOD CULTURE

Specimen: 16:TR:BC0024160U (COMP)

Source: BLOOD

Specimen Desc: UNSPEC

Coll Date: Nov 29, 2016 8:00pm DNUR.AKR1

Recv Date: Nov 29, 2016 8:40pm DLAB.SS

Submitted By: Leal,Brian L MD

Ordered By: Leal,Brian L MD

Facility: SUMMERVILLE L39851140 M39851245

Comments:

Sepsis Bundle Ordered: YES

Sepsis Bundle Ordered: YES

GRAM STAIN, WOUND CULTURE

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)632-9304 CELL
Date/Time 11/28/16 19:55 Status Completed Source HCA:SCA:COCTR

GRAM STAIN, WOUND CULTURE

Procedure: GRAM STAIN

Final

Ver Time: Nov 29, 2016 9:35pm DLAB.GMO

Res Time: Nov 29, 2016 9:35pm DLAB.GMO

GRAM STAIN

MANY GRAM POSITIVE COCCI IN PAIRS, CHAINS & CLUSTERS

MODERATE GRAM POSITIVE BACILLI

SQUAMOUS EPITHELIAL CELLS 0-1 SQUAMOUS EPITHELIAL CELLS/LOW POWER FIELD

WHITE BLOOD CELLS >25 WHITE BLOOD CELLS/LOW POWER FIELD

Procedure: WOUND CULTURE

Final

Ver Time: Dec 3, 2016 10:57am DLAB.EIM

Res Time: Dec 3, 2016 10:57am DLAB.EIM

Organism 1: STAPHYLOCOCCUS AUREUS

QUANTITATION:: HEAVY GROWTH

ISOLATE COMMENTS: SEE SENSITIVITIES

Organism 2: ENTEROCOCCUS FAECALIS

QUANTITATION:: HEAVY GROWTH

ISOLATE COMMENTS: SEE SENSITIVITIES

Organism: STAPHYLOCOCCUS AUREUS

QUANTITATION:: HEAVY GROWTH

ISOLATE COMMENTS: SEE SENSITIVITIES

SUSCEPTIBILITY PROCEDURE: POSITIVE COMBO 34

Anti: CLINDAMYCIN	S	<0.5
Anti: ERYTHROMYCIN	S	<0.5
Anti: GENTAMICIN	S	<4
Anti: OXACILLIN	S	<0.25
Anti: PENICILLIN	BLac	2
Anti: TETRACYCLINE	S	<4
Anti: TRIMETH/SULF	S	<0.5/9.5
Anti: VANCOMYCIN	S	1

Organism: ENTEROCOCCUS FAECALIS

QUANTITATION:: HEAVY GROWTH

ISOLATE COMMENTS: SEE SENSITIVITIES

SUSCEPTIBILITY PROCEDURE: POSITIVE COMBO 34

Anti: AMPICILLIN	S	<2

patientkeeper

Printed: 03/23/17 12:45

By: Schimpf, Dennis K MD

GRAM STAIN, WOUND CULTURE

TURISK, REBECCA C.

Age: 59Y Gender: F DOB:  MRN: D000484121 Phone: (843) 632-9304 CELL

Date/Time 11/29/16 19:55 Status Completed Source HCA:SCA:COCTR

Anti: GENT SYN SCREEN

S

Anti: VANCOMYCIN

S

1

S = SUSCEPTIBLE

I = INTERMEDIATE

R = RESISTANT

BLac = BETA-LACTAMASE POSITIVE

INTERPRETIVE BREAKPOINTS ARE BASED ON CURRENT CLSI AND/OR FDA GUIDELINES.

S = SUSCEPTIBLE

I = INTERMEDIATE

R = RESISTANT

BLac = BETA-LACTAMASE POSITIVE

INTERPRETIVE BREAKPOINTS ARE BASED ON CURRENT CLSI AND/OR FDA GUIDELINES.

GRAM STAIN, WOUND CULTURE

Specimen: 16:TR:B0050232U (COMP)

Source: BREAST

Specimen Desc: UNSPEC

Coll Date: Nov 29, 2016 7:55pm DNUR.LSJ1

Recv Date: Nov 29, 2016 8:32pm DLAB.SS

Submitted By: Leal,Brian L MD

Ordered By: Leal,Brian L MD

Facility: SUMMERVILLE L39851140 M39851245

patientkeeper

Printed: 03/23/17 12:45

By: Schimpl, Dennis K MD

BLOOD CULTURE

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-8304 CELL

Date/Time 11/29/16 19:56 Status Completed Source HCA:SCA:COCTR

BLOOD CULTURE

Procedure: BLOOD CULTURE

Final

Var Time: Dec 5, 2016 6:33am DLAB.JWT1

Res Time: Dec 5, 2016 6:33am DLAB.JWT1

SPECIAL RESULT:

NO GROWTH AFTER 5 DAYS INCUBATION

BLOOD CULTURE

Specimen: 16:TR:BC0024161U (COMP)

Source: BLOOD

Specimen Desc: LEFT ARM

Coll Date: Nov 29, 2016 7:55pm DNUR.LSJ1

Recv Date: Nov 29, 2016 8:41pm DLAB.SS

Submitted By: Leal,Brian L MD

Ordered By: Leal,Brian L MD

Facility: SUMMERVILLE L39851140 M39851245

Comments:

Sepsis Bundle Ordered: YES

Sepsis Bundle Ordered: YES

TRIDENT HEALTH SYSTEMS (COCTR)
EMERGENCY PROVIDER REPORT
REPORT#: 1129-1053 REPORT STATUS: Signed
DATE: 11/29/16 TIME: 1948

PATIENT: TURISK, REBECCA CUZICK UNIT #: D000484121
ACCOUNT#: D00053570373 ROOM/BED:
AGE: 50 SEX: F PCP PHYS: No Primary or Family Physician
SERVICE DT: 11/29/16 AUTHOR: Callahan, Adam PA
REP SRV DT: 11/29/16 REP SRV TM: 1948
* ALL edits or amendments must be made on the electronic/computer document *

CALLAHAN, ADAM P 11/29/16 1948:
HPI-Rash/Abscess/Cellulitis

General

Confirmed Patient Yes

Presentation

Chief Complaint Sore, Tender/swollen area
Hx Obtained From Patient
Onset Occurred Weeks ago (3)
Symptom Duration Waxes and wanes
Progression since Onset Waxes and wanes
Location right breast
Quality Painful
Severity: Onset Moderate
Severity: Current Moderate
Associated with
Denies: Abdominal pain, Bleeding, Dizziness, Fever, Vomiting.
Associated Other Pt denies other symptoms
Exacerbated by Nothing
Relieved by Nothing

Free Text HPI Notes

Free Text HPI Notes

Patient had bilateral breast reduction on Nov 1st 2016 and recently been to an UC for possible breast infection and placed on Bactrim and Keflex which she is still taking. Patient today reports increased swelling, drainage and foul smell from right breast, body aches and chills. Patient was seen in Dr. Schirreff's office yesterday and recieved an shot of antibiotics.

Review of Systems

ROS Statements

All systems rev & neg except as marked.

Basic Review of Systems

Basic ROS GU: No dysuria/frequency, HEM: No bleeding/bruising, NEURO: No change MS, NEURO: No focal deficit, PSYCH: NL thought content

Focused Review of Systems

Skin

Reports: Redness, Swelling.

Past Medical History - Adult

Stated Complaint R/BREAST INF POST OP
Allergies

TURISK_00065

Coded Allergies:

No Known Drug Intolerances (09/30/09)
No Known Intolerances (09/30/09)

**Home Medications
Active Scripts**

clonazepam (Klonopin) 0.5 MG PO BID
#10 TAB
Prov: 05/04/14

Reported Medications

CELECOXIB (CeleBREX) 200 MG PO DAILY
MULTIVITAMIN W-MINERALS (DAILY MULTIVITAMIN-MINERALS) 1 TAB PO BID
DULoxetine (CYMBALTA) 60 MG PO BID
oxycodone (ROXICODONE) 5 MG PO Q4H PRN PRN PAIN
CEPHALEXIN (KEFLEX) 500 MG PO Q8H
SULFAMETHOXAZOLE/TRIMETHOPRIM 800/160 MG (BACTRIM DS)
PROGESTERONE, MICRONIZED (PROMETRIUM)
[TESTOSTERONE] 3 MG
HYDROCORTISONE (CORTEF) 5 MG PO DAILY
LIOTHYRONINE (CYTOMEL)

)(Review of Nursing Notes Rev avail, and agree
Additional Medical History
chronic neck and back pain
Patient History
MOTHER, Deceased; Cause: Addison disease.
FATHER

Family History: Heart disease, Onset: 60+

Smoking status for patients 13 years old or older: Never Smoker

Physical Exam

Initial Vital Signs

Vital Signs

First Documented

	Result	Date Time
Pulse Ox	97	11/29/1938
B/P	150/67	11/29/1938
Temp	36.8	11/29/1938
Pulse	127	11/29/1938
Resp	19	11/29/1938

Last Documented

	Result	Date Time
Pulse Ox	97	11/29/1938
B/P	150/67	11/29/1938
Temp	36.8	11/29/1938
Pulse	127	11/29/1938
Resp	19	11/29/1938

TURISK_00066

Initial VS Reviewed

Basic Physical Exam

Basic PE HEAD: Atraumatic/NC, EYES: PERRL, conj clear, ENT: Membranes moist, NECK: Supple, RESP: No resp distress, CV: Reg rate & rhythm, ABD: Soft/non-tender, EXT: No gross abnormality, NEURO: alert & oriented, NEURO: gross movement NL, PSYCH: NL thought content

Focused PE

General/Const **

General/Const Awake, Alert, No acute distress, Well appearing, Well developed

Head/Eyes

Head/Eyes Atraumatic, Normocephalic, PERRL, EOMI

Ears/Nose/Throat

Ears/Nose/Throat Atraumatic, Airway patent

Resp/Chest

Respiratory/Chest Atraumatic, Breath sounds NL, Breath sounds = bilat

Cardiovascular

Cardiovascular Heart rate NL, Regular rhythm, Heart sounds NL

Skin **

Skin Right breast: Open wound around areola with trace yellow drainage and mild redness. No surrounding redness or red streaking. No masses felt on exam

Interpretation & Diagnostics

Lab Results Interpretation

Results

Laboratory Tests

11/29/16 1955:

9.6 (8.6 L) (79.1 L) (649 H)

143 102 23 H 106 H
4.4 28 0.9

Laboratory Tests:

	11/29 1955
Chemistry	
Bodiam (136 - 145 mEq/L)	143
Potassium (3.8 - 5.1 mEq/L)	4.4
Chloride (101 - 111 mEq/L)	102
Carbon Dioxide (22 - 32 mEq/L)	28
Anion Gap (3 - 12)	13.0
BUN (8 - 20 mg/dL)	23 H
Creatinine (0.4 - 1.0 mg/dL)	0.9
Estimated GFR (MDRD) (>=60)	> 60
Est GFR (Cockcroft-G) (>60 mL/min)	96.4
Glucose (70 - 100 mg/dL)	106 H
Calcium (8.8 - 10.3 mg/dL)	9.6
Total Bilirubin (<1.0 mg/dL)	0.3
AST (<35 Units/L)	24
ALT (10 - 63 Units/L)	21
Alkaline Phosphatase (32 - 101 Units/L)	127 H
Total Protein (6.1 - 8.0 g/dL)	7.6
Albumin (3.4 - 4.8 g/dL)	3.5
Hematology	
WBC (4.0 - 10.8 k/mm3)	9.8
RBC (3.70 - 5.00 M/mm3)	3.27 L
Hgb (11.5 - 14.5 g/dL)	8.6 L
Hct (34.0 - 43.0 %)	29.1 L
MCV (80.0 - 95.0 fL)	89.0
MCH (26.0 - 32.0 pg)	26.3

TURISK_00067

MCHC (32.0 - 35.0 g/dl)	29.8 L
RDW Std Deviation (35 - 46 fL)	52.1 H
RDW Coeff of Var (11.5 - 15.0 %)	16.3 H
Plt Count (135 - 350 K/mm3)	649 H
MPV (9.0 - 12.4 fL)	8.3 L
Immature Gran % (Auto) (0.1 - 0.3 %)	0.02
Neut % (Auto) (40.1 - 76.4 %)	70.1
Lymph % (Auto) (14.3 - 45.9 %)	18.6
Mono % (Auto) (4.0 - 12.7 %)	9.9
Eos % (Auto) (0.0 - 5.4 %)	0.6
Baso % (Auto) (0.0 - 1.2 %)	0.4
Neut # (Auto) (1.3 - 8.4 K/mm3)	6.7
Lymph # (Auto) (0.5 - 5.0 K/mm3)	1.8
Mono # (Auto) (0.1 - 1.3 K/mm3)	1.0
Eos # (Auto) (0.0 - 0.6 K/mm3)	0.1
Baso # (Auto) (0.0 - 0.1 K/mm3)	0.0
Urinex	
Urine Color (YELLOW)	YELLOW
Urine Appearance (CLEAR)	HAZY
Urine pH (5.0 - 7.0)	7.0
Ur Specific Gravity (1.003 - 1.030)	1.007
Urine Protein (NEGATIVE mg/dL)	NEGATIVE
Urine Ketones (NEGATIVE mg/dL)	NEGATIVE
Urine Blood (NEGATIVE)	25
Urine Nitrite (NEGATIVE)	NEGATIVE
Urine Bilirubin (NEGATIVE)	NEGATIVE
Urine Urobilinogen (< 2.0 mg/dL)	NORMAL
Ur Leukocyte Esterase (NEGATIVE Leuk/L)	NEGATIVE
Urine RBC (0 - 2 #/hpf)	0-2
Urine WBC (0 - 2 #/hpf)	0-2
Ur Epithelial Cells (0 - 8 #/hpf)	3-5
Urine Bacteria (RARE #/hpf)	MODERATE *
Urine Glucose (NEGATIVE mg/dL)	NEGATIVE

Microbiology:

Date/Time/Source	Procedure - Status Growth
11/29 2000BLOOD	Blood Culture - COMP
11/29 1955BREAST	Wound Culture - COMP STAPHYLOCOCCUS AUREUS ENTEROCOCCUS FAECALIS
11/29 1955BREAST	Gram Stain - COMP
11/29 1955BLOOD	Blood Culture - COMP

Re-Evaluation & MDM

ED Course

Medication(s) Ordered

Medication(s) Ordered

Anti-Infective Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Vancomycin HCl	250 mL	X1ED ONE IV	11/29 2000 11/29 2059	DC	11/29 2005

Central Nervous System Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Acetaminophen/hydrocodone Bitartrate	1 TAB	X1ED ONE PO	11/29 2030 11/29 2031	DC	11/29 2020

TURISK_00068

Consultation**Consultation**

Referral/Consultant Name

Schimpf, Dennis K MD

Consultant Called Plastic surgery

Requested Call Time 2102

Requested Call Date 11/29/16

Call Returned Call returned

Call Returned Time 2102

Consultant Will see in office

Patient Discharge & Departure**Vital Signs/Condition****Vital Signs**

First Documented:

	Result	Date Time
Pulse Ox	97	11/29/1636
S/P	150/67	11/29/1636
Temp	36.8	11/29/1636
Pulse	127	11/29/1636
Resp	19	11/29/1636

Last Documented:

	Result	Date Time
Pulse Ox	97	11/29/1636
B/P	150/67	11/29/1636
Temp	36.8	11/29/1636
Pulse	127	11/29/1636
Resp	19	11/29/1636

All vital signs available at the time of this entry have been reviewed.

Condition Stable

Clinical Impression

Clinical Impression

Primary Impression: Breast infection

Disposition Decision**Discharge**☒ Discharged to Home Yes☒ Time 2208☒ Date 11/29/16**Discharge/Care Plan**

Counseled Regarding Diagnosis, Lab results, Need for follow-up, When to return to ED

Prescriptions Reviewed Risks, Benefits

Discharge Note

I have spoken with the patient and/or caregivers. I have explained the patient's condition, diagnoses and treatment plan based on the information available to me at this time. I have answered the patient's and/or caregiver's questions and addressed any concerns. The patient and/or caregivers have as good an understanding of the patient's diagnosis, condition and treatment plan as can be expected at this point. The vital signs have been stable. The patient's condition is stable and appropriate for discharge from the emergency department.

The patient will pursue further outpatient evaluation with the primary care physician or other designated or consulting physician as outlined in the

discharge instructions. The patient and/or caregivers are agreeable to this plan of care and follow-up instructions have been explained in detail. The patient and/or caregivers have received these instructions in written format and have expressed an understanding of the discharge instructions. The patient and/or caregivers are aware that any significant change in condition or worsening of symptoms should prompt an immediate return to this or the closest emergency department or a call to 911.

Quality Measures

BP & FAU for HTN FAU with PCP/other doc

LEAL,BRIAN 12/06/16 0852:

HPI-Rash/Abscess/Cellulitis

General

Initial Greet Date/Time 11/29/16 1938

Physical Exam

Initial Vital Signs

Vital Signs

Interpretation & Diagnostics

Lab Results Interpretation

Results

Patient Discharge & Departure

Vital Signs/Condition

Vital Signs

Supervising Physician Note

MidLv Saw Pt Alone

I have reviewed the P/NP's note and plan of care. I was available for consultation as needed at all times during the patient's visit in the emergency department. I agree with the clinical impression, plan and disposition.

Electronically Signed by Callahan,Adam PA on 11/30/16 at 0150

Electronically Signed by Leal,Brian L MD on 12/06/16 at 0852

RPT #: 1129-1053

END OF REPORT

TURISK_00070

PATIENT DISCHARGE INSTRUCTIONS

TURISK, REBECCA C.

Age: 50Y Gender: F DOB:  MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 22:09 Author Callahan, Adam PA Status Draft Source HCA:SCA:COCTR

TRIDENT MEDICAL CENTER
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406NAME: TURISK, REBECCA CUZICK ROOM #:
UNIT #: D000484121 Acc #: D00053570373
ADM Date: 11/29/16
D/C Date: 11/29/16
Dictated By: Callahan, Adam PA
Report Name: PATIENT DISCHARGE INSTRUCTIONS Loc: D.SEDScriptRx Emergency Room Visit Report
Summerville Medical Center
295 Midland Parkway, Summerville, SC 29485 (843) 832-5160
11/29/2016 2209Patient: TURISK, REBECCA
Attending Provider: Brian L Leal, MD
Discharging Provider: Adam Callahan, PA
MRN: D000484121
Acct: D00053570373
Age: 50

DISCHARGE INSTRUCTIONS

SKIN INFECTIONS

SKIN INFECTIONS

You have a skin infection. These infections may develop on their own, or may follow an injury such as a cut or insect sting. Usually there is redness, swelling, pain, and sometimes red streaks in the area of the infection. Minor skin infections may be treated with topical antibiotics, but if the skin infection is severe, hospital care and IV antibiotic treatment may be needed.

Follow These Instructions Carefully:

1. Rest and elevate the affected area until the infection improves.
2. You may apply moist warm compresses to the area for 20 to 30 minutes 4 times daily.
3. You may take acetaminophen (Tylenol) or ibuprofen (Advil, Motrin) for pain, unless another pain medicine was prescribed.
4. If an antibiotic medicine was prescribed, take it all, even if you begin to feel better before it is until completely gone.
5. You may require a tetanus booster if you are not current with your immunizations. Check with your doctor about this important shot.

Follow up with your doctor or this facility if the pain and swelling from your infection do not improve within 2 days.

DRAFT

Page 1 of 2

TURISK_00071

PATIENT DISCHARGE INSTRUCTIONS

TURISK, REBECCA C.

Age: 50Y Gender: F DOB: [REDACTED] MRN: D000484121 Phone: (843)532-9304 CELL

Date/Time 11/29/16 22:09 Author Callahan, Adam PA Status Draft Source HCA:SCA:COCTR

Return to this facility immediately or contact your doctor if you experience any of the following:

- Chills, or other serious problems.
- Spreading areas of itching, redness, or swelling.

Patient Name: TURISK,REBECCA CUZICK Account #: D00053570373

- Trouble swallowing or breathing.
- Dizziness, weakness, or fainting.
- Signs of worsening infection include spreading redness, increased pain or swelling, a fever of over 100, and colored fluid draining from the wound.
- A worsening of your condition in any other way.

FOLLOW-UP:

Physician: Schimpf, Dennis

Follow-up When: Tomorrow

Follow-up Diagnosis: Refer to Discharge Instruction List

Specialty: Plastic Surgery

Address: 102 West 8th North St Summerville SC 29483

Phone: 843-471-1135

Follow-up Notes:

Patient Name: TURISK,REBECCA CUZICK Account #: D00053570373

REPORT: 1129-0507 - PATIENT DISCHARGE INSTRUCTIONS

Dictated by: Callahan,Adam PA Nov 29, 2016 10:09pm

Transcribed by: SCRIPTRX USER Nov 29, 2016 10:09pm

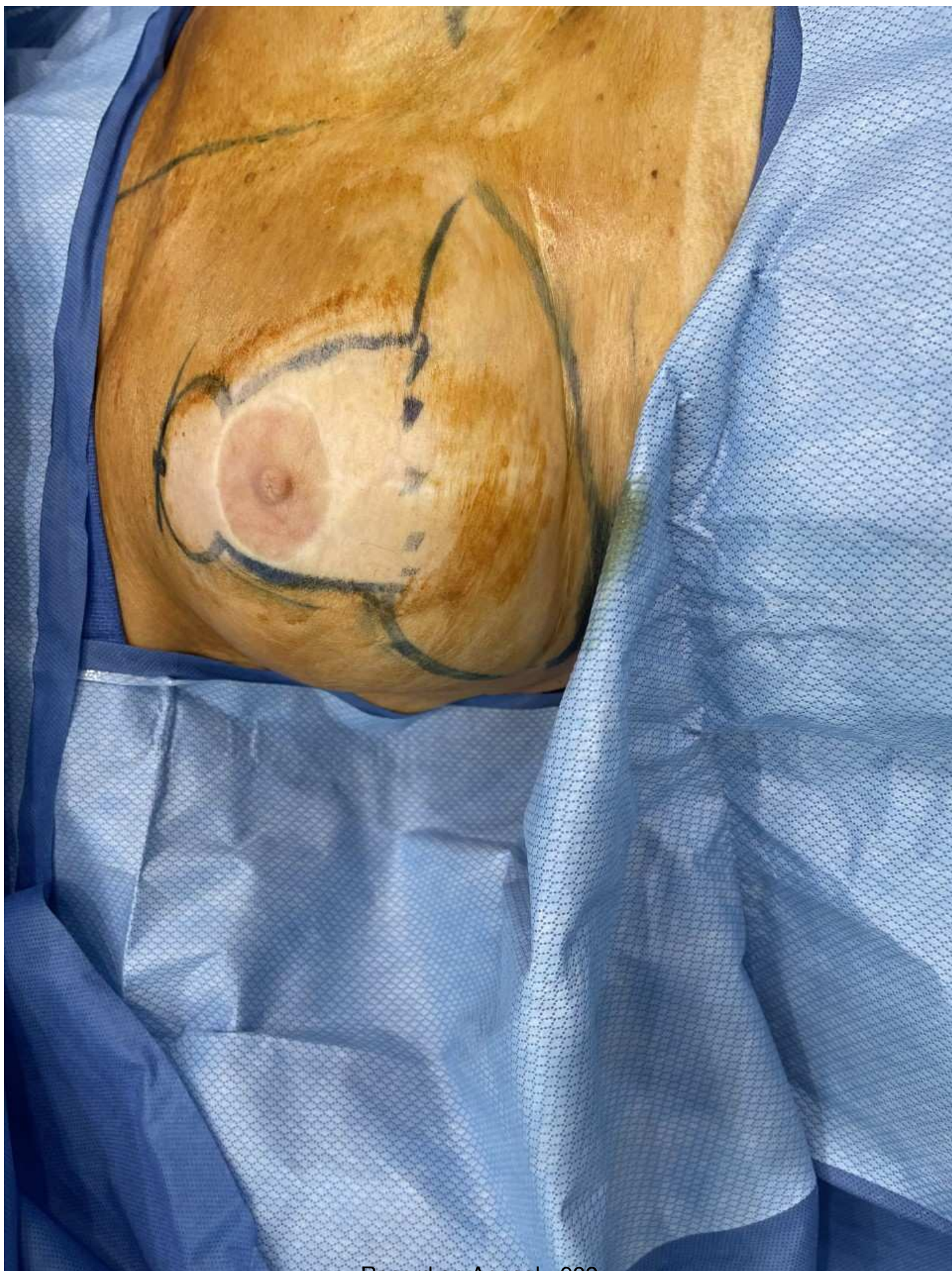
Author: Callahan, Adam PA

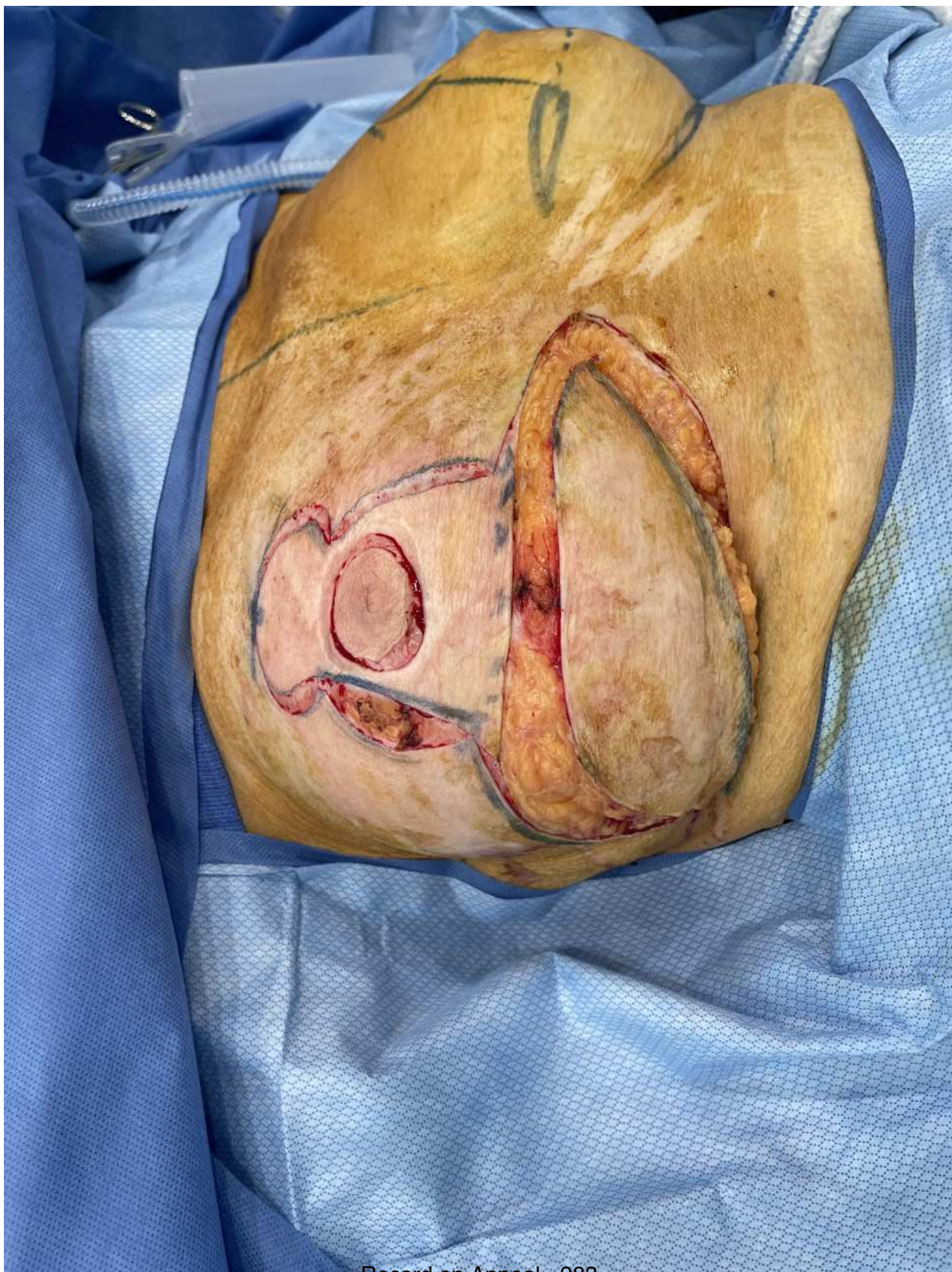
PATIENT DISCHARGE INSTRUCTIONS

DRAFT

Page 2 of 2

TURISK_00072

















RECEIVED

Oct 24 2023

SC Court of Appeals

STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Maite Murphy
Circuit Court Judge

Case No.: 2018-CP-10-02109
Appellate Case No. 2023-000029

Rebecca Turisk,

Appellant,

v.

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

Respondents.

CERTIFICATE OF COUNSEL

I, the undersigned, hereby certify that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

s/Jesse Sanchez

Jesse Sanchez (S.C. Bar No. 101906)
The Law Office of Jesse Sanchez, LLC
751 Johnnie Dodds Boulevard, Suite 200
Mount Pleasant, SC 29464

October 23, 2023
Mount Pleasant, South Carolina