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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Deadra L. Jefferson, Circuit Court Judge

Appellate Case No. 2024-001698

Patricia P. McGougan and
Edgar McGougan,

.....

Appellants,

v.

Richard F. Frisch, M.D., Timothy
E. West, M.D., The Southeastern
Spine Institute, L.L.C., and
Lowcountry Infectious
Diseases, P.A.

.....

Respondents.

RECORD ON APPEAL (VOL. 1)

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4. Was Timothy E. West, M.D. and Lowcountry Infectious Diseases, P.A.'s Deviation of the standard of care a proximate cause of Plaintiff Patricia McGougan's injuries?

_____ YES – *See instructions in bold below.*
_____ NO – *See instructions in bold below. You have found for Defendants Timothy E. West, M.D. and Lowcountry Infectious Diseases, P.A.*

If you answered Questions 1 and 2 or 5 and 6 YES, answer Questions 5, 6, and 7. If you did not answer YES to Questions 1 and 2 or 5 and 6, STOP, sign the last page, and let the Court know that you have finished your deliberations.

5. We the jury unanimously find for Plaintiff Patricia McGougan:

Economic Damages:

\$ _____

Non-economic Damages:

\$ _____

6. We the jury unanimously find for Plaintiff Edgar McGougan:

\$ _____

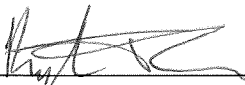
7. If you have found that both Defendants have deviated from the standard of care and that their deviations proximately caused damages to the Plaintiffs, please assign a percentage of negligence to each Defendant. The total of the percentages must equal 100%.

Robert F. Frisch, M.D. and The Southeastern Spine Institute _____%

Timothy E. West, M.D. and Lowcountry Infectious Diseases, P.A. _____%

Total _____%

I certify this decision was the unanimous decision of the jury:



Foreperson

September 16, 2024

**** Please let the Court know when you finish your deliberations.****

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Charleston
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2018CP1005675

Patricia P McGougan et al
PLAINTIFF(S)

Richard F Frisch, M D et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled);
☐ Other
- ☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRPC; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*):
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

This matter came before the Court for a trial by jury on September 9-16, 2024. All issues have been tried and a verdict rendered in favor of the Defendants. The jury was polled and all jurors affirmed the verdict.

Representing the Plaintiffs are Daniel Luginbill, Esq. and Julia Flumian, Esq. Representing the Defendants Richard F. Frisch, M.D. and Southeastern Spine Institute are James Hood, Esq. and Brian Kern, Esq. Representing the Defendants Timothy E. West M.D. and Low Country Infectious Disease, P.A. are Todd Smyth, Esq. and Allie Maples, Esq.

The Court required post-trial motions. Defendants' counsel made no motions and are therefore waived. Plaintiffs' counsel moved for a New trial based on the thirteenth juror doctrine.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

☒ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 09/26/2024 .

Brenda R Kline for Patricia P McGougan, Edgar McGougan

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Fileers or who are appearing pro se. See Rule 77(d), SCRCP.

In South Carolina the thirteenth juror doctrine is a long-standing means by which a trial court may grant a new trial absolute. See *Folkens v. Hunt* 300 S.C. 251, 387 S.E. 2d 265 (1990). "The thirteenth juror doctrine entitles a trial court to act as a thirteenth juror when it finds the evidence does not justify the verdict and it may then grant a new trial based solely on the facts." *Howard v. Roberson*, 376 S.C. 143, 153, 654 S.E.2d 877, 882 (Ct.App.2007) (citing *Norton v. Norfolk S. Ry. Co.*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002)).

In *Norton v. Norfolk Southern Railway Company*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002), the South Carolina Supreme Court explained, "the thirteenth juror doctrine is so named because it entitles a trial court to sit, in essence, as the thirteenth juror when [it] finds 'the evidence does not justify the verdict,' and then to grant a new trial based solely 'upon the facts.'" (citing *Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990)). Stated differently, a trial judge may grant a new trial under the thirteenth juror doctrine if the judge determines the verdict "is contrary to the fair preponderance of the evidence." *Dent v. Redd* 270 S.C. 585, 243 S.E. 2d 460 (1978); see also *Vinson*, 324 S.C. at 404, 477 S.E. 2d at 722 ("Traditionally, in South Carolina, circuit court judges have the authority to grant a new trial upon the judge's finding that justice has not prevailed."). "[T]he trial Judge is the thirteenth juror, possessing the veto power to the nth degree*Worrell v S.C. Power Co.*, 186 S.E. 638 (1938).

In the present case, this Court found there was ample evidence justifying the jury's verdict. Accordingly, the Court denied the Plaintiff's Motion to Invoke the Thirteenth Juror Doctrine. The Court further finds no basis to act as the Thirteenth Juror. Moreover, the Court finds the verdict is amply supported by the evidence, does not shock the conscience of the Court, and is not the result of caprice, passion, prejudice, partiality, corruption, or other improper motive. Based on the foregoing, the Plaintiff's post trial motion premised on the Thirteenth Juror Doctrine is heard and Denied.



Charleston Common Pleas

Case Caption: Patricia P McGougan , plaintiff, et al VS Richard F Frisch M D ,
defendant, et al

Case Number: 2018CP1005675

Type: Order/Electronic Form 4

IT IS SO ORDERED.

s/D.L. Jefferson Ninth Judicial Circuit Judge 2128

Electronically signed on 2024-09-26 16:59:12 page 3 of 3

STATE OF SOUTH CAROLINA

) IN THE COURT OF COMMON PLEAS

) NINTH JUDICIAL CIRCUIT

COUNTY OF CHARLESTON

) CIVIL ACTION NO: 2018-NI-10-44

Patricia P. McGougan and Edgar McGougan,)

Plaintiffs,)

vs.)

Richard F. Frisch, M.D.; Timothy E. West,)
M.D.; The Southeastern Spine Institute,)
L.L.C.; and Lowcountry Infectious Diseases,)
P.A.,)

Defendants.)

NOTICE OF INTENT

FILED
2018 JUN 13 AM 11:54
JULIE M. KAMMERDORN
CLERK OF COURT
BY _____

Pursuant to S.C. Code Ann. §15-79-125, the above-named Plaintiffs file this Notice of Intent to File Suit. Attached as Exhibit A and incorporated by reference herein is a document that lays out the factual allegations and legal claims which qualifies as Plaintiffs' "short and plain statement of the facts showing the party is entitled to relief". Attached as Exhibit B is the Affidavit from Plaintiffs' expert, Sanford H. Davne, M.D., delineating at least one negligent act or omission giving rise to a cause of action. Attached as Exhibit C are the Answers to the Standard Interrogatories as set forth in Rule 33(b) of the South Carolina Rules of Civil Procedure.

Within 90 days and no later than 120 days from the service of the Notice of Intent to File Suit, the parties shall participate in a mediation conference pursuant to S.C. Code Ann. §15-79-125(C) and ADR Rule 5(f).

Pursuant to ADR Rule 4(c), in the event the parties are unable to agree upon a mediator, the Court hereby appoints Nancy A. Chiles to serve as mediator. In the event the aforementioned mediator has a conflict of interest or is unable to serve, the alternative mediator is Harold E. Trask.

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

) IN THE COURT OF COMMON PLEAS
) NINTH JUDICIAL CIRCUIT
) CIVIL ACTION NO: 2018-CP-10- 5675

Patricia P. McGougan and Edgar McGougan,)
)
Plaintiffs,)

vs.)

Richard F. Frisch, M.D.; Timothy E. West,)
M.D.; The Southeastern Spine Institute,)
L.L.C.; and Lowcountry Infectious Diseases,)
P.A.,)
Defendants.)

**COMPLAINT
(MEDICAL NEGLIGENCE)
(JURY TRIAL)**

2018 NOV 30 PM 10:49
CLERK OF COURT
NINTH JUDICIAL CIRCUIT

The Plaintiffs, complaining of the Defendants herein, jointly and severally, would respectfully show unto this Court, upon information and belief that:

1. Patricia P. McGougan (hereinafter referred to as "Plaintiff") is a citizen and resident of the State of South Carolina, County of Horry.

2. Edgar McGougan (hereinafter referred to as "Plaintiff's Husband") is a citizen and resident of the State of South Carolina, County of Horry and is the husband of Patricia P. McGougan.

3. Defendant Richard F. Frisch, M.D. (hereinafter referred to as "Defendant Frisch") is a citizen and resident of the State of South Carolina and at all times relevant herein was licensed to practice medicine in the State of South Carolina.

4. Defendant The Southeastern Spine Institute, L.L.C. (hereinafter referred to as "Defendant Surgical Group") is a corporation organized and existing under the laws of the State of South Carolina, and at all times relevant herein, acted by and through its agents, contractors and employees for the purpose of carrying on its business as a surgical group, and therefore, is liable for the negligent acts and omissions of its agents, contractors and employees under the theories of respondeat superior and non-delegable duty.

5. Defendant Frisch was an agent, contractor or employee of Defendant Surgical Group and at all times relevant herein, was acting within the scope of his employment as an agent, contractor or employee of Defendant Surgical Group, and therefore, Defendant Surgical Group is liable for the acts and omissions of Defendant Frisch and its other agents, contractors and employees.

6. Defendant Timothy E. West, M.D. (hereinafter referred to as “Defendant West”) is a citizen and resident of the State of South Carolina and at all times relevant herein was licensed to practice medicine in the State of South Carolina.

7. Defendant Lowcountry Infectious Diseases, P.A. (hereinafter referred to as “Defendant Practice”), is a corporation organized and existing under the laws of the State of South Carolina, and at all times relevant herein, acted by and through its agents, contractors and employees for the purpose of carrying on its business as a medical practice, and therefore, is liable for the negligent acts and omissions of its agents, contractors and employees under the theories of respondeat superior and non-delegable duty.

8. Defendant West was an agent, contractor or employee of Defendant Practice and at all times relevant herein, was acting within the scope of his employment as an agent, contractor or employee of Defendant Practice, and therefore, Defendant Practice is liable for the acts and omissions of Defendant West and its other agents, contractors and employees.

9. On August 2, 2016, Plaintiff was admitted to East Cooper Medical Center where she underwent a left L4 hemi-laminectomy and L4 - L5 discectomy, performed by Defendant Frisch.

10. On August 3, 2016, Plaintiff was discharged from the hospital by Defendant Frisch with oral antibiotics prescribed: Doxycycline 100 mg twice daily for seven days.

11. On August 16, 2016, Plaintiff was seen by Ryan Aprill, PA-C at Defendant Surgical Group for her first postoperative visit. No signs of infection were noted and x-rays of her lumbar spine did not show any instability or collapse at L4 - 5.

12. On August 23, 2016, Plaintiff was seen by Anne Buck, PA-C at Defendant Surgical Group for complaints of increased incisional drainage and some return of left buttock and lateral thigh pain. Ms. Buck noted “the bandaging shows evidence of serosanguineous drainage” and “there is trace erythema along the margins of her incision.” A course of Bactrim was prescribed for her postoperative incisional draining. Ms. Buck failed to culture incisional drainage.

13. On August 30, 2016, Plaintiff was seen by Ryan Aprill, PA-C for follow-up incision check. Plaintiff informed Ms. Aprill that she had to stop the Bactrim after four days due to severe itching. A minimal amount of drainage was noted on her bandage and was expressed from the incision. A one-week course of oral Doxycycline was prescribed. Ms. Aprill failed to culture incisional drainage.

14. On September 1, 2016, Plaintiff contacted Defendant Surgical Group with continued complaints of incisional drainage. Ms. Aprill noted a minimal amount of drainage on her bandage and "a small area in the center of the incision where the drainage appears to be coming from." She was instructed to continue on the Doxycycline as planned. Ms. Aprill failed to culture incisional drainage.

15. On September 8, 2016, Plaintiff was seen for a follow-up visit by Ms. Aprill, who noted that her incision seemed to be closing up and there was a minimal amount of drainage on her bandage. Ms. Aprill failed to culture incisional drainage.

16. On September 20, 2016, Plaintiff was seen by Defendant Frisch with complaints of fevers and increased pain. Defendant Frisch noted wound dehiscence in the mid-portion of her incision, but no active drainage. Plaintiff was admitted to the hospital for MRI scan and blood cultures and to discuss treatment options.

17. The MRI scan on September 20, 2016 showed a 3.5 cm fluid collection just posterior to the laminectomy site with moderate adjacent tissue edema and multiple smaller fluid collections within the soft tissues at the surgical site and the impression noted "the differential diagnosis would include postoperative infection or small seromas."

18. Final report on nasal MRSA screen culture was called to nursing staff on September 21, 2016 at 8:15 a.m. as "heavy growth of methicillin resistant staphylococcus aureus."

19. On September 21, 2016, Plaintiff was seen for infectious disease consultation by Defendant West. Defendant West's assessment was "seroma versus perhaps abscess formation." Defendant West noted that he talked with Defendant Surgical Group about antibiotics "and to wait for right now" and "then we could perhaps start her perhaps on vancomycin if surgery is done and await culture results."

20. On September 22, 2016, Plaintiff was taken to the operating room by Defendant Frisch and underwent incision and drainage of lumbar spine, where a pocket of purulent material was found over the previous surgical decompression site. Lumbar fluid cultures were obtained and IV Vancomycin 1 gm was given at 4:30 p.m. in the operating room.

21. On September 23, 2016, Defendant West prescribed IV Vancomycin 1.25 gm every 12 hours, which was administered for three days, with one additional dose on September 26, 2016 prior to discharge home.

22. On September 26, 2016, final lumbar fluid culture results were called to nursing staff showing moderate growth of methicillin resistant staphylococcus aureus.

Defendant West noted “doing well” and “probably could go on Minocycline 100mg P.O. bid X 14 days.”

23. Plaintiff was discharged from the hospital on September 26, 2016 by Defendant Frisch with a prescription for oral antibiotics only: Minocycline 100mg, one capsule to be taken twice daily for 14 days.

24. On December 13, 2016, Plaintiff called Defendant Frisch's office complaining of increased back and leg pain with difficulty getting out of bed. MRI scan was scheduled which showed “potential granulation tissue in the area of the prior discectomy which potentially causes some compression and lateral recess.”

25. On December 19, 2016, Plaintiff complained of continued back pain and low grade fever. She was admitted to East Cooper Medical Center by Defendant Frisch for evaluation and infectious disease workup.

26. Blood cultures drawn on December 19, 2016 grew methicillin resistant staphylococcus aureus. CT scan on December 19, 2016 was consistent with L4 and L5 vertebral body osteomyelitis with early L5 vertebral compression fracture.

27. On December 20, 2016, Plaintiff's MRI scan showed persistent fluid collection in the left L4 - L5 paraspinal operative bed concerning for abscess with adjacent myositis and abnormal signal vertebral body osteomyelitis.

28. Plaintiff was followed by Defendant West in hospital and started on IV antibiotics via PICC line for treatment of osteomyelitis and bacteremia. She was discharged on January 3, 2017, with a PICC line for three additional months of IV vancomycin and erythromycin treatment by home health nurses.

29. Plaintiff was seen by Dr. Peter Grossi at Duke Medical Center on July 25, 2017 for continual low back pain. X-rays showed almost complete collapse of the disc space at L4 - L5. Dr. Grossi did not recommend any surgical intervention at the time.

30. Defendant Frisch, Defendant Surgical Group, Defendant West, and Defendant Practice, jointly and severally, were negligent, grossly negligent, willful, wanton, reckless, and careless in the following particulars:

- a. In failing to promptly diagnose and treat Plaintiff's post-operative wound infection;
- b. In failing to promptly prescribe a sufficient course of IV antibiotics to effectively treat Plaintiff's post-operative wound infection;
- c. In failing to properly train, supervise and hire their employees; and
- d. In breaching their non-delegable duty to the Plaintiff.

31. As a direct and proximate result of the negligent acts and omissions of the Defendants, jointly and severally, Plaintiff had to undergo additional medical and surgical procedures, extended hospitalizations and home health services, substantial medical expenses, lost wages, severe pain, suffering, mental anguish, and loss of enjoyment of life, and will continue to do so in the future.

32. As a direct and proximate result of the acts and omissions of the Defendants, jointly and severally, Plaintiff's Husband suffered loss of his wife's comfort, care, services, society, and support, and will continue to do so in the future.

WHEREFORE, the Plaintiffs demand a jury trial and are informed and believe that they are entitled to judgment against the Defendants jointly and severally, for actual damages in excess of One Hundred Thousand and No/100 (\$100,000.00) Dollars, for such punitive damages as may be assessed by the jury, for the costs of this action, and for such other and further relief as the Court and a jury may deem just and proper.

Brenda R. Kline

O. Fayrell Furr, Jr., Esquire (#2246)

Brenda R. Kline, Esquire (#68163)

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(843) 626-7621

Attorneys for Plaintiff

11/20

, 2018.

Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Patricia P. McGougan and Edgar McGougan,

Plaintiff,

vs.

Richard F. Frisch, MD, Timothy E. West, MD,
The Southeastern Spine Institute, LLC and
Lowcountry Infectious Diseases, PA,

Defendants.

) IN THE COURT OF COMMON PLEAS

) C.A. No.: 2018-CP-10-5675

) **ANSWER OF TIMOTHY E. WEST, M.D.**
) **AND LOWCOUNTRY INFECTIOUS**
) **DISEASES, P.A. TO PLAINTIFFS'**
) **COMPLAINT**

) **(Jury Trial Requested)**

FILED
2019 JAN -4 PM 12:51
JULIE J. ARMSTRONG
CLERK OF COURT
BY 

NOW COMES the Defendants, Timothy E. West, M.D. (hereinafter "Dr. West" or "this Defendant") and Lowcountry Infectious Diseases, P.A. (hereinafter "the practice" or "this Defendant") (hereinafter collectively "these Defendants"), and respond to the allegations of the Plaintiffs' Complaint as follows:

1. These Defendants deny each and every allegation of the Plaintiffs' Complaint not hereinafter specifically admitted.

2. As to the allegations contained in Paragraphs 1 and 2 of Plaintiffs' Complaint, these Defendants are without sufficient information upon which to form a belief as to the truth of these allegations and, therefore, leave Plaintiffs to their strict burden of proof.

3. As to the allegations contained in Paragraph 3, 4 and 5 of Plaintiffs' Complaint, these allegations are not directed toward these Defendants, and therefore, no response is required.

4. As to the allegations contained in Paragraph 6 of Plaintiffs' Complaint, Dr. West admits that he is a resident of South Carolina and a duly licensed medical doctor specializing in the field of infectious disease.

5. As to the allegations contained in Paragraph 7 of Plaintiffs' Complaint, the practice admits only that it is a duly authorized professional association existing under the laws of South Carolina and that it maintains an office in Charleston County. All other allegations are denied.

6. As to the allegations contained in Paragraph 8 of Plaintiffs' Complaint, these Defendants admit only that Dr. West practiced medicine at Lowcountry Infectious Disease at all times relevant to this action. All other allegations are denied.

7. As to the allegations contained in Paragraphs 9, 10, 11, 12, 13 14, 15, 16, 17 and 18 of Plaintiffs' Complaint, these allegations are not directed toward these Defendants and, therefore, no response is required. To the extent a response is required, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her care, treatment and diagnoses and to the extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

8. As to the allegations contained in Paragraph 19, these Defendants admit only that Dr. West saw Mrs. McGougan on the stated date and that this paragraph references only selected portions of the medical record entries from that day. Further responding, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of the care, treatment and diagnoses and to the extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

9. As to the allegations contained in Paragraph 20 of Plaintiffs' Complaint, these allegations are not directed toward these Defendants and, therefore, no response is required. To the extent a response is required, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her care, treatment and diagnoses and to the

extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

10. As to the allegations contained in Paragraphs 21 and 22 of Plaintiffs' Complaint, these Defendants admit only that these paragraphs refer to only selected portions of the medical record entries from those days. Further responding, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of the care, treatment and diagnoses and to the extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

11. As to the allegations contained in Paragraphs 23, 24, 25, 26, and 27, these allegations are not directed toward these Defendants and, therefore, no response is required. To the extent a response is required, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of the care, treatment and diagnoses and to the extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

12. As to the allegations contained in Paragraphs 28, these Defendants admit only that these paragraphs refer to only selected portions of the medical record entries from those days. Further responding, these Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of the care, treatment and diagnoses and to the extent these allegations differ from the medical records, these Defendants deny the same and demand strict proof thereof.

13. As to the allegations contained in Paragraph 29 of Plaintiffs' Complaint, these Defendants are without information sufficient to admit or deny these allegations and therefore, deny the same and leave Plaintiffs to their strict burden of proof.

14. As to the allegations contained in Paragraph 30 (including all subparts (a)-(d)) of Plaintiffs' Complaint, these Defendants deny the same and demand strict proof thereof.

15. As to the allegations contained in Paragraph 31 of Plaintiffs' Complaint, these Defendants deny the same and demand strict proof thereof.

16. As to the allegations contained in Paragraph 32 of Plaintiffs' Complaint, these Defendants deny the same and demand strict proof thereof.

17. As to the allegations contained in the WHEREFORE paragraph, those being the remaining allegations of Plaintiffs' Complaint, these Defendants deny the same.

WHEREFORE, having fully answered and denied the allegations of Plaintiffs' Complaint, these Defendants assert the following additional defenses:

ADDITIONAL DEFENSES

1. Plaintiffs' Complaint fails to state a claim upon which relief can be granted against these Defendants and, therefore, should be dismissed with prejudice pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure.

2. That the care and treatment administered by these Defendants conformed to and was in full compliance with recognized standards of care that would be exercised by providers in the same specialty under the same circumstances. Accordingly, the Plaintiff is barred from recovery against these Defendants.

3. Plaintiff's injuries, if any, were caused in whole or in part by the acts or omissions of others for whose conduct these Defendants is not responsible and/or resulted from conditions unrelated to any conduct of these Defendants as may be proven through discovery and/or at trial.

4. Plaintiff's alleged injuries and damages may have been the result of an independent, intervening, and superseding cause over which these Defendants had no control such

that any alleged action or alleged omission on the part of these Defendants was not the proximate cause of the alleged damages.

5. Upon information and belief, Plaintiff suffered from one or more significant medical conditions and the injuries complained of herein are the result of a natural disease process and/or Plaintiff's injuries are a recognized complication of said process and, therefore, the Plaintiff is not entitled to any recovery from these Defendants.

6. Any recovery by Plaintiff must be reduced or offset by amounts Plaintiff has received or will receive from others for the same injuries to Plaintiff claimed in this lawsuit.

7. Plaintiff's claims are barred because these Defendants did not breach any legal duty owed to the Plaintiff.

8. Plaintiff's alleged injuries and damages, if any, were caused in whole or in part by Plaintiff and/or her representatives' own comparative/contributory negligence, as may be proven in discovery and/or at trial and, therefore, the alleged injuries and claim for damages should be diminished proportionally according to Plaintiff's culpable conduct.

9. With respect to Plaintiff's demands for punitive damages, these Defendants assert their conduct, as alleged herein, does not rise to the level required to sustain a claim for punitive damages. Further, the award or assessment of punitive damages as prayed for by the Plaintiff would violate these Defendants' constitutional rights under the Fifth, Sixth, and Fourteenth Amendments of the United States Constitution and Article I, Section 3 of the South Carolina Constitution and, therefore, may not be awarded to Plaintiff, in that:

- a) The judiciary's ability to correct a punitive damage award only upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;

- b) Any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;
- c) Any award of punitive damages based upon the wealth of these Defendants violates due process guarantees;
- d) The jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards, is arbitrary, promotes grossly excessive awards and is inconsistent with due process guarantees;
- e) Assuming arguendo that the standard governing the imposition of punitive damages exists, the standard is void for vagueness; and
- f) The Plaintiff's claim for punitive damages violates the equal protection clause of the 14th Amendment of the United States Constitution and Article I, Section 3 of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth of these Defendants.

Further, these Defendants specifically incorporate by reference all standards of limitations regarding the determination and enforceability of punitive damage awards contained in the decisions of Exxon Shipping Co. v. Baker, U.S. Supreme Court Op. No.07-219 (June 25, 2008); State Farm v. Campbell, 538 U.S. 408 (2003); BMW of North America v. Gore, 517 U.S. 559 (1996) and Cooper Industries, Inc. v. Leatherman Tool Group, Inc., 532 U.S. 424 (2001), together with all such standards applicable under state law.

10. Punitive damages are a punishment, a quasi-criminal sanction for which these Defendants have not been afforded the specific procedural safeguards prescribed in the Fifth and Sixth Amendments to the United States Constitution and in the Constitution of South Carolina.

11. That even if these Defendants were negligent as alleged in the Complaint, which is

specifically denied, the acts of these Defendants are not the direct and proximate cause of Plaintiff's alleged injuries and damages, so as to bar the Plaintiff from recovery against these Defendants.

12. To the extent allowed by law, these Defendants hereby invoke the protections afforded by law regarding the limitations on non-economic damages as set forth in S.C. Code §15-32-220 et seq. and associated provisions.

13. To the extent allowed by law, these Defendants hereby invoke the protections afforded by law regarding the limitations on joint and several liability as set forth in S.C. Code §15-38-10 et seq. and associated provisions.

14. To the extent allowed by law, these Defendants hereby invoke the protections afforded by law regarding the limitations on punitive damages as set forth in S.C. Code §15-32-530, et seq. and associated provisions.

15. Plaintiffs' recovery must be reduced and/or precluded to the extent Plaintiffs have failed to properly mitigate their alleged damages.

16. These Defendants hereby give notice that they intend to rely upon such other defenses as may become available or appear through discovery or otherwise, and hereby reserve the right to amend this Answer to assert any such defenses.

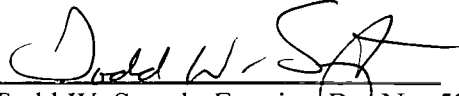
WHEREFORE, having fully answered the Plaintiffs' Complaint and asserted the foregoing additional defenses, these Defendants respectfully request:

- (1) a trial by jury of twelve;
- (2) this Court to dismiss this matter with prejudice as to these Defendants and enter judgment in their favor and against Plaintiff; and
- (3) this Court to award these Defendants their costs and expenses, including attorney's

fees incurred in this matter and grant whatever additional relief the Court deems appropriate.

Respectfully submitted,

SMYTH WHITLEY, LLC

A handwritten signature in black ink, appearing to read "Todd W. Smyth", written over a horizontal line.

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Lowcountry Infectious Diseases, P.A.*

January 2, 2019
Charleston, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Patricia P. McGougan and Edgar McGougan,

Plaintiffs,

Versus

Richard F. Frisch, M.D.; Timothy E. West,
M.D.; The Southeastern Spine Institute,
L.L.C.; and Lowcountry Infectious Diseases,
P.A.,

Defendants.

) IN THE COURT OF COMMON PLEAS

)

)

) C/A No. 2018-CP-10-05675

)

) **DEFENDANTS ROBERT F. FRISCH, M.D.**

)

) **AND THE SOUTHEASTERN SPINE**

)

) **INSTITUTE, L.L.C.'S ANSWER TO**

)

) **PLAINTIFFS' COMPLAINT**

)

) **(Jury Trial Requested)**

)

)

)

)

)

FILED
JAN 11 PM 4:09
CLERK OF COURT

The Defendants Richard F. Frisch, M.D. and The Southeastern Spine Institute, L.L.C. (hereinafter "these Defendants"), by and through their undersigned attorneys, hereby respond to the allegations in the Plaintiffs' Complaint subject to all affirmative defenses and motions, as follows:

1. These Defendants deny each and every allegation of the Plaintiffs' Complaint which is not specifically admitted herein.

2. These Defendants are without sufficient information at this time to admit or deny the allegations contained in Paragraphs 1 and 2 of the Plaintiffs' Complaint and therefore deny the same.

3. These Defendants admit the allegations contained in Paragraph 3 of the Plaintiffs' Complaint.

4. In response to Paragraph 4 of the Plaintiffs' Complaint, these Defendants admit only that The Southeastern Spine Institute, L.L.C. is organized and existing under the laws of the State of South Carolina. Any and all remaining and inconsistent allegations contained in Paragraph 4 of the Plaintiffs' Complaint are denied.

5. In response to the allegations contained in Paragraph 5 of the Plaintiffs' Complaint, these Defendants admit only that Dr. Frisch was an agent and/or employee of The Southeastern Spine Institute, L.L.C. Any and all remaining and inconsistent allegations contained in Paragraph 5 of the Plaintiffs' Complaint are denied.

6. The allegations contained in Paragraphs 6, 7 and 8 of the Plaintiffs' Complaint are not directed toward these Defendants and, therefore, no response is required. To the extent a response is required to the allegations contained in Paragraphs 6, 7 and 8 of the Plaintiffs' Complaint, these Defendants deny the allegations contained in Paragraphs 6, 7 and 8 of the Plaintiffs' Complaint.

7. In response to the allegations contained in Paragraphs 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29 of the Plaintiffs' Complaint, these Defendants deny, as written, the same, and crave reference to the medical records for a complete and accurate account of the medical treatment provided to Plaintiff Patricia McGougan.

8. These Defendants deny the allegations contained in Paragraphs 30 (including subparts (a) through (d)), 31 and 32 of the Plaintiffs' Complaint, including the WHEREFORE Paragraph, being the remaining allegations contained in Plaintiffs' Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,

THESE DEFENDANTS ALLEGE:

(No Deviation from Standard of Care)

9. That the care and treatment administered by these Defendants conformed to and was in full compliance with the standard of care. All care and treatment administered by these Defendants were within acceptable medical standards and methods, and, at no time pertinent hereto, did these Defendants deviate from any medical standard while caring for or tending to the

Plaintiff Patricia McGougan. Consequently, the Plaintiffs are barred from recovery against these Defendants.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(No Proximate Cause)

10. That, even if these Defendants were negligent, as alleged in the Complaint, which is specifically denied, the negligence of these Defendants is not the direct or proximate cause of any injury alleged by the Plaintiffs and therefore these Defendants are not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Punitive Damages Unconstitutional)

11. That any award or assessment of punitive damages as prayed for by the Plaintiffs would violate these Defendants' Constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Limitation of Punitive Damages)

12. Any punitive damages awarded in this case would be subject to the limitations described in S.C. Code Ann. § 15-32-350.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Noneconomic Damage Awards)

13. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, et. seq. These Defendants are a health care provider as defined by S.C. Code Ann. §15-32-210 and

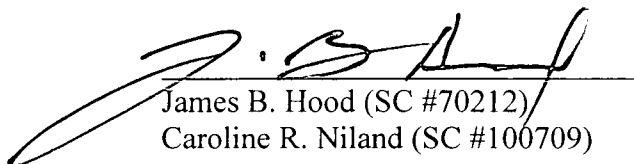
pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Reservation and Non-Waiver)

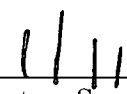
14. These Defendants reserve any additional and affirmative defenses as may be revealed or become available to it during the course of their investigation and/or discovery in the case and is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered the Plaintiffs' Complaint and setting forth their affirmative defenses, these Defendants, Richard F. Frisch, M.D. and The Southeastern Spine Institute, L.L.C., pray that the Plaintiffs' Complaint be dismissed with prejudice and that she be awarded the costs and reasonable fees associated with this matter and such other relief as the Court may deem just and proper

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Attorneys for the Defendants
Richard F. Frisch, M.D. and The Southeastern Spine
Institute, L.L.C.


_____, 2019
Charleston, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	
Patricia P. McGougan and Edgar McGougan,	)	C/A No. 2018-CP-10-05675
	)	
<i>Plaintiffs,</i>	)	DEFENDANTS ROBERT F. FRISCH, M.D.
	)	AND THE SOUTHEASTERN SPINE
Versus	)	INSTITUTE, L.L.C.'S FIRST AMENDED
	)	ANSWER TO PLAINTIFFS' COMPLAINT
	)	(Jury Trial Requested)
Richard F. Frisch, M.D.; Timothy E. West,	)	
M.D.; The Southeastern Spine Institute,	)	
L.L.C.; and Lowcountry Infectious Diseases,	)	
P.A.,	)	
<i>Defendants.</i>	)	

The Defendants Richard F. Frisch, M.D. and The Southeastern Spine Institute, L.L.C. (hereinafter "these Defendants"), by and through their undersigned attorneys, hereby amend their answer to the allegations in the Plaintiffs' Complaint subject to all affirmative defenses and motions, as follows:

1. These Defendants deny each and every allegation of the Plaintiffs' Complaint which is not specifically admitted herein.
2. These Defendants are without sufficient information at this time to admit or deny the allegations contained in Paragraphs 1 and 2 of the Plaintiffs' Complaint and therefore deny the same.
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THESE DEFENDANTS ALLEGE:
(No Deviation from Standard of Care)

9. That the care and treatment administered by these Defendants conformed to and was in full compliance with the standard of care. All care and treatment administered by these Defendants were within acceptable medical standards and methods, and, at no time pertinent hereto, did these Defendants deviate from any medical standard while caring for or tending to the

Plaintiff Patricia McGougan. Consequently, the Plaintiffs are barred from recovery against these Defendants.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(No Proximate Cause)

10. That, even if these Defendants were negligent, as alleged in the Complaint, which is specifically denied, the negligence of these Defendants is not the direct or proximate cause of any injury alleged by the Plaintiffs and therefore these Defendants are not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Punitive Damages Unconstitutional)

11. That any award or assessment of punitive damages as prayed for by the Plaintiffs would violate these Defendants' Constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Limitation of Punitive Damages)

12. These Defendants pleads all applicable statutory caps on punitive damages, including but not limited to, the caps described in S.C. Code Ann. § 15-32-530, et seq., as amended.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Noneconomic Damage Awards)

13. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, et. seq. These Defendants are a health care provider as defined by S.C. Code Ann. §15-32-210 and

pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Reservation and Non-Waiver)

14. These Defendants reserve any additional and affirmative defenses as may be revealed or become available to it during the course of their investigation and/or discovery in the case and is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered the Plaintiffs' Complaint and setting forth their affirmative defenses, these Defendants, Richard F. Frisch, M.D. and The Southeastern Spine Institute, L.L.C., pray that the Plaintiffs' Complaint be dismissed with prejudice and that she be awarded the costs and reasonable fees associated with this matter and such other relief as the Court may deem just and proper

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February 25, 2020
 Charleston, South Carolina

STATE OF SOUTH CAROLINA) SOUTH CAROLINA CIRCUIT COURT 9
COUNTY OF CHARLESTON) DOCKET NO. 2018-CP-10-05675

PATRICIA P. MCGOUGAN AND EDGAR MCGOUGAN)
 Plaintiffs,)
versus)
)
RICHARD F. FRISCH, TIMOTHY E. WEST,)
SOUTHEASTERN SPINE INSTITUTE, AND)
LOWCOUNTRY INFECTIOUS DISEASES,)
 Defendants.)

H E A R I N G
BEFORE THE HONORABLE DEADRA L. JEFFERSON

DATE: September 9-16, 2024
TIME: ***
LOCATION: South Carolina Circuit Court 9

TRANSCRIBED BY: MARY RAGSDALE

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25	IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.)	

1 MR. LUGINBILL: Not with the court reporter we do not,
2 your Honor.

3 THE COURT: I mean in general having --

4 MR. LUGINBILL: We have not -- we haven't identified
5 and ready to go if we haven't exchanged. We haven't agreed
6 on a disability or any of those things that --

7 THE COURT: See, I haven't talked about exhibits?

8 MR. HOOD: I mean I sort of think I know what he's
9 using. He probably knows what we're using. They're just
10 medical records, but no --

11 THE COURT: How many -- like, give me a -- usually we
12 have an exhibit list. It has everything listed and if you
13 have them pre-marked so that the court reporter can have --
14 because her doing it one at a time can be very kind of
15 choppy.

16 MR. HOOD: So -- so the Defendant's exhibits are
17 organized in a list and numbered so that we would be able to
18 start rolling them in.

19 THE COURT: So where -- do you have that list? Have
20 you shared it with co-Counsel? I mean with opposing Counsel?

21 MR. HOOD: No, we had -- we haven't --

22 THE COURT: So --

23 MR. HOOD: -- exchange this.

24 THE COURT: -- is that something you all need to maybe
25 take benefit of and talk with each other and know what list

1 you have? Do you have your list pre-marked?

2 MR. LUGINBILL: We're in the same position, your Honor.
3 We've got them ready to go. We have no exchange.

4 THE COURT: Do you all think talking about -- I mean
5 are there things you all disagree? I guess I'm trying to
6 figure out --

7 MR. LUGINBILL: I don't think there's going to be any
8 questions as to the admissibility of -- of the vast majority
9 of your Honor.

10 MR. HOOD: Yeah, I can certainly (crosstalk).

11 THE COURT: So maybe you all can do that during lunch.
12 Compare your -- compare your list for me. Let me know which
13 ones you agree on so that we can go ahead and do that with
14 the court reporter ahead of time. That just makes life so
15 much easier. Because she can't type and write at the same
16 time.

17 MR. HOOD: Understood. We'll -- we'll work through it
18 at lunch.

19 THE COURT: It just makes life -- a whole life and it
20 makes it easier for me too. I have to admit so.

21 MR. HOOD: Okay.

22 THE COURT: Okay.

23 MR. HOOD: Thank you.

24 THE COURT: And if you all could do that, that would be
25 helpful. I have reviewed the motions in limine that were

1 submitted and all of them deal with evidentiary issues. I
2 don't generally rule on evidentiary issues before testimony
3 is presented. So what I -- because it -- it's sort of a
4 duplicated effort, not sort of, it's a duplicated effort.
5 Because then I have to hear it ahead of time. It never plays
6 out that way again through the witness.

7 And in addition to that, a motion in limine is not
8 binding. So it ends up in my estimation. I wouldn't say
9 it's a waste of time, but I have no point of reference in
10 terms of the facts of this case.

11 I prefer that what you all would do is if there's an
12 evidentiary matter that comes up that you listed in your
13 motions in limine, that you let me know you have a matter of
14 law, we will then excuse the jury. I will hear the -- the
15 evidence in its totality, both direct and cross to create a
16 proffer if necessary. Then hear any argument and rule on it.
17 Because then I have some point of reference as to how it fits
18 into the case. And that's just my preference.

19 Is there any exception from the Plaintiff?

20 MR. LUGINBILL: Your Honor, if I could get
21 clarification just so --

22 THE COURT: Except the boiler plate stuff that I think
23 really should be sort of -- you all should sort of know
24 better. So it falls into the "no better category."

25 MR. LUGINBILL: The only one that I would say is more

1 about a -- a method of presenting evidence, not evidence
2 itself would be Plaintiff's Number 8, which is showing to the
3 jury or -- or reading from any report or medical record.

4 THE COURT: Like I said, I think that falls under the
5 boiler plate, should know that --

6 MR. LUGINBILL: Thank you, your Honor.

7 THE COURT: I would think, when you all agree, Exhibit
8 Number 8 talks about reading from reports that are not in
9 evidence.

10 MR. HOOD: Yeah. We -- we intend to follow the rules
11 of evidence.

12 THE COURT: That's right. Yeah. And -- and the reason
13 -- and -- and -- and I don't -- I just like to be fully
14 informed when I make an evidentiary decision. And the funny
15 thing about motions in limine, the questions are never the
16 same. The answers are never the same. I hear things that
17 weren't done during the motion in limine which may really
18 have colored what decision I would've made.

19 So I find it to be a better practice to do it the way I
20 just suggested because it creates a full record for
21 everybody. And then there's really no question about -- and
22 the funny thing even then is to -- still can rest anyway.
23 But I just find that to be a more practical way to handle it.

24 So I had -- I had the Plaintiff's motions to limine 1-
25 11, which really fall under the category of sort of, you

1 know, common sense, boiler plate, black letter precedent,
2 rules of evidence that I would think you still would need to
3 make a contemporaneous objection.

4 And then I had Number 14, which was related to
5 multi-district orthopedic bone screw litigation. You know, I
6 -- I -- I don't know that they're actually even going to
7 present that, but I have to hear it in camera. I -- I -- I
8 wouldn't know. I wouldn't have any point of reference to be
9 able to make an informed decision about that.

10 And then I also had, I think you all -- Number 214, you
11 gave two motions Number 14. One is Plaintiff's motion in
12 limine a Number 14 to exclude testimony related to
13 multi-district orthopedic bone screw litigation. And then
14 you had one Plaintiff's motion in limine a Number 14 to
15 preclude pitting the Plaintiff against her medical providers
16 in publishing inadmissible hearsay to the jury for
17 cross-examination. So I'm assuming that should have been
18 Number 15?

19 MS. FLUMIAN: 12.

20 THE COURT: 12. Okay.

21 MS. FLUMIAN: Thank you.

22 THE COURT: You're welcome. So I'm now -- also if
23 there's anything that you want to be filed, you need to make
24 sure you file it electronically because the copies that you
25 all provided to me, I write on them. I do -- I don't and

1 there's no way for me to file them.

2 MS. FLUMIAN: Your Honor, did you also receive our
3 motion Number 13?

4 THE COURT: Let me see here. I got 1-11, I got 14, and
5 I have 12. And then I have -- I have Defendant Timothy E.
6 West and Lowcountry Infectious Diseases pretrial brief. I
7 have Defendant Richard Frisch, MD and Southeastern Spine's
8 pretrial brief. I have the Plaintiff's pretrial brief. I
9 have Plaintiff's witness list. I have Plaintiff's motion in
10 limine 1 through 11. Plaintiff's 14 and 12. And then I have
11 Defendant Timothy E. West, MD in Lowcountry Infectious
12 Diseases PA's composite motion in limine. And that's all I
13 have.

14 MR. LUGINBILL: Judge, there was a 13 we had intended
15 to provide the Court. It's really less a motion in limine
16 and just permission to allow me to address in my opening
17 arguments that we were not the firm that initially started
18 this case and that we're coming in behind them due to the
19 health of the original attorneys.

20 THE COURT: Is that really -- they don't get to see the
21 pleadings. They don't know that. Why is it relevant?

22 MR. LUGINBILL: Well, the pleadings could come in
23 through discovery. They could come in through --

24 THE COURT: They can't come in. And then pleadings are
25 not admissible to a jury. That's the rules of procedure.

1 MR. LUGINBILL: I've seen them published is why I've
2 asked that. I've seen --

3 THE COURT: That's probably because nobody objected.
4 But I -- you all need to know I strictly adhere to the rules
5 unless somebody doesn't make an objection. Now, I don't
6 insert myself in the trial.

7 MR. LUGINBILL: That was the only concern, your Honor.
8 I just didn't want to create --

9 THE COURT: I don't know that it's really, I mean the
10 jury have no way of knowing unless you told him that. I just
11 think it introduces an issue that really is not --

12 MR. LUGINBILL: Understood, your Honor.

13 THE COURT: Yeah, I don't know that I -- I -- I think
14 it attempt to -- I don't know that it adds anything to the
15 case or makes anything more or less probable. All right. So
16 according to my list -- thank you, ma'am.

17 The Plaintiff's witness list that was submitted, you'll
18 have eight witnesses on here; is that correct? Which is
19 Patricia McGougan, Edgar McGougan, Dr. Blass, Dr. Davne,
20 Jarrod Cox, John Prince, Dula Ann Leggette, and Amanda Mills.
21 How long was Ms. Mills' deposition and do you all have any
22 issues with her deposition and have you all resolved them if
23 you do?

24 MR. LUGINBILL: It's pretty good time, your Honor.
25 It's about a 20 minute deposition.

1 THE COURT: Are there any -- you all have any -- have
2 you all watched it? I mean, have you provided them with the
3 designations? Do you plan to play the whole thing? What's
4 -- what's the plan?

5 MR. LUGINBILL: I plan -- we play -- play the entire --

6 THE COURT: Did you all have any exceptions?

7 MR. KERN: There were some, a couple hearsay
8 objections. And --

9 THE COURT: Did you all provide that to me?

10 MR. KERN: We have not seen the designation yet.

11 THE COURT: I'm sorry, I didn't hear you.

12 MR. KERN: We have not (inaudible).

13 THE COURT: You need to get it to -- yeah. Do they
14 need time to edit their video? If -- if -- if anything is
15 sustained, is it really like major? I mean, is it?

16 MR. KERN: Fairly minor objections, your Honor.

17 THE COURT: Okay. Then I need that after lunch so that
18 I -- because I'll need it to watch it myself. And I need the
19 deposition as well. All right. Are you all going to need?
20 I'm sorry, jumping around. Do you all -- are you all going
21 to need to avail yourselves with any technology in this
22 courtroom? Are you going to need to hook up to anything?
23 Are you going to need to practice with anything? Are you
24 going to need?

25 MR. LUGINBILL: Yes, ma'am.

1 THE COURT: Okay. So I'll leave that to you all and
2 the clerk so that you can have enough time to try to take
3 care of that. Now, I had -- Madam Court Reporter, there
4 should be a 21 on your list and it should be Amanda Mills
5 (inaudible). Okay. So then that Mr. -- Dr. Frisch is one
6 of the Defendants. Dr. Davne, whose witness is he?

7 MR. HOOD: He's ours, your Honor.

8 THE COURT: Dr. Glaser (ph)?

9 MR. HOOD: He's ours as well.

10 THE COURT: Dr. West is a party. Dr. Simmons?

11 MR. SMYTH: That's our witness, your Honor.

12 THE COURT: Dr. Cuddy?

13 MR. SMYTH: That's ours as well.

14 THE COURT: And the PAs, whose witnesses are they?

15 MR. HOOD: Those are ours, your Honor. One of whom we
16 do have a technology question for you.

17 THE COURT: Okay. I'm listening.

18 MR. HOOD: So one of the tech or PAs that she's out of
19 state.

20 THE COURT: Uh-huh.

21 MR. HOOD: We had reached out to your Honor's office
22 about availability.

23 THE COURT: (Crosstalk) all last week.

24 MR. HOOD: Good. But anyway, so we were just reaching
25 out about using Webex to present her testimony. I don't

1 believe that it was objected to.

2 THE COURT: I don't think you're going to be able to
3 use Webex. I think you will have to use whatever technology
4 the court -- yeah, they usually use the OWL.

5 MR. HOOD: Okay. Well, we'll work with him --

6 THE COURT: Because Webex creates another transcript.

7 MR. HOOD: Okay.

8 THE COURT: And so, yeah.

9 MR. HOOD: Yeah, we can -- we can use any of the
10 platforms that --

11 THE COURT: Yeah, we'll -- we'll figure -- yeah, thank
12 you for letting us know in advance. So we'll get that hooked
13 up and then we probably need to do a little test run just to
14 make sure when she is logged in. We can do that in
15 (inaudible). We -- we'll figure it out. Yeah.

16 MR. HOOD: And she's probably going to be Wednesday
17 either afternoon or the earliest Thursday likely. So we got
18 some time to --

19 THE COURT: Yeah.

20 MR. HOOD: -- figure this out.

21 THE COURT: We'll figure it out. Thank you for letting
22 me know in advance.

23 MR. HOOD: Yes, ma'am.

24 THE COURT: Okay. Kyle Cox, whose witness is that?

25 MR. LUGINBILL: That's ours, your Honor.

1 THE COURT: Huh?

2 MR. LUGINBILL: That's ours.

3 THE COURT: Okay. Because you didn't have him
4 originally listed, so you added him to your list?

5 MR. LUGINBILL: We did. He said, "He's a -- a very
6 short --"

7 THE COURT: Oh, you don't have to apologize, I'm just
8 making sure.

9 MR. LUGINBILL: Yeah.

10 THE COURT: And Jarrod Cox, did you add him to your
11 list as well?

12 MR. LUGINBILL: I believe he was on the -- one of them
13 was on the list, Jarrod --

14 THE COURT: Yeah, Jarrod was on the list. I apologize.
15 John Prince was already on the list as well. And Robert
16 Edger McGougan of course was the husband. Marjorie Prince is
17 your witness or whose witness is Marjorie Prince?

18 MR. LUGINBILL: Also ours, your Honor.

19 THE COURT: Okay. And Theresa Johnson, whose witness
20 is that?

21 MR. LUGINBILL: That, your Honor, we will not be
22 calling Ms. Johnson on the --

23 THE COURT: Okay. And then I have Ms. Leggette, is she
24 also being called as a witness?

25 MR. LUGINBILL: She is not, your Honor.

1 THE COURT: Okay. And then we talked about Ms. Mills.

2 MR. LUGINBILL: Oh, your Honor, I misspoke. Ms. --
3 yes, Ms. Dula Ann is.

4 THE COURT: Okay. Now, is there anything else you need
5 to take up pretrial other than exhibit list technology? I
6 know you all must be hungry. It's been a long Monday
7 morning, but standard for my day, but I don't know long for
8 the jurors, so I'm going to let them go to lunch. The
9 fellows would've -- you all already got their phone Number s
10 and everything and other information you all need? Got them
11 situated with parking and everything or we'll do that this
12 afternoon? Okay. Is there anything else you need to say
13 from the Plaintiff?

14 MR. LUGINBILL: Not I can think of.

15 THE COURT: From the Defense?

16 MR. HOOD: No, your Honor.

17 MR. SMYTH: No, your Honor.

18 THE COURT: Okay. How long do you all need for -- is
19 it an hour and -- I'm not good at math. Let me see. What
20 time is it now? It's almost 1:15. 2:30, is that -- that --
21 that's an hour and 15 minutes. Does that suit everybody's
22 needs?

23 MR. HOOD: Sounds great.

24 THE COURT: Okay. Please bring in the jury for me.

25 And any exception be swearing to jury before they go to

1 lunch from Plaintiff?

2 MR. LUGINBILL: No, ma'am.

3 THE COURT: From the defense?

4 MR. HOOD: No, your Honor.

5 THE COURT: From the defense?

6 MR. SMYTH: No, your Honor.

7 THE COURT: Any exception to the jury taking notes from
8 Plaintiff?

9 MR. LUGINBILL: No, ma'am.

10 THE COURT: From the Defense?

11 MR. HOOD: No, Your Honor.

12 THE COURT: The Defense?

13 MR. SMYTH: No, Your Honor.

14 THE COURT: Thank you guys. And have you all made any
15 attempts to resolve this case? Did you all have mediation or
16 anything?

17 MR. LUGINBILL: We had some discussion, Your Honor.

18 THE COURT: I'm just curious.

19 MR. LUGINBILL: We got the same ballpark. We didn't
20 get on close enough to the 50 yard one.

21 THE COURT: Is it worth any further discussion or is
22 everybody in their fixed-in respective positions?

23 MR. LUGINBILL: We can only speak to the Plaintiffs,
24 your Honor, yep.

25 THE COURT: How far apart? You said you all in the

1 same ballpark you all?

2 MR. LUGINBILL: So we're in the three to \$400,000
3 range.

4 THE COURT: Oh, that far apart?

5 MR. LUGINBILL: Given -- given the total Number s, it's
6 not that far.

7 THE COURT: Well, I saw Mr. Hood's case, and it's not
8 -- I think it's not a case like me. You all can remain
9 standing once everybody comes in for me.

10 (Jury enters courtroom.)

11 THE COURT: Have we got everybody and our alternate?

12 THE BAILIFF: All jurors present.

13 THE COURT: Ladies and gentlemen, if you would raise
14 your right hand so the clerk can administer the oath to you.

15 (Jury sworn)

16 THE CLERK: If you have accepted this oath, please be
17 seated. If you have not accepted this oath, please remain
18 standing. Let the record reflect all jurors have been
19 seated.

20 THE COURT: Thank you, ma'am.

21 Ladies and gentlemen, you've been selected for the case
22 of McGougan versus Frisch West. And the other additional
23 parties in this case. We're going to take a lunch break. I
24 know this has been a long day for you all. We've dealt with
25 some of the pretrial matters that we needed to dispose of so

1 that we can move along a little bit more smoothly when we
2 resume after lunch. We're going to break until 2:30, which
3 gives you about an hour and 15 minutes, give or take for
4 lunch.

5 When you return, you'll go directly to your jury room
6 and the bailiffs will give you instructions regarding that.
7 Please don't have any contact with anyone in or about the
8 courthouse as you return. Please only interact with those
9 that you know to be your respective jurors. I'm not aware of
10 any media reports about this case, but in the event that
11 there may be, please do not read, watch, or listen to any
12 media accounts.

13 Please don't do any independent research on the
14 internet. And also I would ask that you not make any posts,
15 social posts, or otherwise. There's so many sites anymore.
16 I've lost track of them. So I'm not going to try to name
17 them. But I would ask that you not make any posts regarding
18 your jury service on any social networking sites. You would
19 be amazed the people that watch those sites all day and call
20 us and let us know that you've made a comment.

21 And I would not want anyone's impartiality to be
22 questioned based on a, you know, incidental reference to your
23 jury duty. So I would ask that you refrain from doing that
24 while you're serving on jury duty during the course of this
25 week. I hope you all have a great lunch. We'll see you at

1 2:30 at which time we'll resume with opening arguments and
2 we'll probably get a couple witnesses in today. At least I'm
3 hopeful of that. Have a good lunch. We'll see you at 2:30.

4 (Jury exits courtroom.)

5 THE COURT: All right. Is there anything else we need
6 to take care of before you all go get some nourishment?

7 From Plaintiff?

8 MR. LUGINBILL: No, ma'am.

9 THE COURT: From the Defense?

10 MR. HOOD: No, your Honor.

11 THE COURT: All right. Guys, if you all -- you can
12 leave anything you want to in here, this court will be
13 locked. It's also videoed. So your stuff is secure. Does
14 anybody need the clerk's assistance? I assume you all
15 already using wireless and nobody needs to directly look up
16 to anything. All right.

17 MR. LUGINBILL: If we can stay in while we break to
18 work with the technology I know.

19 THE COURT: You're probably going to have the deputies
20 have to go to lunch so you all can negotiate with them about
21 how long you want to stay and work. Or if you want to come
22 back a little earlier from lunch and work on it.

23 MR. LUGINBILL: Come back at 2:00?

24 MS. FLUMIAN: Come back early.

25 THE COURT: You all want to come back at maybe what,

1 2:15?

2 THE DEPUTY: 2:15 is good, your Honor.

3 MR. LUGINBILL: Okay.

4 THE COURT: Great.

5 MR. LUGINBILL: 2:15 it is.

6 THE COURT: All right. Have a good lunch.

7 (Off the record.)

8 THE COURT: All right. Did you all check out the
9 technology?

10 MR. LUGINBILL: Yes, Your Honor.

11 THE COURT: And everything works the way you need it
12 to?

13 MR. LUGINBILL: Yes, ma'am.

14 THE COURT: Did you all have your exhibit list?

15 MR. HOOD: Your Honor, the Defendants have exchanged
16 with Plaintiff our exhibit list and I gave a copy to the
17 court reporter. We've gone ahead and pre-marked the exhibits
18 for the first witness who's going to be called today and
19 shared those with Counsel.

20 THE COURT: Okay. I need a full exhibit list. Do you
21 all have that?

22 MS. FLUMIAN: I apologize, using BATES that we aren't
23 using. So I -- I --

24 MR. LUGINBILL: Your Honor, big confusion is based in
25 part because of the length of it and there's multiple

1 (inaudible). The BATES Number s are all parties either not
2 unified and so we're making sure that all the cross
3 references they're, you know, their BATES 127 is the same as
4 our, what we think 127 is going to be. Our paralegal is in
5 the process of trying to get parked and up here with our
6 printed exhibits and the list. I can email it and we have
7 shared it with the Counsel.

8 THE COURT: We can't email any of those things to me.
9 We have different firewalls and things on our email. We're
10 not going to be able to print it. We're not even going to be
11 able to download it. So the deposition you sent me, I need
12 the hard copy and I'm going to need it anyway for the record.
13 So I'm going to need the original and I'm going to need a
14 transcript if you have one. Because we're not going to be
15 able to download. It doesn't allow us to download anything.

16 MR. LUGINBILL: Understood.

17 THE COURT: Okay. Now, and you all told me you did
18 test your technology, right?

19 MR. LUGINBILL: Yes, ma'am.

20 MR. HOOD: We did.

21 THE COURT: You all need any further assistance from
22 the clerk's office on that?

23 MR. HOOD: I feel like that's a loaded question.

24 THE COURT: Huh?

25 MR. HOOD: I feel like that's a loaded question.

1 THE COURT: It might be. Well, at this moment do you
2 all need anything?

3 MR. HOOD: We're -- we're ready to proceed, your Honor.

4 THE COURT: Okay. And do you all have a witness list
5 as well or are you all in the same quandary as the Plaintiff
6 with your witness list? I mean --

7 MR. HOOD: Exhibit?

8 THE COURT: Exhibit list. I'm sorry, I misspoke.

9 Thank you so much. I appreciate it.

10 MR. HOOD: Does she want our objections now?

11 THE COURT: I need your objections to the deposition.
12 I need those.

13 MR. HOOD: The same?

14 THE COURT: Just for the deposition. Thank you, sir.
15 And then as soon as you all can get me a transcript of it.
16 And do you have the sealed original of the deposition?

17 MS. FLUMIAN: Of the video, your Honor?

18 THE COURT: Uh-huh. You're going to need it for the
19 record.

20 MS. FLUMIAN: Yes, ma'am. We have it. It's being
21 brought to us right now.

22 THE COURT: Okay. And is there a transcript that goes
23 along with it?

24 MS. FLUMIAN: Yes, your Honor. In that Dropbox that we
25 sent you, you should have --

1 THE COURT: Can't do anything.

2 MS. FLUMIAN: And I --

3 THE COURT: State does not allow us to download
4 anything.

5 MS. FLUMIAN: As soon as I said it, it felt stupid.

6 THE COURT: That's okay. Don't feel -- I mean, you
7 know, with -- it's a part of our security protocol, we can't.
8 I can't even do my own updates on my computer. Yeah. So --
9 and they do that for a reason, a valid one. Because, you
10 know, it has a, you know, one wrong thing gets corrupted,
11 everything is corrupted, so --

12 MS. FLUMIAN: Yes, your Honor.

13 THE COURT: Yeah, they don't allow us to do any of
14 that. So I'll put for -- even if they did, I still would
15 need the sealed copy to be made a court's exhibit. And I
16 also need -- I need it so I can watch it or read the
17 transcript so I can give consideration to the objections.
18 And you all if you want the objection filed, I need you to
19 electronically file it. And then --

20 MR. LUGINBILL: On the written transcript for the --
21 for that deposition, your Honor, because it was done so
22 recently, I don't know that we've gotten --

23 THE COURT: That's fine. If you have the video, I can
24 watch it.

25 MR. LUGINBILL: I can certainly print out and hand you

1 a copy of the -- of the deposition transcript, but I do have
2 --

3 THE COURT: Oh, that's fine.

4 MR. LUGINBILL: -- I do have the sealed of the video.

5 THE COURT: Okay. That's fine.

6 MR. LUGINBILL: Thank you.

7 THE COURT: You're welcome.

8 Do you all have -- are there any items that are listed
9 on the Defendant's exhibit list that you all do not have an
10 objection to that you all have agreed upon?

11 MS. FLUMIAN: Your Honor, without having looked at each
12 and every one of these exhibits, my concern is always that
13 all collateral source information has been redacted. So I
14 unfortunately, I -- I can't say, "Yes all of these have or
15 have not been consented to." But certainly if all collateral
16 source information has been redacted, that would be --

17 THE COURT: Yeah, I want you all over the evening to
18 get together with your list and see what you can agree upon
19 and what you can't agree upon. And I -- I need to have some
20 answers-in-one on those because then we can mark and admit
21 those things that don't have any legitimate objections and
22 then we can then expend time on those that have objections.
23 We will have notepads for the jury and something for them to
24 write with. Yes. Yeah. Go ahead and put -- you can put
25 them in their seats actually.

1 Right. In terms of examination. All right. Mr. Hood,
2 are you all going to go first and then Mr. Smyth or have you
3 all talked about that?

4 MR. HOOD: We have, your Honor, and I mean the way that
5 it's actually done is it's Frisch then West and then
6 Southeastern and then Lowcountry.

7 THE COURT: Yeah.

8 MR. HOOD: So we're sort of kind of lumped together.
9 We plan to go first. I think there are going to be a few
10 witnesses that we might let them go first because they're
11 going to take -- take --

12 THE COURT: Just let me know. And let the court
13 reporter know so she can keep track of making sure her record
14 is acting -- well, she'll get to know your names,, but I
15 just, yeah, I just needed to know.

16 MR. HOOD: And how -- how is your preference on
17 multiparties? Would you rather -- so for example a Defense
18 witness that clearly Mr. Luginbill is going to cross-examine.
19 Would you rather both Defendants examine the witness first so
20 he cross-examines one? Do you like to do --

21 THE COURT: You know that's a good question.

22 MR. HOOD: -- all the pleadings?

23 MR. LUGINBILL: (Inaudible) that is my preference that
24 I could request that.

25 MR. HOOD: What word, please?

1 THE COURT: Yeah, what do you all, what can you all
2 agree on?

3 MR. LUGINBILL: That both Defendants do whatever exams
4 they're going to do first to allow the Plaintiffs with the
5 adverse party to --

6 THE COURT: To have to do it twice? Is that agreeable
7 to you all?

8 MR. LUGINBILL: -- unbroken --

9 MR. HOOD: It's agreeable to me. I think it'll speed
10 it up.

11 MR. SMYTH: I think so, your Honor, I think that makes
12 most -- most sense.

13 MR. HOOD: You did get a message with redirect --

14 THE COURT: I don't think, yeah, going back and forth
15 it -- it -- it sounds like that makes some sense.

16 MR. HOOD: Fewer (inaudible).

17 THE COURT: Yes. As long as you all good I'm good.
18 All right. And also I don't take speaking objections so if
19 there's an objection I expect you to stand and say you have
20 an objection. I'll ask you for the basis of the objection,
21 whether it be relevance, leading, pitting, you know, the
22 myriad of objections that we have. I just don't -- I do not
23 prefer to have long expository statements made in the
24 presence of a jury that reveals to them things are really not
25 proper or appropriate for their consideration.

1 If I need a longer argument or I need a further record
2 made such as a proffer or otherwise I will excuse the jury.
3 I'll take it up in camera and then we'll resume with the
4 examination. Just trying to make sure there's nothing else I
5 need to ask you all before we get started.

6 All right. And I assume also in terms of opening
7 argument that you will go first Mr. Hood and then Mr. Smyth,
8 is that the order you all agreed on?

9 MR. HOOD: That is the order.

10 THE COURT: Okay. All right. Bring the jury for me.
11 And I have appointed Number 270 as the foreperson.

12 MR. HOOD: In case it matters, it'll be Brian Kern on
13 behalf of Dr. Frisch.

14 THE COURT: I'm sorry -- I'm sorry. Repeat that for me
15 Mr. Hood?

16 MR. HOOD: Yes, ma'am. Brian Kern would provide the
17 opening statement for Defendant Frisch.

18 THE COURT: Okay. So let me be clear. Dr. Frisch is
19 represented by...?

20 MR. HOOD: Jamie Hood and Brian Kern at the Hood Law
21 Firm.

22 THE COURT: And West is represented by?

23 MR. SMYTH: Todd Smyth and Allie Maples.

24 THE COURT: And Southeastern Spine?

25 MR. HOOD: Jamie Hood and Brian Kern of Hood Law Firm.

1 THE COURT: And Lowcountry Infectious Diseases? I --
2 I'm asking for the court reporter because she needs to be
3 able to identify and I appreciate your indulgence.

4 (Jury enters courtroom.)

5 THE BAILIFF: All jurors present, your Honor.

6 THE COURT: Thank you. Ladies and gentlemen, I hope
7 you all had a pleasant lunch. We appreciate your patience as
8 we try to work through some of the logistics for the trial so
9 that we would not have to stop and start after opening
10 instruction and opening argument.

11 Each of you has a notepad. If you would write your
12 juror Number on the sticker on the front of each notebook.
13 You'll be allowed to take notes during the course of this
14 trial and I'll give you some further instructions regarding
15 that near the conclusion of my opening instructions to you.

16 You've been selected for the case of McGougan versus
17 Frisch West, Southeastern Spine Institute, and Lowcountry
18 Infectious Diseases. I'm going to give you some preliminary
19 instructions so that you will better understand how we will
20 be proceeding in the trial of this case.

21 The first thing that will occur is that the attorney
22 for the Plaintiff, and the Plaintiff is the person who has
23 brought this suit or cause of action, their attorney will
24 make an opening statement which will be followed by similar
25 statements by the attorneys for each of the Defendants.

1 These opening statements, ladies and gentlemen, are not
2 arguments. Arguments will come at the conclusion of the
3 case. The purpose of an opening statement is for Counsel to
4 outline his or her claims and the evidence which they claim
5 or they intend to present in support of those claims. In
6 other words, they will present to you what they believe the
7 evidence will show in this case.

8 Following the opening statements, each side will
9 present its evidence once again with the Plaintiff going
10 first. Evidence may take many forms. It may be testimony,
11 documents, models, photographs, or the like. You should pay
12 close attention to all of the evidence which is presented by
13 each party because you, the jury, are the sole finders of the
14 facts in this case. And no one else will be permitted to
15 waive the evidence and render a verdict based upon it.

16 After all of the evidence has been presented, the
17 attorneys will make their closing arguments and unlike the
18 opening statements, the final remarks will be true arguments
19 that is each side will emphasize certain portions of the
20 evidence and try to persuade you to agree with their version
21 of the facts.

22 Keep in mind that the opening statements as well as the
23 closing arguments of Counsel do not represent evidence in
24 this case. Give the attorneys your undivided attention, but
25 keep in mind that what they say is not evidence.

1 After the arguments are finished, I'll explain to you
2 the law which applies to this case. You'll then retire to
3 the jury room to consider the facts and the law and once
4 you've done so, you'll return a verdict in favor of one side
5 or the other.

6 During the course of this trial, the Plaintiff has the
7 burden of proving their claims. They must meet this burden
8 by proving their claims by the greater weight or the
9 preponderance of the evidence. What we mean by the greater
10 weight of the evidence can be illustrated by imagining a
11 traditional set of scales. When the case begins, the scales
12 are even.

13 After all of the evidence has been presented, if the
14 scales should remain evenly balanced or if they should tip
15 even slightly in favor of the Defense, then the Plaintiff
16 would've failed to have met their burden of proof and your
17 verdict would be for the Defense.

18 If on the other hand the scale should tip even slightly
19 in favor of the Plaintiffs, then they will have met their
20 burden of proof and your verdict would be for the Plaintiffs.
21 There are a few additional comments that I'll share with you
22 before we begin.

23 As I mentioned earlier, although I'm the only person
24 who can tell you what the law is, you are the only ones who
25 can determine the facts. I do not have the right to indicate

1 to you how I might feel about the testimony and evidence
2 presented throughout the trial and it will be my intention to
3 be fair and impartial toward each of the parties involved.
4 In fact, pursuant to our state constitution, the trial judge
5 is not entitled to an opinion about the facts.

6 Also, from time to time, the attorneys will object to
7 some bit of testimony or evidence which is being presented.
8 Just as in sports, business, or any other structured
9 activity, there are certain rules that we must obey in the
10 presentation of evidence. These rules have a definite
11 purpose. They ensure that you receive the most trustworthy
12 and reliable evidence that is information that is available.

13 An objection is the procedure that is used for the --
14 for Counsel to call a possible violation of these rules to my
15 attention as the judge of the court. And for this reason,
16 you should never hold an attorney's objection against them,
17 nor should you conclude from the Court overruling or
18 sustaining an objection that I favor one side or the other.
19 In fact, you should expect objections. They're a very
20 healthy part of our adversarial process.

21 Also, from time to time, we may have matters of law
22 that we need to take up and we will have to exclude you from
23 the courtroom while we discuss those matters. The reason we
24 do this is because you are the finders of the facts and
25 sometimes when I'm discussing matters of law with Counsel, it

1 might be necessary for me to make some comment about the
2 facts in connection with a ruling.

3 And for this reason, we exclude you from the courtroom
4 so that in no way will you be influenced by anything that the
5 Court may say or do in connection with the facts of the case.
6 As I've indicated, you will have the opportunity to take
7 notes. Note-taking is the privilege that you may choose to
8 exercise or choose not to exercise. Please don't feel you're
9 required to take -- take notes. Not everyone finds note-
10 taking helpful to them.

11 If you should decide to take notes, please don't try to
12 record everything that is said. It's physically impossible.
13 Even before a court reporter makes any attempt to fully
14 provide a transcript, they go back and listen to their backup
15 tapes to make sure that everything that they have taken down
16 is accurate. So as you can well imagine, being able to take
17 down things verbatim is impossible, and as I've explained,
18 you are the finders of the facts. So please do not allow
19 note-taking to become a distraction to you because it is very
20 important for you to observe the demeanor of each witness as
21 you determine how you are to weigh testimony. You may want
22 to keep an outline of the main points that are being made so
23 that when you retire to deliberate, you can allow your notes
24 to refresh your memory.

25 Please be reminded that your notes are for your

1 specific and your individual purposes. They're not to be
2 shared with anyone else, and I would remind you that your
3 notes should not be considered any more -- shouldn't be given
4 any greater weight than the recollections of other jurors.
5 Their recollections should be considered just as reliable as
6 notes that may have been taken by a fellow juror, and also
7 during breaks and recesses, your notes will be left with us
8 and they'll be secure, and we do that to make sure that
9 there's no premature temptation to deliberate regarding any
10 fact or issue in the case.

11 Finally, ladies and gentlemen, I would ask that you pay
12 close attention to all of the evidence that is presented
13 because again, you, the jury, are the finders of the facts in
14 this case and as a result you will have to evaluate the
15 credibility which is simply a legalistic term, meaning the
16 believability of each witness who will testify in this case.
17 Each of you is participating in a time-tested system and it
18 is essential that each of you listen carefully to all of the
19 evidence and I'm sure that each of you will perform that duty
20 accordingly.

21 I have selected your foreperson. Just so that you
22 know, the foreperson is a purely random selection. We just
23 need a scrivener so to speak, someone that will fill out the
24 verdict form or write out any questions the jury may have
25 during deliberations. I would emphasize that your foreperson

1 does not have any greater vote or voice than any other juror.
2 It is simply that again we need a scrivener.

3 And, sir, I will give you further instructions for
4 regarding that role at the conclusion of the case. In order
5 to preserve everyone's rights, I'm going to give Counsel to
6 take exception to anything that the Court has said by way of
7 opening instruction.

8 Any exceptions from the Plaintiff?

9 MR. LUGINBILL: No, ma'am.

10 THE COURT: From the Defense, Mr. Hood?

11 MR. HOOD: No, your Honor.

12 THE COURT: Mr. Smyth?

13 MR. SMYTH: No, your Honor.

14 THE COURT: Ladies and gentlemen, I would ask that you
15 give Counsel your undivided attention.

16 You may proceed.

17 MR. LUGINBILL: Thank you, your Honor.

18 THE COURT: You're welcome.

19 MR. LUGINBILL: Good afternoon.

20 THE JURY: Good afternoon.

21 MR. LUGINBILL: What brings us to the Charleston County
22 Courthouse today is the standards of care that doctors have
23 to follow in their occupation. The medical standards of care
24 means what a reasonable doctor would do in the same or
25 similar circumstances. These rules exist for the safety of

1 patients. They're there to protect patients from avoidable
2 and unnecessary harm while helping the doctors get the best
3 outcome for the patient. They are in essence a safety.
4 These rules will come from many different sources.

5 Some rules come from the law, some come from the
6 surgeons, or the doctors, or specialties, some come from
7 academic setting, they do research and then publish that and
8 doctors then take that in, they synthesize it with their
9 practices and over time the standard of care gets developed.
10 It's not static, it changes as we learn, but where it starts
11 is that every patient who is treated by a doctor is entitled
12 to a careful evaluation.

13 The evaluation should be made with a diligence and
14 methods diagnosis that are usually approved in that practice
15 of doctors of ordinary learning, judgment, and skill under
16 the same or similar circumstances. Meaning if you're an
17 orthopedic, if you're an infectious disease specialist, you
18 will do your exam using the same proven methods as everyone
19 else in the industry.

20 In this case, we're going to be focused on the
21 standards of care for the prevention of infections following
22 spinal surgery and we'll also be talking about the standard
23 of care for treatment of the spinal surgical infection if it
24 happens. These standards of care which you prefer, these
25 medical safety rules are effective in preventing patient

1 harm, but only if they're enforced like any other safety.

2 And that's what we're here to do this week to enforce those
3 safety rules.

4 So let's take a look at the other safety rules that we
5 have. IV antibiotics must be used to treat deep surgical
6 site infections to prevent serious harm or death to patients.
7 This is going to mean a lot more to you after you hear all
8 the testimony. So IV versus oral antibiotic is going to be
9 an important issue in this case.

10 You're going to hear the testimony of many doctors.
11 One of those doctors has already testified that he won't be
12 here this week, but we'll have -- we have his testimony and
13 you're going to hear it read. He'll agree that deep space --
14 he's finalized and he'll agree that deep space spinal
15 infections have to be treated with IV antibiotic.

16 You're going to hear from Dr. Simmons, the infectious
17 disease doctor that is hired by Dr. West. He's going to say
18 the same thing. Deep space surgical infections must be
19 treated with IV antibiotics.

20 If a doctor chooses to use oral antibiotics to treat a
21 deep surgical site infection instead of sufficient IV
22 antibiotics and as a result the patient is injured, then that
23 doctor is responsible for the harm that they cause.

24 The third standard of care that we'll talk about is
25 that a physician was performed follow-up blood tests for

1 patients who have had a surgical drainage of a deep space
2 surgical infection in order to prevent serious harms. You're
3 going to hear from again, multiple doctors, both surgeons and
4 infectious disease specialists, who will say that the
5 monitoring of the antibiotics that are given is important to
6 know whether or not the antibiotics are working, to know
7 whether or not that infection is trying to come back, to know
8 whether or not the antibiotics are causing some other harm to
9 the patient. Your medicine is perfectly safe and so you have
10 to monitor, see what that medicine's doing to the body.
11 Monitoring is just as important as administrating because at
12 the end of the day you're not testing, you just guess it and
13 we don't guess with patient's agent.

14 So let me tell you the story what happened in this
15 case. In July 28, 2016, Southeastern Spine had one of his
16 physician assistants, and I'm going to shorten that, "PA" met
17 with a new patient. This patient had been referred to them
18 from her primary care doctor following an MRI. That MRI
19 showed in his vein that she needed to be evaluated by a
20 surgical practice.

21 When the PA met the patient, she documented several
22 things. One of the things she documented is that the patient
23 had a prior gastric bypass surgery and that's the surgery
24 where they reduced the size of his stomach so that to help
25 patients lose weight.

1 The PA -- the PA also documented that the patient had a
2 diagnosis of rheumatoid arthritis. Patients -- now I'm going
3 to shorten that to "RA". Patients with RA are considered
4 immunocompromised. That means that their immune systems
5 don't work as well as without -- when your immune system
6 doesn't work as well you have a hard time fighting off
7 infections.

8 The PA noted that she was taking two separate
9 medications to treat her RA, one of which is called Enbrel.
10 You'll hear testimony about that and the other one's called
11 Arava you will hear some testimony about that. You will hear
12 that both of those drugs reduce the immune system and body's
13 ability to fight off infections.

14 The PA reviewed the MRI -- she reviewed and did a
15 physical exam. She got Dr. Frisch to see the patient all
16 same day. Dr. Frisch meets the patient after looking it up
17 same day and evaluating the patient. He determined that she
18 did in fact qualify and was a good candidate for a
19 microdiscectomy to take that little piece of disc that had
20 pushed out and was pushing on her nerves -- patient consent
21 to it.

22 So on August the 2nd, Dr. Frisch took her back to the
23 operating room. Dr. Frisch makes an incision right about
24 here in the lower part of her back. He goes in, dissects
25 down to the spine where that disc lives, takes it out, sows

1 the patient back up and discharges her out. She stays the
2 night for observation. She is sent home the following day.
3 She was given doxycycline, an antibiotic, as part of her
4 discharge instructions and she was sent home with orders to
5 come back in two weeks. In two weeks, she comes back to the
6 order and she sees PA Aprill -- and we'll hear from Ms.
7 Aprill during this trial.

8 Ms. Aprill examined the patient and reported that
9 everything was looking pretty good. She had good relief from
10 her preoperative pain. In fact, the patient reported that
11 she was a one out of 10. The incision looked good, there was
12 no drainage, no redness, no swelling.

13 PA Aprill renewed the patient's pain medications and
14 gave her what's called a Medrol Dosepak which is steroids.
15 She set the patient up to come back in four weeks. However,
16 just one week later on August the 23rd, the patient called in
17 and she made an appointment to be seen by Dr. Frisch. She
18 was seen not by Dr. Frisch, but by another PA. This PA's
19 name is Ms. Anne Buck and you'll be hearing from her today or
20 this week as well.

21 Ms. Buck noted that the patient's pain had now come up
22 to a six out of 10, but what was more concerning was that the
23 surgical site, the incision itself had come up and yellow
24 fluid coming out of it. There was some redness around the
25 margins of the incision and there was what she called

1 granulation tissues in the middle of it. So presumably
2 concerned for infection, Ms. Buck ordered Bactrim, which is
3 an antibiotic, broad-spectrum antibiotic meaning it works
4 fairly well on a lot of things.

5 She told the patient to stay off of her RA meds and
6 gave her an appointment to come back in one week. She took
7 no cultures of the fluid, was not tested in any way. She
8 took no blood work. She took no vitals and Dr. Frisch did
9 not see the patient. Patient returns in one week as she was
10 told. This time the patient was seen by Ms. Aprill, not Ms.
11 Buck. Ms. Aprill documented again that her pain was very
12 minimal and that she had, was not having any fevers, but the
13 wound was continuing to drain through.

14 Now, in the records there's no description of what the
15 wound looked like at that time, so there was a description
16 that the patient had developed a rash from the first
17 antibiotic and so she switched her antibiotics from the
18 Bactrim to doxycycline, which is just a different antibiotic,
19 and told her to come back in one week. And the vitals were
20 done, culture was not done of the fluid, no blood work was
21 done, and Dr. Frisch did not see the patient again.

22 Again, she was told to come back in one week, just two
23 days later on September the 1st the patient called into
24 Southeastern Spine and asked to be seen by Dr. Frisch because
25 the drainage was continued. She was seen by doctor -- by PA

1 Aprill. She documented the wound looked the same as it did
2 two days ago. She documented that there was still an open
3 area in the middle of the incision and there was still some
4 drainage.

5 PA Aprill instructed the patient to continue taking the
6 antibiotics and come back in a week. Again the fluid was not
7 cultured. Again, no blood work was done. And again Dr.
8 Frisch did not see the patient. One week later as she
9 returns, PA Aprill sees her again and this is on 28th. She
10 notes that the wound is not yet healed and there's still some
11 drains through the bandage, but it's not draining as much.
12 We don't know what it looked like.

13 PA Aprill did not prescribe any additional antibiotics
14 and she told the patient she could come back in two weeks,
15 but fluid was there, it was not cultured. No blood work was
16 done and again Dr. Frisch did not see the patient.

17 And 9/20 the patient was back as instructed. This time
18 she's seen by Dr. Frisch. Dr. Frisch noted that she had pain
19 returning on her left side, that she had some mild fevers and
20 that the wound had dehiscence which means had opened up.

21 Dr. Frisch immediately admitted her to East Cooper
22 Hospital and ordered an MRI as part of the full infection
23 workup. He also requested that Dr. West, the infectious
24 disease doctor consult to see the patient. At East Cooper,
25 the patient had a nasal swab done specifically to test for a

1 germ of biological called MRSA, Methicillin-resistant Staph
2 aureus. We're going to call it MRSA because that's just easy
3 for everybody. They ordered blood work at the hospital and
4 they did the MRI that Dr. Frisch asked him.

5 The MRI showed fluid at the surgical site, the very
6 area where Dr. Frisch was working in the surgery on August 2,
7 now had fluid around it. There's fluid in the tissue around
8 it and there's fluid building up in the paraspinal muscles
9 above that tissue.

10 Dr. West agreed to consult on the patient and to help
11 manage what appeared to be in effect. He ordered antibiotics
12 be held until Dr. Frisch goes in and decides whether he could
13 take some of that -- drain that fluid out and have it tested.

14 On the 21st, Dr. Frisch did that. The fluid was
15 cultured. He did what's called, "An incision and drainage."
16 He opened the surgical wound back up, drained all that fluid
17 out of it. Dr. Frisch does note -- said that, "He saw a
18 purulent pocket of fluid," purulent meaning visibly infected,
19 but he didn't need to test it because it was infected. He
20 needed to test it for what it was infected with.

21 Dr. Frisch had to cut away some of the soft-tissue
22 around that pocket that was also infected. He inserted the
23 drain of the wound, close to the incision. The fluid tested
24 positive for MRSA. It's important to know that -- that MRSA
25 is resistant to some biotic -- antibiotics, but it's not

1 uncured. You just have to treat it appropriately.

2 After surgery, Dr. West assumed the responsibility of
3 developing a treatment plan to treat this infection. The
4 goal was to rid her of the MRSA and prevent a recurrence of
5 the infection. He did order for her to start an IV
6 antibiotics. You will hear that she received a total of
7 seven doses. And as soon as she was discharged from the
8 hospital she repeated them again oral antibiotic. She was
9 discharged on 9/26 again after receiving the seven doses.

10 At discharge, Dr. West told the patient to follow-up
11 with Dr. Frisch and Dr. Frisch only. She was not given any
12 instruction to report back to Lowcountry Infectious Diseases
13 either at the Charleston office or at the Myrtle Beach
14 office, which is actually quite close to where she lives.

15 Patient returned on October 11th to Southeastern Spine
16 where she's seen by PA Aprill for follow-up. Wound looks
17 good. This time we have no redness. We have no drainage
18 with stitches in that Dr. Frisch put in -- in the operating
19 room and they were able to go ahead. She went ahead and took
20 those stitches out. There was no instructions given to the
21 patient about whether or not she could resume any of her RA
22 medications. There was no further antibiotic ordered. There
23 was no blood work ordered. Again, Dr. Frisch did not see the
24 patient.

25 She was given a follow-up and she came back in on

1 November the 28th and this is the big period of time. It's
2 going to be an issue in the case, but she goes from October
3 11th to November the 28th. No follow-up at either Lowcountry
4 Infectious Diseases or Southeastern Spine.

5 Ms. Buck documented that the patient had increasing
6 pain. She was eight out of 10 now. When she tested for
7 reflexes she had a weakness on her left side, the same side
8 that was affected after the initial surgery and when she had
9 her first effect.

10 During this visit, the patient reported that she had
11 been restarted by her other doctors on her Arava, which is
12 one of her RA medications. She also told Ms. Buck that she
13 had just completed a course of oral steroids that had been
14 given to her part of her RA treatment.

15 You'll hear testimony that both Arava and oral steroids
16 can suppress the immune system, but knowing that no further
17 antibiotic was ordered, no blood work was ordered. There
18 will be a dispute in the testimony that you will have to
19 resolve it as to whether Ms. Buck was offered an MRI that
20 day. What is undisputed is as I said, no blood work was done
21 and Dr. Frisch did not see this patient on this day for these
22 symptoms. She was called to come back again for follow-up in
23 four to six weeks. A patient couldn't wait that long. Two
24 weeks later, she called in on December the 13th. She said
25 that, "Her pain is precinct and she needed to be seen by Dr.

1 Frisch."

2 PA Aprill called her back and spoke with her on the
3 phone and set up an MRI on December the 6th, which was a
4 Friday. And the patient got Southeastern Spine, did the MRI,
5 and then she did get to meet with Dr. Frisch.

6 Dr. Frisch again recommended that she go into the
7 hospital for another infectious disease work up. Now, East
8 Cooper -- or sorry Southeastern Spine on that Friday, no
9 blood work was done, and no antibiotics were prescribed. The
10 patient, her husband, and Dr. Frisch discussed whether she
11 could come back on Monday to go into the hospital. You're
12 going to hear that they didn't know they were going to be
13 going to the hospital that day and they were not prepared to
14 go to hospital.

15 You're going to hear that she was supposed to, that
16 weekend, get to do Christmas with her grandbaby and she did
17 not want to miss that. She asked Dr. Frisch if that was
18 reasonable and safe and Dr. Frisch probably wasn't happy
19 about it, but he did tell her, "No" and he said, "It was
20 reasonable that she could do that as long as she didn't get
21 worse." She will let him know and that she for sure showed
22 back up on Monday.

23 You're going to hear testimony that they did call in on
24 Saturday and say, "Hey, more than you can handle." And they
25 were advised just come Monday. And so that's what they did.

1 They came Monday. She again admitted, there was again an
2 antibiotic or a MRI done. She was again given blood work and
3 she was again tested for MRSA.

4 This time the blood tests that were done came back
5 positive for MRSA. The same MSRA and all the doctors are
6 going to tell you that it's the same MRSA she had infection.
7 The MRI showed that there was another abscess in the same
8 place -- in that same surgical site area and there was some
9 involvement with the vertebrae itself. It's unclear just
10 what it was yet. She was admitted. She started on
11 antibiotics.

12 On December 24th, they did another MRI to see what
13 was going on. The progressing was getting better.
14 Unfortunately, on December 24th, MRI showed that the
15 infection had gotten under her L4-L5 disc and it was also
16 into the bones at L4 and L5. And this happened while she was
17 already in the hospital. She remains hospitalized at East
18 Cooper until January 3, 2017. She was discharged is what's
19 called a PICC line, but she has to have now three months of
20 antibiotic -- IV antibiotic, which could be delivered by a
21 home health nurse.

22 And she finally got through with all of her antibiotic
23 treatment and she's a little stronger. She sought a second
24 opinion about her back from him. You'll hear that she wanted
25 to go. Was there anything that could be done to give her

1 back to you? You'll hear that that wasn't an option. And
2 you'll see the MRIs that show that this is completely gone
3 now. There is no L4-5 whatsoever. And the two bones settled
4 into each other and collapsed down and have now fused
5 together.

6 Another fusion like a surgeon does, where they put it
7 where they wanted. It's just fused and it's sunk down
8 because of that that's permanent. That's never going to be
9 right. The patient we may have addressed is Ms. Pat
10 McGougan, her husband Edgar is with her, she's got her boys,
11 she's got a brother, and a sister-in-law.

12 You're going to get to meet this family. You're going
13 to get to hear from their eyes what she went through. So who
14 are we suing? Why are we suing? We're suing Southeastern
15 Spine and Dr. Frisch. And you can think of the two of them
16 as the same. Southeastern Spine is the PAs and it's
17 Dr. Frisch and it's the person who answered the phone is all
18 Southeastern Spine.

19 We suing them because they violated the first, she
20 didn't get a unique and independent thorough exam that took
21 all of her unique history into consideration. She was just
22 another account. She got treated like every other
23 (inaudible).

24 The Southeastern Spine, they've been in Charleston
25 County a long time and I'm not here to tell you that they do

1 bad work all the time. I think they do good work the vast
2 majority. Dr. Frisch used to be a partner in that facility.
3 He'll testify that he no longer is a partner and that he
4 doesn't have any control how corrupt (inaudible) regardless
5 of who own Southeastern Spine now they have a duty to meet
6 the standard of care for the patients that they treat.

7 Southeastern Spine and Dr. Frisch do three very
8 important things at the very first meeting with that. The
9 first is that she had a disc radiation. It's not a dispute
10 about that. Everybody in this case is going to agree she
11 had. Second thing is that she had a history of rheumatoid
12 arthritis and everybody in this case, all the doctors are
13 (inaudible) that that means she was immunocompromised.
14 Everybody knew from (inaudible) she wasn't going to be able
15 to fight off infections as well as the (inaudible).

16 They also knew she had a history of gastric bypass
17 which had caused her a condition caused called malabsorption
18 syndrome. With gastric bypass because the -- something's
19 smaller, it doesn't absorb everything as well and that
20 includes oral antibiotics.

21 We're also suing Southeastern Spine and Dr. Frisch
22 because the postoperative follow-up care between August 3 and
23 September 16, was not reasonable for Pat. You'll hear
24 testimony that -- that -- that sampling of fluid would've
25 been confusing and nobody does that and it's bad. But you're

1 also going to hear testimony from infectious disease doctors
2 who say, "Go ahead and get the sample, we'll help you
3 interpret it. If you don't feel comfortable with spine
4 surgeon, call us and ask us. We'll help."

5 You are going to hear testimony that the use of the
6 oral antibiotic without any follow-up, without any blood
7 work, without any monitoring wasn't acceptable because you
8 haven't heard unique conditions of RA and the malabsorption
9 syndrome from the bypass surgery. You have to know whether
10 it's working or not. Again, if you're not testing, you're
11 just guessing and they never did any blood work. It's
12 undisputed in this case that from August the 2nd when she
13 walked in to the hospital for that surgery until she was
14 discharged on January 1, 2017, Southeastern Spine never did
15 any blood work or sent her to have any blood work done other
16 than what you talked about.

17 Why is that dangerous? If you don't make a plan of
18 care that's unique to that patient, that patient doesn't get
19 what they need. You have to account for her increased risk
20 and how hard it's going to be to treat her if she does get
21 the risk. Everybody agrees spinal surgery involves a risk of
22 infection. All surgery involves the risk of infection, but
23 when you know if it's happening and you've got a client
24 who's at more at risk, or a patient who's more at risk of it
25 happening, then you have to alter your plan of care to

1 address that for the safety of the patient.

2 Proper antibiotics, you will hear from the doctor given
3 early enough and long enough, more likely than not, as the
4 judge showed you by a preponderance of evidence more likely
5 than not, had the antibiotics that she needed -- been given
6 early enough when the infection first showed that it was
7 happening and been given long enough, it would've eradicated
8 the infection. It would not have come back and none of us
9 would be here today and she'd still have a good back.

10 We are suing Dr. West and Lowcountry Infectious
11 Diseases because Dr. West assumed the duty of taking care of
12 her in that hospital. He set the plan for just seven doses
13 of IV antibiotics which lead to the malabsorption.

14 You're going to hear from Dr. Blass infectious disease
15 doctor. He's going to explain to you that seven doses is
16 nowhere close to enough for any patient. It certainly wasn't
17 enough for this patient. And he's also going to testify that
18 the choice of antibiotics given orally wasn't going to work
19 for this patient and he should have known better he
20 (inaudible).

21 You'll also hear from Dr. Davne who's his spine surgeon
22 and he will tell you his practice, how long an IV antibiotic
23 were given after drainage, and what he's used to seeing when
24 he follows patients and follow-up in the office for other
25 doctors.

1 Now, before we brought the case to trial, we wanted to
2 make sure to -- we wanted to make sure that if the
3 antibiotics had been given in time it would really matter.
4 And so we asked our doctors, but we also asked their doctors
5 and all of them agreed that earlier intervention changes the
6 outcome. They may disagree on how much it changes it and
7 they may disagree on the edges, but that's correct. Medicine
8 that's different -- doctors that we continue, but they do
9 agree on is when that infection is small, if you treat it
10 then it goes away, you right the patient is fine.

11 If you let it get going and you wait and it gets
12 systemic and everywhere in the blood, all over much -- much
13 harder and once it gets into the bones it's going to start to
14 drain bones. Every doctor in this case will tell you that
15 the infection she had is what caused the damage her back
16 everyone. The only issue is whether how could stop
17 (inaudible).

18 And you're also going to hear from Dr. Cuddy who's one
19 of the experts. Dr. Cuddy is over at MUSC and he and a
20 colleague wrote a book chapter specifically about spine
21 surgery infections. In that book chapter, he specifically
22 says that IV antibiotics following a spinal surgery infection
23 are effective for eliminating the infection and avoiding any
24 further form of infection. So because we know that the
25 antibiotics would've worked, most likely we can bring this

1 case. Talk briefly about if you culture it what would it
2 show, you're going to hear testimony that nobody cultured it
3 -- no culture of standard of care confusing.

4 And again, you're going to hear from the infectious
5 disease doctors who will say it's not that confusing. We can
6 have (inaudible). Why it's important to culture it is if you
7 know what the organism is, you'll know what's susceptible to
8 it. Remember I put that versus susceptible some things and
9 not others. So if you know what is susceptible to that you
10 get the right antibodies that's unique to that patient, you
11 get the one that has and the infection (inaudible).

12 At the end of the case, you'll be given a verdict form.
13 And on that verdict form, if we have tipped those scales even
14 slightly in Pat's favor that she should have had a longer
15 course of IV antibiotics and she should have had her testing
16 done even in August once it started draining, then you'll
17 have to decide how much harm was caused.

18 Judge Jefferson has talked already today about the fact
19 that you have to rely on the evidence you hear in this
20 courtroom and you are collectively going to have to decide
21 what's a fair amount of compensation. So my job throughout
22 this trial along with these women is to show you the evidence
23 of what her harms and losses are. Our job (inaudible) the
24 tools you need to do your job. So what are you going to do?

25 You're going to hear the doctor's testimony, you're

1 going to see the journal the doctor relied on the backup
2 (inaudible). You're going to see MRIs and you're going to
3 see blood work results. But at the end of the day, what
4 you're really going to hear is that Pat was a 62-year-old
5 nurse working at Loris hospital (inaudible) just outside of
6 (inaudible) and that she loved being a nurse. In fact she
7 was a nurse supervisor.

8 She'd been a nurse supervisor for a long time and that
9 nurse supervisors help the other nurses, help the doctors,
10 help the patients to jump in and do actual on hands-on
11 nursing as they need to handle codes. This nursing and --
12 and she's -- she's taking care of the patients. She loved
13 helping the doctors, she really loved helping the nurses. I
14 didn't want to bring this case, but she's paying everything
15 different amounts. Depends on what she does. Depends on
16 what she doesn't do. (Inaudible) she did and what she tries
17 to do.

18 We are going to hear that Pat never went back to work
19 that after August the 2nd and she never will go back because
20 she can't be a nurse. Her back is too unstable and now time
21 has gone on and she is 70 years old not that she likes it and
22 she was going to retire at 70. See she had ever had a plan.
23 You're going to hear that she was going to work full time,
24 five more years, get their kids through college and then she
25 was going to drop back part time until she was 70 years old

1 and they were going to enjoy everytime. That hasn't happened
2 because she never got there.

3 You're going to hear about Edgar having to change her
4 bandages. Is that (inaudible) it day after day after day
5 about pain. You'll have to hear about Edgar having to help
6 her use the bathroom, take a shower. You're going to hear
7 from the family, had come in, take over simple things
8 cooking, basic cleaning and the things that she had the
9 (inaudible) had been doing her whole life for everyone else
10 she couldn't do it. People had to come to (inaudible). I'm
11 making a mistake (inaudible) they do. But you hear that
12 testimony because it tells you what that's lost. It gives
13 you something to compare what she is now versus what she was.

14 Some of the damages you have discovered are -- are
15 easy, those medical that you're going to get those, the loss
16 wages and not being able to go back to work and you're going
17 to get that information, tax returns and pay off stuff.

18 The harder part is to really value and understand how
19 that loss of income changed everything. And how per loss of
20 her ability to work and -- and be who she was to change
21 everything. You are going to hear that they have been living
22 in Edgar's family home in Green Sea, South Carolina. He
23 opened that house, they had plans for that house to keep that
24 house -- going to be a family place on that side of the
25 family. Pat had a place on the farm that she grew up there.

1 Her brother is here he's going to tell you about that.

2 You're going to hear from Edgar that (inaudible) had
3 that they had to give up the house (inaudible). You are
4 going to hear about missed baseball games and Christmas
5 visits and church outings. So then you're going to hear
6 about how she does it miss and what she does in order to be
7 able to do and what it costs her.

8 And you're going to hear about how she has to make a
9 choice and she wants to -- Wednesday supper at the church.
10 She can go and help cook and sit in those hard foam chairs
11 and eat the food she loves and then she has to spend the
12 whole next day in bed and take -- and take opioids. You're
13 going to hear she hates taking opioids and she will not do
14 it. Part-wise because -- because of her stomach surgery
15 destroyed her stomach, or that's a cost to them, or she just
16 stay home.

17 Every day, every week you're going to hear the kind of
18 things that she has to make that decision. Before all this,
19 she did what she wanted when she wanted. And you may feel
20 sympathy of course, but you're not allowed to allow sympathy
21 affect your verdict. You know decide on just that evidence
22 that I talked about.

23 Those two cases are battery 11, some cases are smaller
24 and have -- they have them in the same courthouse. Somebody
25 might got a cut in a car wreck, trip and fall something had

1 three months, pain and doctor (inaudible). In most cases
2 they ask for something down here. Other cases they go
3 permanent injury and it is there, but they're okay for the
4 most part.

5 Some cases people are (inaudible) bed balance, they're
6 all have millions of dollars in that (inaudible). This is
7 big case, five years of waiting (inaudible) time after. At
8 the end of the day and at the end of this case, one thing to
9 be very clear, she suffered a great loss. She didn't have
10 to. And it is for you to decide what to do. Your verdict
11 help can fix and it can make -- give her options that will
12 take (inaudible).

13 At the end of the case, I'm going to be asking you, if
14 I told you the Number that you've asked for now seem like a
15 lot, if you haven't seen, you've heard me talk about it, but
16 the Judge says, well, I say not. I think at the end of the
17 case when you see, and heard the witnesses, and you've seen
18 the MRI. We know that you'll see that this is the kind of
19 case that require me to ask you for a very large Number
20 (inaudible). Thank you for your time. (Inaudible) justice
21 defense on behalf of (inaudible). I really appreciate your
22 service, we cannot do this without you. Thank you.

23 MR. KERN: May I please the Court?

24 THE COURT: Yes, sir, you may proceed and please try to
25 speak directly into that microphone. Otherwise nothing you

1 say is going to be recorded.

2 MR. KERN: Okay. Thank you.

3 THE COURT: You're welcome.

4 MR. KERN: Good afternoon.

5 THE JURY: Good afternoon.

6 MR. KERN: Thank you all for being here. This is a
7 case about a patient who needed a spine surgery and who then
8 experienced a delayed discovery of a -- with a unique
9 timeline involving hibernating bacteria throughout my
10 readers. Make the mistake that timeline in this case
11 matters. Okay? There are really three phases to this case.
12 I -- we'll ask you want to take -- pay close attention to
13 this week. First, we will talk about Ms. McGougan's initial
14 surgery on August 23, 2016, and -- and her postoperative care
15 that evolved from there.

16 During that time frame, she saw the practitioners
17 between August 16, 2016, and September, 26 times in 35 days.
18 That includes the date of her reverse scheduled pre --
19 postoperative surgery for an appointment. And on the day
20 that she was readmitted to the hospital was September 20th,
21 we believe that six days of 35 days, 30 days plus five.

22 During this time period, the physician assistant spoke
23 with and saw her regularly and they communicated what they
24 were doing, what they were seeing to the surgeon Dr. Frisch,
25 that's how they worked. The nurse -- physician's assistants

1 do not work independently. Everything they do is monitored
2 and discussed with Dr. Frisch.

3 This team approach is consistent with how medicine is
4 practiced everywhere. It allows patients to be seen when
5 they need to be seen. Extraordinary circumstances arise. It
6 allows them to be seen sooner.

7 During this time period, a postop -- postoperative
8 decision was conmpleted. It was evaluated. There was
9 concern, but the signs and the symptoms simply weren't there
10 to diagnose. They didn't add up. Doctors were looking at
11 the objective criteria that medical practitioners used to
12 evaluate a patient just didn't add up. The picture was not
13 complete. And so they continued to monitor her and they
14 watched her and they talked to her. When they ultimately
15 decided that something was going wrong, they identified the
16 problem, they evaluated it, they tested it, they addressed
17 it, and they got the treatment that she needed.

18 The physician's assistants will confirm that at every
19 visit they discussed infection, they evaluated infection,
20 they looked at the wound, they felt the incision, and they
21 tried to figure out what was going on. This was part of
22 their comprehensive routine patient care, is what they do
23 every day.

24 The second phase begins after she leaves the hospital
25 September 26, 2016. That is when her condition changed. She

1 was admitted to the hospital, identified the abscess. She
2 had a surgery to remove the fluid from the lower spine. Keep
3 in mind that when we're talking about the wound, there are
4 two components of it.

5 The incision site that you can see physically in the
6 surgical site that is deepened. Her surgical abscess was
7 found with the MRI. That's how you diagnosed (inaudible),
8 especially in the absence of other objective factors. What
9 happened is, as of September 20th, her condition changed and
10 that's when the new presentation was addressed. She was then
11 treated in the hospital by attending medical practitioners,
12 including the surgeon, including his PAs, and including the
13 infectious disease specialist.

14 The infectious disease specialist treated her in the
15 hospital with IV antibiotics and came up with the treatment
16 plan for what she needed based upon the medical evidence for
17 when she left the hospital. She agreed, she -- she was given
18 the medication, and she took it. She -- she was a good
19 patient.

20 The third phase begins sometime later. That starts on
21 -- on November 28, 2016. So between September 26th and
22 November 28th was a -- was a time period of about 65 days.
23 On -- on November 28th, she presented again to the
24 Southeastern Spine, she had increased pain. She's a
25 rheumatoid patient. She knows what her pain is.

1 On that day, she thought her pain was due to her
2 rheumatoid arthritis. She reported that to the PA,
3 nevertheless PA Buck -- Ann Buck who you all will hear from
4 later. So she evaluated her. She looked at the incision,
5 the incision looked good. It was clean, it was diagnosed of
6 infection, nothing concerning. She knew her history. They
7 knew what to look for, they knew how the conversation was
8 going.

9 So she sent her home with pain medication and a plan to
10 watch it. Again, this had just happened. So the team,
11 including Ms. McGougan, knew what to look for and knew what
12 was happening. They knew what the risks were, but at that
13 day, she felt like the pain was due to her rheumatoid
14 arthritis. There's dispute that between September 26, 2016
15 and November 28, 2016, she did not call any of her doctors
16 with any complaints. That's a completely different patient
17 that existed on August and September of 2016 when she was
18 seen six times in 35 days.

19 Eventually, she called with more pain and brought her
20 back in. They tested her. They evaluated her again. They
21 identified an infection. Infectious disease came back in and
22 they treated it. Our ability to identify infections is
23 difficult. It's a known risk. Plaintiff's lawyer, Mr.
24 Luginbill mentioned that. That's -- they're called known
25 risks because they happen (inaudible).

1 In this case, the infection presented is an individual-
2 deficient patient. The reason in post-surgical patients,
3 medical professionals are well conversant with the signs and
4 symptoms to infections and they can address them when they
5 present themselves.

6 Predicting how individual patients will present is art.
7 It's not science. It's difficult. Every patient is
8 different. That's because the range of patients with
9 different illnesses, backgrounds, and presentations is a wide
10 spectrum. And talking about practicing medicine and medicine
11 is an exact sciences. It is true that she had rheumatoid
12 arthritis and when she underwent the initial lumbar spine
13 surgery.

14 However, you'll also hear this week that the surgical
15 team knew about her background. It took her off of the
16 medications used to treat rheumatoid arthritis
17 preoperatively, and it took appropriate steps to manage her
18 condition for a surgery that she needed.

19 The injury that happened to her occurred in early July,
20 2016 and she stopped working then because her condition was
21 so bad. What happens is that sometimes -- some rheumatoid
22 arthritis patients take medications that can impact their
23 immune response to certain factors. Patients are -- these
24 patients are common. Surgeons know how to -- how to treat
25 them. They see them every day.

1 The appropriate treatment for these patients when the
2 surgeon's identified as a group is to take them off of the
3 medications, which they did, and then you restart the
4 medication and then there's a -- a clinical indication to do
5 so after she's recovered from the surgery. It was never that
6 indication in this case, in August and September 2016, which
7 she never went back on those medications after she left the
8 hospital after her first surgery.

9 Rheumatoid arthritis can also cause slow healing of
10 incisions. So remember there's a surgical site that the disc
11 is operated on and there's an incision and the incision can
12 be slow healing in rheumatoid patients just like diabetics,
13 just like some smokers, just like folks with elevated BMI
14 sometimes these are patients that the medical team knows
15 about and they evaluate they see it every day.

16 It complicates the evaluation process because if a
17 person with a known condition has a wound and incision that
18 is slowly healing that fits within that patient's condition.
19 So you have to look at other criteria, objective criteria to
20 evaluate whether the patient's compromised.

21 Another medical issue you are going to hear about this
22 week is the difference between serosanguineous drainage and
23 infected infectious pus. They are two different substances.
24 When Ms. McGougan was reported to Southeastern Spine on
25 August of 2016 -- on September of 2016, the drainage that she

1 reported and that was observed was serosanguineous. That is
2 fluid. That is completely normal in a slow-healing incision.
3 We base medical community see it all the time to patients.
4 That is a (inaudible) presentation than infectious process
5 feel different. They look different, and they are different,
6 and they mean different things to the medical practitioners.
7 This is an -- especially important in how we evaluate the
8 case and the conduct of the physician assistants and the
9 surgeon in the days and weeks following her initial surgery.

10 You'll hear that in early July 2016, Ms. McGougan
11 failed conservative pain therapy. When she hurt her disc,
12 she consulted her rheuma drug -- her rheumatologist, she
13 consulted her primary care physician, and she saw a
14 chiropractor all through those modalities failed to address
15 her pain, but they knew that she needed the surgical consult.
16 So her team -- her medical team, was all incomplete on what
17 needed to be done.

18 You'll understand -- you'll hear that she understood
19 her own medical history and was an active participant in her
20 medical history in care. You will hear that the surgical
21 team's approach (inaudible) problem needed to be solved and
22 it was. They identified a change in her condition. They
23 treated the infection based upon objective data. She
24 received immediate intervention and the infection was
25 treated. That's different than an incision site issue.

1 We're talking now about a deeper surgical bad infection, but
2 most (inaudible).

3 You'll hear that is -- that the infection withstood
4 recognized medical treatment and hibernated for months
5 following her discharge from the East Cooper Medical Center
6 in September of 2016. Afterwards, despite her best -- best
7 effort to intervention by the surgical and infectious disease
8 teams, she developed more of a complication. That's
9 undisputed. It is kind of like fitting together the pieces
10 of the puzzle same in your position in the PA, a patient like
11 this presents a complicated presentation and a complicated
12 history, takes time, takes focus, and it takes objective data
13 to make a diagnosis.

14 When she began having complaints once after her second
15 surgery in September of 2016, it was another puzzle. The
16 pieces didn't fit together again, remember she did not come
17 back to see her doctors, whatever, 60 days with no
18 complaints. It is important to point out that patients are
19 not data points. They're not treated the same way. Each
20 patient is treated individually. They're -- each patient's
21 in data points say something different based upon their own
22 individual presentation.

23 Our patients are people and doctors always -- always
24 look out for the patients and never rely on one thing or
25 another in the diagnosis. For example, with an incision,

1 they look at the physical cure itself. Is it -- is it
2 swollen? Is it red? Is it inflamed? Does it look infected?
3 What does it look like? A normal postoperative incision? Is
4 there tenderness? Does it hurt when we touch it? When they
5 feel it?

6 That's what physician's assistants and surgeons do at
7 -- at a -- a visit for a postoperative. They touch the
8 patient, they evaluate the incision, and they're keeping
9 their eyeballs on it. It's all their senses. They're
10 required. No doctor wants their patient to have a bad
11 outcome. No -- happens it doesn't mean that anybody did
12 anything wrong, especially in an infection case.

13 The law states that a doctor -- medical practitioner
14 cannot guarantee an outcome for any of their patients. That
15 would be impossible. The law does not require that. The
16 fact that Ms. McGougan can develop and no complication does
17 not make anybody liable with that.

18 The law requires that a doctor acts reasonably. We
19 will show you the testimony in the medical records that Mr.
20 --
21 Dr. Frisch, his team acted reasonably when they treated Ms.
22 McGougan.

23 My name is Brian Kern. I'm here with Jamie Hood.
24 We're proudly representing Dr. Frisch spine surgeon at
25 Southeastern Spine for being sued today -- this week.

1 Dr. Frisch grew up in an army family. He spent time in
2 Alabama and North Carolina before his family settled up in
3 Pennsylvania. He went to medical school at (inaudible)
4 University in Philadelphia. He went -- and did a fellowship
5 in San Francisco in orthopedic surgeon at -- and then trained
6 also at the Alvin Science Institute of Medicine in
7 Philadelphia. He's the past president of the South Carolina
8 Spine Society, who is president elect the South Carolina
9 Orthopedic Association.

10 You'll hear from him this week and you will -- and he
11 will defend himself and his team because he acted reasonably.
12 Inappropriately and they were when they were treating and
13 evaluating Ms. McGougan in the summer of 2016. His team
14 includes his physicians' assistants, Ryan Aprill and Ann Buck
15 will hear from them this week. Dr. Frisch will explain to
16 you what he did, what he saw, how his team operates, and how
17 he evaluates patients (inaudible).

18 We're thankful for you all as jurors today. It's been
19 a long day, but without you we would never be able to resolve
20 this case. For the purpose of evaluating the facts of this
21 case, I'd like to go over some dispute facts and first
22 settlement he or she go.

23 The first one is that this surgery wasn't -- it was
24 necessary. She was suffering. She needed it she -- she
25 suffered an injury that she could not recover from the

1 surgery treatment. Nobody disputes that. She'll not dispute
2 that.

3 The second undisputed fact is that Ms. McGougan may
4 have rheumatoid arthritis reported about that the team and if
5 the team took it into account when they prepared her for
6 surgery and treated her post-of -- they knew what her
7 medications were, what medications do or don't give the
8 patients when they're on them or not, and they evaluated her
9 with that knowledge.

10 You'll hear from Dr. Frisch, he understood her
11 presentation. He was satisfied when appropriate plan of care
12 had been implemented and that she and everybody else
13 understood what her condition was, what her risks were, and
14 what was going on in her body.

15 The third undisputed fact is that Dr. Frisch's team
16 consistently saw and evaluated her. We'll show you through
17 the records and testimony what that means, what it looks
18 like, and what they did. The -- the notes prove that at
19 every visit with this team, they evaluated and considered
20 infection. And when her condition changed, that is when the
21 (inaudible).

22 The fourth undisputed fact is that when she was treated
23 in the hospital on September 20, 2016, there was no bone
24 involvement of any of the infection. This is a soft-tissue
25 infection. It's important. There're a lot of words from

1 Mr. Luginbill about the long-term damages that she suffered.
2 A lot of that's due to infection in her bone that was not
3 there in September of 2016.

4 The fifth undisputed fact is that after the second
5 surgery, the bacteria hibernated. All the experts will say
6 that. It's -- it's a unique presentation. That means that
7 the bacteria went normal, there was no infection, and then
8 two and a half months later, the bacteria woke up and caused
9 an infection. It was causing no symptoms for over two
10 months. She reported none and none was expected.

11 We will show you the evidence and let you put it
12 together for yourselves to determine how the team operates,
13 whether they were reasonable and what they did. I think that
14 is important -- it is important to point out these medical
15 issues to you on the forefront so that we can have a
16 conversation this week that you understand. You know what a
17 complication is and you understand that once an infection,
18 the suspected medical teams have to react and diagnose and
19 treat them when the data changes and shows them what to do.
20 And that's what happens here.

21 There are two sides to every story. There's our side
22 and their side. It's your job to (inaudible). I implore you
23 to listen to all of the evidence before making a decision.
24 I'll ask you to keep an open mind when you begin hearing
25 evidence? With the Plaintiff, because they have the burden

1 of proof -- goes first. They will always go first. They
2 will close. They will finish first and last. You'll
3 hear their evidence and then you'll hear our evidence. At
4 the end of the case, you'll hear their closing argument and
5 you'll hear our closing argument. And they have a chance to
6 go first and last again at the end. They have the advantage
7 of going first and last because they have the burden of
8 proof. They have to prove their case. Technically, the
9 Defendants don't have to put up any evidence at all. It's
10 their burden to prove to you that surgical and medical teams
11 here who acted unreasonably, they were -- negligently reach
12 the standard here.

13 Just because there is a lawsuit does not mean somebody
14 did something wrong. It's your constitutional right to file
15 a lawsuit (inaudible) dispute that. Does not indicate an
16 admission, something went wrong before something actually
17 went wrong.

18 The standard of care, as we saw earlier, is what a
19 reasonable position would do under the same or similar
20 circumstances. So what -- what are you going to be tasked
21 with doing this week to evaluate whether Dr. Frisch is --
22 acted reasonably? What questions will you be facing? Well,
23 were they reasonable in treating her? Did they evaluate her?
24 Did they lay hands on her? Did they take action when the
25 infection presented itself? Did they bring in the

1 appropriate consultants? Wouldn't they reasonable in
2 assessing when she should go back to the hospital? Which in
3 and of itself is not an easy decision for many reasons.

4 With all of that reasons based upon the medicine that
5 existed in the field eight years ago. Plaintiff must prove
6 that the practitioners deviated from the standard of care.
7 The evidence we will bring is dropped from the medical
8 experts is that Dr. Frisch's team did everything right and
9 they've met the standard of care. They acted reasonably,
10 they took a reasonable approach, they acted appropriately,
11 and that means they comply with the standard of care.

12 It is important as you listen to the witnesses this
13 week, including the experts, that you evaluate them
14 individually based upon their own presentation, their own
15 education, their own credibility as they testify, their
16 background, their practice. Who are we talking to this week?
17 What are they saying? And why are they saying it's important
18 for you to consider those for each witness as they come in.
19 What do they bring to the table and -- and what is their
20 experience to testify on a particular subject? That's what
21 experts do.

22 Dr. Frisch and the PAs, we will have two experts this
23 week. Dr. John Glaser, who's a professional -- professor of
24 orthopedic surgery, spine surgery at the MUSC, and he works
25 with the VA as well.

1 We also have Michael Dailey. He's an infectious
2 disease doctor. He is with -- he's from Atlanta and he'll
3 testify about the appropriate infection assessment and
4 treatment. These are board-certified physicians. They're
5 experts in their field (inaudible).

6 Thank you again for your patience today and during this
7 trial. I know all of you have work, family obligations.
8 It's not convenient. We'll make every effort to accommodate
9 you and we appreciate your patience as we get through this
10 week. But without you, again, these individuals, the doctors
11 can't get the results and we can't come to the resolution of
12 the case.

13 Based upon all of the evidence that is presented to
14 you, I submit that you will come to the conclusion that
15 Dr. Frisch, his team, Southeastern Spine acted appropriately.
16 They acted reasonably that standard of care and make truly
17 value took care of Ms. McGougan.

18 For all these reasons when we come to the end of this
19 case and we are going to ask you to return a verdict in favor
20 of Dr. Frisch and his practice. And that means that you find
21 that they were not negligent and they acted appropriately.
22 Thank you.

23 THE COURT: Is everyone comfortable or does anyone need
24 a comfort break?

25 UNKNOWN JUROR: My (inaudible) diabetic kit.

1 THE COURT: Okay. We'll take a brief comfort break.
2 During the break, please do not discuss the case. If you go
3 with the bailiffs, let us know when you're done and we'll
4 resume opening up.

5 (Jury exits courtroom.)

6 THE COURT: Okay. I assume we'll be at ease for about
7 five minutes. You all can feel free to move around. Just be
8 back in five minutes. Thank you.

9 (Off the record.)

10 MR. HOOD: We're ready, your Honor.

11 (Jury enters courtroom.)

12 THE BAILIFF: All jurors present, your Honor.

13 THE COURT: Thank you. Ladies and gentlemen, we'll now
14 resume with argument.

15 Mr. Smyth you may proceed.

16 MR. SMYTH: May I please the Court, your Honor?

17 THE COURT: Yes, sir.

18 MR. SMYTH: Good afternoon, ladies and gentlemen of the
19 jury. My name is Todd Smyth and I'm along with Allie Maples
20 and my paralegal representing Tim West. And the last thing
21 you wanted to do at 4:15 in the afternoon is hear from a
22 third lawyer -- the same case, but we do have a little
23 different aspect of the case and I want to tell you a little
24 bit about Dr. West.

25 Dr. West is an infectious disease specialist. He's

1 practiced in the Charleston area for over 30 years. He's
2 also a husband and father. He's been married to his wife
3 Marshall for 54 years. They got two boys that they used here
4 in the Lowcountry and he's been an integral part of the
5 health care system in South Carolina.

6 Dr. West is passionate about things that you and I
7 probably are not all that passionate about. He spent his
8 entire career studying bacteria, viruses, things that can
9 attack the human body. And he's done that with excellence.
10 He published papers on it. In fact, he's actually published
11 a paper that you may hear about this week, involves the very
12 bacteria that sadly affected Ms. McGougan's back.

13 Dr. West has taken care of thousands of patients in his
14 career. He's taken care of people from every in -- of every
15 walk of life and -- and all kinds of different situations.
16 He's very knowledgeable about infections and how to treat
17 them. He prides himself on giving excellent care and he's
18 done that for 35 years in his community. It's interesting
19 when you look back at Dr. West's career. I mentioned to you
20 that he retired in -- in 2019.

21 When he started his career in the 1980s. It was in the
22 middle of the AIDS epidemic. Dr. West did something unusual.
23 He started that clinic for those that couldn't afford care,
24 (inaudible), prisoners, people that were fighting that virus.
25 He did that against his department, his wishes, but he did

1 that because he cared about his patients.

2 And then you look at the end of his career, when he
3 retired in 2018, he thought that was going to be it. I bet
4 his wife Marshall did too. But within a year, something
5 changed. Our worlds were turned upside down. COVID-19 hit.
6 Dr. West was in retirement, could have stayed there. He
7 wasn't bored. His wife wasn't ready to kick him out of the
8 house, but he knew he had a set of skills that could help the
9 people of our community. So he came out to (inaudible) to
10 take care of those patients that were affected by COVID.

11 And he did that because he cares about his patients and
12 he prides himself in providing good quality care. He's here
13 this week not because he wants to be. He's here this week
14 because a patient filed a lawsuit against him. It alleged
15 something very serious. Medical negligence.

16 Dr. West takes the job very seriously and that hits him
17 right in the heart. He cares about patients, he cares about
18 the job he does. This is personal. Dr. West doesn't owe,
19 doesn't have any ill will towards the McGougans. They're
20 very kind people. I got to know them in the process of this
21 case. There's no ill will between them. But make no mistake
22 about it, Dr. West believed his care was appropriate. You've
23 heard a little bit about the timeline. I'm just going to
24 focus now on the time that he was involved. Because Ms.
25 McGougan had already had her surgery in August.

1 She was hospitalized in September by Dr. Frisch.
2 Dr. Frisch did exactly what you would expect that this spine
3 surgeon to do. He removed an abscess that he saw on -- on
4 the -- the most important thing as far as our case is
5 concerned that he did is he took the fluid out of that
6 abscess and he sent it to a lab. Why did he do that?

7 Number one, you need to know two pieces of patient.
8 The lab gives Dr. West that helps him with his treatment
9 plan. The first thing is, what is the bacteria? Which
10 bacteria are we dealing with that's causing this infection?
11 In this case, that was MRSA, MRSA something Dr. West has
12 treated many times successfully. It was not his first time.

13 The other really important piece of information that
14 the lab gives you is it gives you a list of medications,
15 antibiotics that are affected against that bacteria. Dr.
16 West used that list to treat Ms. McGougan. This case
17 involves allegations of deviation from the standard of care.
18 Dr. West will tell you the medications on that list are
19 exactly what doctors used to treat that bacteria.

20 You've already heard some of the criticisms of Dr. West
21 care should have gotten more, should have got more
22 antibiotics, and should have gotten stronger antibiotics,
23 should have gotten for longer. That's a message that tends
24 to resonate, right, as Americans, we hear that a lot more or
25 is better. Go through your favorite fast food drive through

1 the (inaudible) combo put the offer. You want to supersize
2 that? Four is better. Right?

3 Go to the grocery store to buy your favorite snack or
4 drinks. You buy three, you get one free. Four is better.
5 Use your credit card, spend more money. You get more miles,
6 you get more points. You can get your own cash back. Four
7 is better.

8 A few people (inaudible) this week. It's not medical
9 knowledge, but common sense. Common sense tells you that
10 more is not gold, but more always comes with a cost. It's
11 true in life. It's true in that you get that extra size
12 combo meal, you're going to get more calories than you
13 probably need. You spend that money on the credit card,
14 you're going to have more debt than you probably want.
15 There's always a cost associated with more. And that's
16 exactly the case in Mr. McGougan's case.

17 Dr. West is going to tell you why he chose antibiotics
18 that he chose and it's important for you to know what those
19 are because you're going to hear about them this week. The
20 first drug that was used to treat this bacteria is called
21 vancomycin. It's given through an IV straight into the
22 patient's body. So it gets into their veins and gets to
23 harbor the infection quickly. That medication was ordered by
24 Dr. West. It's the normal standard for treating MRSA. It's
25 given to her twice a day, every day from the day they knew

1 what that bacteria was.

2 They'll tell you he used that treatment many times and
3 it's very effective, but it's also very difficult to manage.
4 And physicians determined that Ms. McGougan was ready to go
5 home on 9/26. Dr. West didn't quit his plan of care at that
6 point. He sent her home with a different antibiotic, one
7 called minocycline and he ordered that prescription to be
8 taken for two weeks, 14 days, two times a day at the highest
9 dose that's available. One milligram.

10 And the reason that you ordered that particular
11 antibiotic is because he knew it was also effective against
12 her rheumatoid arthritis and she wasn't able to take the
13 medications that she normally took to suppress the pain with
14 that. And so there was logic behind exactly what he had
15 done. But also, and even more important is that minocycline
16 is very well known to be reactive to MRSA. It's perfect for
17 the type of infection that she had.

18 So Dr. West knew that prior experience, he didn't go
19 rogue. He didn't choose a medication that wasn't on that
20 list of the lab. He chose one that he used before. One that
21 other infectious disease providers use on a regular basis
22 because that's a standard of care. And that's the kind of
23 care that Dr. West provides to patients.

24 You've already heard reference to experts. None of us
25 practice medicine. None of you practice medicine. So it's

1 hard to know what standard to hold a doctor to. And we're
2 going to bring you an infectious disease expert by Brian
3 Simmons who practiced infectious disease probably even longer
4 than Dr. West. And he practices in Memphis, Tennessee. At
5 one point in his career, he was an investigator for the CDC,
6 but he's very knowledgeable about postsurgical infections and
7 the treatment of them. He's going to come here and testify
8 what he believes the standard of care is and why he believes
9 the care that Dr. West provided the medication's appropriate.

10 You're also going to hear from experts from the other
11 parties and they're going to have different opinions and the
12 law respects that. As Judge Jefferson will tell you at the
13 end of the case when she gives you the law, there are many
14 different ways to treat medical problems. Doctors have to
15 exercise their clinical judgment about what is the best
16 treatment for their patient.

17 Just because they use a different treatment from what
18 another doctor would use, doesn't mean it's wrong, doesn't
19 mean it's outside the standard of care. There's a lot of
20 different options within the standard of care that physicians
21 can use to treat problems. Dr. Simmons is going to tell you
22 that Dr. West chose one of those solutions that is recognized
23 and accepted within their profession.

24 This other expert's going to be critical. Dr. West's
25 care, they're going to tell you, well obviously she had a

1 recurrence of disinfection so the treatment didn't work. As
2 you've heard already that that bacteria went into
3 hibernation. It was a period of time between when Dr. West
4 saw Ms. McGougan in the hospital in September and when she
5 returned the next time to see him in December was 85 days.
6 And during those 85 days with her testimony that not one time
7 did the patient reach out to Dr. West to say she was having a
8 problem, that anything had changed, that the condition was
9 worse, that she was worried she might have another infection.

10 In fact, the evidence is going to show that Ms.
11 McGougan was doing better. She wasn't healed. Most
12 postsurgical patients take a little while to heal, but she
13 was doing the things that her doctors told her to do. She
14 was walking, she was participating in physical therapy, her
15 wound was looking better.

16 None of those things gave her any reason to (inaudible)
17 back request. As you've already heard, she was not supposed
18 to be taking her rheumatoid arthritis medication during that
19 time, but towards the end she had a flare-up and she decided
20 to resume those medications. You're going to hear testimony
21 about what effect that can have on difficult bacteria like
22 the MRSA. So you're going to hear a lot of scientific
23 testimony. This -- you're going to hear from a lot of people
24 that are a lot smarter than me who -- who treat these kinds
25 of infections on a regular basis.

1 I would urge you to use your common sense. Use the
2 things that you do, you deal with daily. When you deal with
3 people who you trust, why do you trust them? Who do you
4 believe is credible? Does this describe the truth or is this
5 just somebody's opinion? Is it supported by the medical
6 literature? These are all things that you can consider as
7 you listen to the evidence in this case.

8 Once you've heard all the evidence, and by the way we
9 go last and so you'll hear from our case at the end of the
10 week and as Mr. Kern suggested, you know it's important to
11 Dr. West that you wait to make any decisions until you've
12 heard all the evidence. Because you have only seen one side
13 of the coin until you've heard it all.

14 So once you've heard all the evidence and you've
15 listened to the testimony of the witnesses, you've heard from
16 Dr. West, you heard from the experts. I'll get one more
17 chance to come back up here and talk to you in closing
18 argument. And I'm going to ask you to return the verdicts.
19 It says, "The care and the treatment that Dr. West provided
20 to Ms. McGougan was appropriate." It's the same care that he
21 provided to hundreds of other patients in treating this
22 difficult bacteria that was well within the standard of care
23 he was not (inaudible). Thank you for your time and
24 attention. Appreciate it.

25 THE COURT: Mr. Luginbill, you may proceed.

1 MR. LUGINBILL: Thank you, your Honor.

2 THE COURT: You're welcome.

3 MR. LUGINBILL: Pursuant to Rule 611. We would call PA
4 (inaudible).

5 MS. FLUMIAN: Aprill.

6 MR. LUGINBILL: Aprill, sorry.

7 THE COURT: Is she present? Yes, ma'am. If you come
8 forward to be sworn.

9 THE CLERK: Please raise your right hand and place your
10 left hand on the Bible.

11 Germaine Ryan Aprill,

12 being duly sworn, testified as follows:

13 THE CLERK: Please be seated. Please state your full
14 name, spelling your last name directly in the microphone.

15 THE WITNESS: Germaine Ryan Aprill, A-P-R-I-L-L.

16 THE COURT: Could you spell your first name as well?

17 THE WITNESS: G-E-R-M-A-I-N-E.

18 THE COURT: Thank you. You may proceed.

19 DIRECT EXAMINATION

20 BY MR. LUGINBILL:

21 Q. My very best (inaudible) this whole case. I hope
22 I have brought myself over after that night because I don't
23 know if we've ever met.

24 A. No, sir.

25 Q. Tell me at Southeastern Spine how things work with

1 PAs and the surgeons in terms of when you're meeting the
2 patients for the very first time. Do you meet them with the
3 surgeon or do you meet them by yourself?

4 A. Every physician probably has a different plan for
5 that. The way that we worked with Dr. Frisch is that a
6 patient would come in for their initial visit. Sometimes he
7 would see the patient from start to finish. Other times one
8 of the PAs would go in and see the patient, do the initial
9 work up, kind of get their history of present illness, which
10 is their story, what's going on, examine the patient and then
11 go out and present that patient to Dr. Frisch.

12 He then would go in, review all the notes that we had
13 put in or the conversation that we had just had. He would
14 review previous notes from their primary care physicians, any
15 kind of studies that they came with, and he would make the
16 diagnosis and the treatment plan for that patient.

17 Q. As PAs, are you able to make a diagnosis?

18 A. Yes.

19 Q. And you're able to order medicines?

20 A. Yes.

21 Q. And if necessary you could call in consult?

22 A. Yes.

23 Q. Do you have to have Dr. Frisch's permission to do
24 any of those things?

25 A. Not his permission, but we do work closely

1 together. PAs practice under a supervising position. So we
2 are part of a medical team.

3 Q. Is it fair to say then that if either you,
4 yourself, or Ms. Buck saw something in the patient and
5 documented that finding in the patient's record, that Dr.
6 Frisch would know that?

7 A. Yes.

8 Q. Now, I may not -- did this yet, but I want to show
9 you what's been marked as Plaintiff's 80 for identification.
10 Do you know who filled that out?

11 A. No.

12 Q. Okay. Are you familiar with the form?

13 A. Can I see it again? No. This might have been
14 something that our surgical scheduler may have had. This is
15 not a form that I would typically fill out the (inaudible)

16 Q. Okay. Do you have an independent recollection of
17 treating Pat?

18 A. Yes, I do.

19 Q. When you first saw her as a patient, do you recall
20 what her complaint was?

21 A. From review of my notes, she had a complaint of
22 lower back pain and leg pain.

23 THE COURT: Could you pull that microphone a little bit
24 closer to you so that your voice isn't muffled and speak
25 directly into it for me. Thank you.

1 THE WITNESS: Is that better?

2 THE COURT: Much better. Thank you.

3 BY MR. LUGINBILL:

4 Q. I'm going to show you what is marked for
5 identification as Plaintiff's 101. Are you familiar with
6 those records?

7 A. Yes.

8 Q. Is that how they're normally kept at Southeastern
9 Spine based on when you were there?

10 A. What do you mean by that?

11 Q. Does that look like a typical Southeastern Spine
12 Surgery Center records?

13 A. Yes, for a follow-up visit.

14 Q. See if the folks over here can help put that up on
15 screen. So you'll sit here and then everybody else will see
16 if that will be an accurate copy.

17 THE COURT: Unless it's been admitted, it is not to be
18 published. Unless you can identify that there's not hearsay
19 subjective (inaudible) in that document. It can't be
20 published.

21 Ladies and gentlemen, I have a brief matter law to take
22 up outside your presence. During the break, please do not
23 discuss the case. And please leave your notepads on the
24 seats.

25 (Jury exits courtroom.)

1 THE COURT: All right. Let me see what it is you're
2 referring to. And I need a list of exhibits. That's the
3 only way the court reporter and I can stay on. That's the
4 only way we can reconcile what's been admitted and what
5 hadn't been admitted. Otherwise it becomes a real random
6 exercise.

7 MS. FLUMIAN: Yeah.

8 THE COURT: Yes, ma'am. Thank you.

9 MS. FLUMIAN: Your Honor, I apologize. This is not
10 filed, but this is the deposition you requested.

11 THE COURT: Thank you. Appreciate it.

12 MS. FLUMIAN: This is our proposed exhibit list.

13 THE COURT: And the court reporter needs one as well.

14 MS. FLUMIAN: Yes, ma'am.

15 THE COURT: But these don't have Number s on them.
16 This isn't --

17 MS. FLUMIAN: Okay. I apologize. What I intended to
18 do, your Honor, is the Number s correlate with what would be
19 in the exhibit Number .

20 THE COURT: Yeah, but he's referring to a 101.

21 MS. FLUMIAN: Yes.

22 THE COURT: And I don't see that on here.

23 MS. FLUMIAN: That is because he has the BATES stamps.
24 These are the prior BATES stamp pages. Yes.

25 THE COURT: Yeah. I need something that's detailed

1 like what Mr. Hood gave me.

2 MS. FLUMIAN: Yes.

3 THE COURT: So that's the only way the court reporter
4 and I are going to be able to keep on track of this Number of
5 exhibits to know what's coming in, and what's not coming in,
6 and what I make rulings about it. Okay. So what is it that
7 you're referring to that you're telling me to be published?

8 MS. FLUMIAN: Just use theirs.

9 THE COURT: And do you all have --

10 MS. FLUMIAN: Just use --

11 THE COURT: -- objection about it. I sort anticipated
12 what was about to happen.

13 MR. HOOD: No, your Honor. He -- Counsel has now
14 showed us what 101 is and it's a note that we -- we do not
15 have an objection to.

16 THE COURT: What is 101?

17 MR. HOOD: It is a -- it looks like a follow-up office
18 visit at Southeastern Spine where Ms. Aprill was the care
19 provider.

20 THE COURT: And was she -- and what is it? Is it what
21 your client reported to her for symptoms or otherwise?

22 MS. FLUMIAN: Yes.

23 THE COURT: Okay. All right. And so what Number
24 exhibit is that going to be?

25 MR. LUGINBILL: I would like the judge, to speed it up

1 and take all of these collectively.

2 THE COURT: You can't do them collectively if you're
3 going to make separate references. They all need separate
4 Number s. That's the only way the record's going to be put.

5 MR. LUGINBILL: They are.

6 THE COURT: Are they separate notes?

7 MR. LUGINBILL: They're separate notes.

8 THE COURT: From separate dates? They each have to
9 have a Number ? So have you showed them all to them?

10 MR. LUGINBILL: Yes, I've shown them all.

11 THE COURT: Okay. How many are there in total?

12 MR. LUGINBILL: Your Honor, (inaudible), I'm going to
13 see.

14 THE COURT: Thank you.

15 MR. LUGINBILL: The co-Counsel advice here.

16 MS. FLUMIAN: Thank you.

17 THE COURT: Okay.

18 MR. LUGINBILL: We could provide the three versions of
19 exhibits to the Defendant they are on the same records.

20 THE COURT: Okay. So what Number s are there? Sir,
21 are you saying you want to use their exhibit? I don't think
22 you're going to be able to do that. Does that make sense
23 what I'm saying? You're going to have to have your own
24 exhibit Number s.

25 MR. LUGINBILL: Okay.

1 THE COURT: Because you can't bring into evidence their
2 exhibits. Does that make sense?

3 MR. LUGINBILL: (Inaudible) I will do one at a time --

4 THE COURT: How many of them are there? And I need to
5 know what Numbers they're going to have? Because the court
6 reporter has to mark them. They have to have Number s. We
7 have to know what we're referring to.

8 MR. LUGINBILL: Okay.

9 THE COURT: Uh-huh.

10 MR. LUGINBILL: So what I will do --

11 THE COURT: I need to know how many you have. First
12 question.

13 MR. LUGINBILL: The short answer is I may not use all
14 of these. I could have as many as 10.

15 THE COURT: I need you to determine how many you got.
16 Because she got be able to mark them. She can't do it ad hoc
17 and sort of mark them as you go along. That's not going to
18 work. You know, she's typing. She has to type and she has
19 to keep an exact record of what's coming in. She has to
20 describe what it is and it has to have a Number . She has to
21 keep a separate record.

22 (Off the record.)

23 MR. LUGINBILL: Sixteen, your Honor.

24 THE COURT: Need to make sure you refer to each
25 individual Number . And you've shown you all have no

1 objection to any of these. Are you seeking to admit these
2 documents? Are you seeking to have her refresh her memory
3 with them?

4 (Off the record.)

5 THE COURT: So those are one through 16. Do you all
6 have any exception to one through 16?

7 MR. HOOD: Defendant Frisch does not have exception to
8 those exhibits.

9 THE COURT: Ma'am?

10 MS. MAPLES: No objections on behalf of Defendant --

11 THE COURT: So can we mark and admit those without
12 objection. Plaintiff's one through 16?

13 MS. MAPLES: Yes, your Honor.

14 MR. HOOD: Yes.

15 THE COURT: Okay. Please bring in the jury.

16 (Jury enters courtroom.)

17 THE BAILIFF: All jurors present, your Honor.

18 THE COURT: Thank you.

19 Ladies and gentlemen, we appreciate your patience.

20 We'll now resume the witness's testimony.

21 You may proceed.

22 MR. LUGINBILL: Thank you, your Honor.

23 THE COURT: You're welcome.

24 BY MR. LUGINBILL:

25 Q. I'm showing you what's been marked Plaintiff's

1 Exhibit 2. This is the encounter date from March 15, 2017 --
2 strike that.

3 I'll show you what's marked Plaintiff 16, which is --
4 you have a complete evidence of 2016.

5 A. Uh-huh.

6 Q. Do you recognize that document?

7 A. Yes, I do.

8 Q. Okay. Am I correct this would be a visit with
9 Ms. McGougan at Southeastern Spine where you as a PA saw her?

10 A. Yes.

11 Q. And these would be your notes; is that right?

12 A. That is my note.

13 Q. All right. Is that on the screen by you?

14 A. Uh-huh.

15 Q. When you come in to see a patient in follow-up, do
16 you go back and look at the prior medical records in the file
17 of that patient?

18 A. Yes.

19 Q. Would you have discussed this patient with Dr.
20 Frisch or PA Buck?

21 A. Maybe not beforehand, but if there was need to
22 afterwards, yes.

23 Q. And when you go back and file ahead of time, I
24 assume you'd want to know what kind of surgery she had,
25 correct?

1 A. Sure.

2 Q. You'd want to know comorbidities or other
3 preexisting problems she may be dealing with, correct?

4 A. Correct.

5 Q. You going know what medication she's on, right?

6 A. Yes.

7 Q. You want to know what -- what her prior surgeries
8 were, correct?

9 A. Correct. Yes.

10 Q. And you did all that from the prior records?

11 A. Yes.

12 Q. So on this date, August 11th, you were seeing her
13 for her initial follow-up following the (inaudible); is that
14 correct?

15 A. No, that is not correct.

16 Q. Okay. On 8/11 -- on August 2017, I have some
17 dates back. You are correct I'll switch back. I -- I'm
18 going to show you Plaintiff's Exhibit 1. This would be the
19 initial encounter that you would've reviewed prior to seeing
20 Ms. McGougan?

21 A. Yes. This looks like her initial first patient
22 visit.

23 Q. Okay. And what's important in that document to
24 you if you're seeing her in terms of what we've documented?

25 A. Everything.

1 Q. Okay. Anything particular that you're looking at?

2 A. You're looking at what she's complained of.

3 You're looking at her past medical history, you review her
4 past surgical history.

5 THE COURT: Any cell phones on they need to be turned
6 off or they'll be taken and not returned.

7 THE WITNESS: Any current medications that she is
8 taking. Any allergies to medications. Does she have any
9 pertinent family history? Her personal and social history
10 that includes alcohol consumption, tobacco use, physical
11 examination. Does she have any weakness on exam? It has her
12 imaging findings from that visit and then has her diagnosis
13 and the treatment plan.

14 BY MR. LUGINBILL:

15 Q. So what you saw for the first time -- what you
16 know is that this patient who has a preexisting condition of
17 rheumatoid arthritis -- rheumatoid arthritis, RA, correct?

18 A. She does.

19 Q. And you would've known that she had had a prior
20 gastric bypass surgery, correct?

21 A. Correct.

22 Q. And you would've known that she had undergone a
23 discectomy and (inaudible), correct?

24 A. No, that's not mentioned in this note.

25 Q. Do you know whether or not she had anything done

1 during the A2 surgery other than disc removal -- or
2 discectomy?

3 A. This notice is from prior to that surgery?

4 Q. Correct. That was planned with discectomy.

5 A. The plan was for her to have a discectomy, yes.

6 Q. Do you know as the (inaudible), have you reviewed
7 the record? Do you know whether or not there was also a
8 laminotomy done as part of that treatment?

9 A. That would be in her post-op -- operative note.

10 Q. Okay. Do you have any dependent knowledge whether
11 that's what happened?

12 A. From this note, no. Because she had not had
13 surgery yet.

14 Q. Do you take a note on it? Did you -- as you said
15 here, know the answer to that question or no?

16 A. Oh, yes.

17 Q. Okay. Did she have a laminotomy?

18 A. I would have to review the operative note. Do you
19 have that?

20 Q. We can get it. I'm going to show you your note.
21 Is that your note?

22 A. Yes, it is.

23 Q. Show that. So now, this patient on 8/16 of 2016
24 is in -- in the office. You are seeing her for the first
25 post-op. And the interest of time fair to say that she looks

1 like it's supposed to look after the surgery and you've got
2 down the wound looks good?

3 A. Yes. Correct.

4 Q. When you did the physical examination, she was
5 wearing the brace that she was supposed to be, correct?

6 A. Correct.

7 Q. All of her strength, all of that was good, no
8 signs of infection, correct?

9 A. Correct.

10 Q. All right. So what you did for her is continue
11 the no bending, no lifting, no twisting, keep the braces on.
12 You want her to walk every day up her tolerance level. He
13 gave her some more pain medication. That was the tramadol,
14 correct?

15 A. Correct.

16 Q. And you gave her a Medrol Dosepak. What is a
17 Medrol Dosepak?

18 A. It's a course of oral steroids.

19 Q. Are steroids a good oral steroids known to have
20 immunosuppressive effects?

21 A. Yes, they can.

22 Q. She's -- also given her a prescription for
23 Neurontin, right? And that's to help with nerve pain?

24 A. I did not give her that prescription. She had
25 that.

1 Q. Okay. Fair enough. And told it would've -- one
2 tablet a day?

3 A. Yes.

4 Q. Anything goes wrong, call you or the office and
5 present as doing well then come back to the office as
6 scheduled forward, correct?

7 A. Correct.

8 MR. LUGINBILL: Your Honor, we have all these, can I
9 just put it in (inaudible) Defendant.

10 THE COURT: I've already admitted them, but it's up to
11 you how you proceed with questioning the witness. You're
12 referring to a document, you're -- referring to this
13 corresponding on them?

14 BY MR. LUGINBILL:

15 Q. I'm showing you Plaintiff's Exhibit 4. Can you
16 see that okay on your screen?

17 A. Yes.

18 Q. I'm -- ask for our time sequence. This is not
19 your note, but you would see her following this submission
20 and you would review this to make your next note; is that
21 fair?

22 A. That's fair.

23 Q. Are you familiar with how PA -- all PAs at
24 Southeastern Spine do their notes and you can read and
25 interpret what they mean, and what they were trying to say?

1 A. I'm not familiar with how everybody does their
2 notes.

3 Q. Did you and Ms. Buck work together for
4 Dr. Frisch's patients pretty consistently?

5 A. Yes, we did.

6 Q. Do you feel like you were able to ask the
7 practitioner who would've seen Pat read this and know what
8 you needed to take away from it?

9 A. Yes. From -- based on what this -- I could tell
10 certain things.

11 Q. All right. And so what this show --

12 THE COURT: Mr. Luginbill, I don't mean to interrupt
13 you, but if you don't speak into that microphone, nothing
14 you're saying is being recorded. You have put it down there
15 it's not wrong, change it. You have to either move the
16 podium or situate yourself. That's where you're comfortable.
17 Thank you.

18 BY MR. LUGINBILL:

19 Q. With packing back to the office, use our -- do
20 pretty well, then began to have left body and lateral thigh
21 pain in last one, correct?

22 A. Per this note, yes.

23 Q. Left buttock lateral thigh that's consistent with
24 something in the L4, L5 nerve (inaudible); is that fair?

25 A. Can you repeat that?

1 Q. Pain in the left buttock and over the lateral
2 thigh would be part of the L4-L5 (inaudible)?

3 A. Part of it, yes.

4 Q. She was now, like, six out of 10 in her pain when
5 she was a one when you saw her; is that correct?

6 A. If I remember from the previous note, yes.

7 Q. One through six in pain in two weeks; is that
8 fair?

9 A. According to this note, yes.

10 Q. Now, as a PA in a surgical practice, increasing
11 pain or pain that you are not expecting is clinically
12 important, correct?

13 A. Yes.

14 Q. And it can be a lot of things. It's not
15 definitive about any one thing that's causing pain, but it's
16 sort of an indicator that you need to go look, correct?

17 A. Yes.

18 Q. One of the things that you need to look for would
19 be infection?

20 A. Yes.

21 Q. She also has a wound that has opened and started
22 draining, correct?

23 A. Yes.

24 Q. You just -- it was described by (inaudible)
25 serosanguineous. Now it's fair to say that every

1 practitioner has a slightly different definition of what they
2 mean by serosanguineous, but it's not cause, it's not the
3 thick heavy stuff. It is not completely clear. It's
4 something in between?

5 A. I would not say that there's a difference in
6 serosanguineous. Serosanguineous is serosanguineous
7 drainage.

8 Q. Can -- serosanguineous drainage of blood?

9 A. Yes.

10 Q. Can it have the fibrous pourings of the beginning
11 of infection?

12 A. No.

13 Q. And it exudate?

14 A. No.

15 Q. So it's either blood or that's what makes it
16 serosanguineous?

17 A. It's serous fluid combined with blood.

18 Q. So I want to make sure I'm clear that it's your
19 testimony that it cannot have any signs of infection and
20 still be called serosanguineous?

21 A. You would -- I -- I don't know that.

22 Q. If the fluid then has indication of infection, if
23 it's cloudy, but not blood. Is that a symptom of infection?

24 A. Purulent drainage would be a sign of infection.

25 Q. I understand that's the (inaudible). So isn't --

1 are you saying then that is drainage that you're seeing isn't
2 reddish with blood, but is more yellowish to greenish.
3 That's purulent and not serosanguineous?

4 A. Yellowish to greenish would probably look like
5 pus, yes.

6 Q. Okay. At this time she hadn't developed any fever
7 or chills and she had finished taking her postoperative
8 antibiotics and she finished the Medrol Dosepak that you gave
9 her. Is it concerning to you as a PA if you had seen this
10 patient two weeks after you gave her a Medrol Dosepak that
11 her pain went up instead of down?

12 MR. HOOD: Objection, your Honor, I think the --

13 THE COURT: Basis?

14 MR. HOOD: Misstates the evidence.

15 THE COURT: Rephrase the question, please.

16 BY MR. LUGINBILL:

17 Q. If you had seen Ms. McGougan on 8/23 rather than
18 (inaudible), you saw the exact same thing, would it be
19 concerning to you that that patient you saw two weeks earlier
20 who had a one in the pain scale and who you had given
21 steroids to decrease inflammation was now at six?

22 MR. HOOD: Same.

23 THE COURT: Basis?

24 MR. HOOD: Misstates the evidence that --

25 THE COURT: Please rephrase the question.

1 MR. LUGINBILL: Okay.

2 THE COURT: Make sure you're within what is accurately
3 reflected in the records and with what is within the ambit of
4 her function as a physician's assistant. She's not an expert
5 witness.

6 BY MR. LUGINBILL:

7 Q. Part of your role when you're seeing patients
8 involved, whether you or Ms. Buck, is to look at them and be
9 the eyes and ears of the surgeon to help diagnose if there's
10 any problems post surgery; is that fair?

11 A. Yes.

12 Q. So when you're evaluating a patient that's in your
13 office, you -- you look for signs and symptoms of potential
14 bugs, correct?

15 A. Yes.

16 Q. Would the fact that her pain had gone from a one
17 to a six after she completed a Medrol Dosepak, would that be
18 a concerning sign?

19 A. Not necessarily concerning, but warranting
20 investigation.

21 Q. When you gave the Dosepak, it was to reduce the
22 inflammation for that?

23 A. Yes. She was having pain at nighttime.

24 Q. And you know that one of the side effects from
25 potential side effects of that medication is suppression of

1 her immune system, correct?

2 A. Yes.

3 Q. And you knew she was an RA patient and you know
4 that she wasn't taking her RA meds, just being an RA patient
5 also makes her slightly immune suppressing, correct?

6 A. Correct.

7 Q. So you're looking at an RA patient, now two things
8 that are potentially suppressing her immune system and her
9 wound has opened on this day, correct?

10 A. It does not say that her wound is open.

11 THE COURT: Is this a good place for you to stop
12 Mr. Luginbill?

13 MR. LUGINBILL: Yes, ma'am.

14 THE COURT: Ladies and gentlemen, we're going to take
15 advantage of this break and testimony to take our evening
16 recess. During the break, please do not discuss the case
17 among yourselves or with anyone else. Please leave your
18 notepads on your seats, we'll secure them during the break.
19 We'll resume in the morning at 9:30.

20 You'll come directly to your jury room. Please don't
21 have any contact with anyone in or about the courthouse.
22 Again, we would not want an innocent conversation to be
23 observed and misinterpreted. This is a regular Monday for
24 us. I know this is a different experience for you all and
25 now it's probably been taxing. I hope you all have a

1 wonderful and restful evening.

2 And again, we will resume in the morning at 9:30 and
3 I'm sure the bailiffs have given you all instructions about
4 where you are to park tomorrow. I think we'll be parking
5 next door, not down the street. So they'll give you some
6 instructions regarding that. Have a great evening. See you
7 in the morning at 9:30.

8 (Jury exits courtroom.)

9 THE COURT: Okay. Ma'am, you're excused for the day.
10 Subject to being recalled. I'll remind you're still under
11 oath and please don't discuss your testimony with anyone
12 during the break.

13 MS. Aprill: Yes, ma'am.

14 THE COURT: Thank you.

15 MR. LUGINBILL: Your Honor.

16 THE COURT: Yes, sir.

17 MR. LUGINBILL: On that point of her being recalled,
18 Mr. Hood and I were discussing earlier, she has to be in
19 surgery tomorrow. I do not want to mess that up at all.

20 THE COURT: Uh-huh. Which sort of calls into the
21 wisdom of starting her right now instead of someone else,
22 right?

23 MR. LUGINBILL: Well, yes, ma'am.

24 THE COURT: Uh-huh.

25 MR. LUGINBILL: But that was the witness that we had.

1 THE COURT: Okay.

2 MR. LUGINBILL: Our intent is to call the experts
3 tomorrow morning and not respondent.

4 THE COURT: Okay.

5 MR. LUGINBILL: Or let me say, do I have the Court's
6 permission to do that?

7 THE COURT: I -- I -- as long as they -- I -- I don't
8 have a dog in the fight. Do you all have any exception? I
9 would assume you all want to accommodate -- assist him in
10 accommodating your witness in being present for the surgeries
11 that have been scheduled.

12 MR. HOOD: Yes, Your Honor. On behalf of Dr. Frisch
13 and Southeastern Spine, we have no objection and our
14 intention is to call her in our case-in-chief which she's
15 scheduled to be here Thursday for the day to accommodate that
16 so --

17 THE COURT: So maybe I'll need to talk to Mike.

18 MR. HOOD: But we have no problem with this plan for
19 tomorrow.

20 THE COURT: Yeah. In terms --

21 MR. HOOD: Moving experts.

22 THE COURT: Is that acceptable?

23 MS. MAPLES: Yes.

24 THE COURT: Okay. Perfect. All right. Now tomorrow
25 I'm going to need a list of witnesses, I mean it's exhibits.

1 MS. MAPLES: Yes, ma'am.

2 THE COURT: And I'm going to tell you what the method
3 is to it. The court reporter and I -- I literally -- I -- I
4 document the exhibits, who they came in through, whether they
5 were in exceptions, the time they came in and the day.
6 That's the only way she and I can reconcile exactly what we
7 have. Because she has to do a detailed list that is a part
8 of the court file that goes into a whole locked room that
9 documents everything. And the only way we can follow that
10 and keep everybody on the same page is if we have that.

11 So if you all could accommodate us and prepare that, I
12 greatly appreciate it. And it should be similar to what the
13 Defendants have provided to the Court.

14 MS. MAPLES: Yes, your Honor.

15 THE COURT: In the same format. It just keeps us --

16 MS. MAPLES: Yes, your Honor.

17 THE COURT: -- all in it. And if you have any
18 documents that have been admitted, I need you to leave them.

19 Ma'am, you can go on and enjoy your day. They'll let
20 you know when they need you back.

21 I need you all to give those to the court reporter. So
22 -- because she has to document with the clerk every day, all
23 of the exhibits.

24 MS. MAPLES: Yes, your Honor.

25 THE COURT: All right. Is there anything else we need

1 to take up before we adjourn for the day?

2 From the Plaintiff?

3 MR. LUGINBILL: No, ma'am.

4 THE COURT: From the Defense?

5 MR. HOOD: No, Your Honor.

6 THE COURT: All right. Guys, you all have a good
7 evening. See you at 9:30. You can leave anything in this
8 courtroom you'd like to see as you exit it will be locked.

9 (THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 5:07

10 PM)

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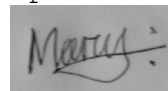
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CERTIFICATE OF TRANSCRIBER

I, MARY RAGSDALE, a court-approved transcriber, 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 of the captioned case, relative to appeal, in the South Carolina Circuit Court of Charleston County, South Carolina, on the September 9, 2024.

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

September 9, 2024

A rectangular stamp containing a handwritten signature in dark ink. The signature appears to be 'Mary' followed by a flourish and a colon.

MARY RAGSDALE

Transcriber

1

2

3 CONTINUATION OF PROCEEDINGS - SEPTEMBER 10, 2024.

4 THE COURT: Good morning. You may be seated. All
5 right. Do we have that witness list -- I mean exhibit list.
6 I was going to say witness list.

7 MS. FLUMIAN, do you all have your exhibit list?

8 MS. FLUMIAN: Yes, ma'am.

9 THE COURT: Have you all had a chance to talk about
10 exhibits?

11 MS. FLUMIAN: We've provided them digitally, your
12 Honor, as well as hard copies today to opposing Counsel, but
13 we've had no conversation.

14 THE COURT: Okay. Yes, sir.

15 MR. HOOD: This is the same one from yesterday.
16 There're just a couple --

17 THE COURT: It's just an update. Thank you. Do you
18 all have one for the court reporter as well?

19 MR. HOOD: We do.

20 THE COURT: Thank you. I appreciate it.

21 MS. FLUMIAN: Your Honor, would you like me to call
22 (inaudible)?

23 THE COURT: Court reporter needs a copy. Yes, ma'am.
24 Thank you.

25 All right. Is there anything before we proceed? From

1 Plaintiff?

2 MR. LUGINBILL: No, ma'am.

3 THE COURT: From the Defense?

4 MR. HOOD: No, your Honor.

5 THE COURT: Who's your first witness?

6 MR. LUGINBILL: Plaintiff will be calling Dr. Davne.

7 THE COURT: Is he present?

8 MR. LUGINBILL: He is.

9 THE COURT: Okay. If you can go ahead and come to the
10 stand, you go ahead and get the jury to come in. And just a
11 reminder, if you all could speak loudly and clearly we're on
12 the digital system. If you don't speak into that microphone,
13 it is highly likely that anything you say will not be
14 recorded.

15 And also if you ask to approach the bench and I say no,
16 don't take it personal, I have no way of recording anything
17 you say. And so I figured better safe than sorry, I'll just
18 send the jury out and we'll have the discussion unless it's
19 something like the restroom or something.

20 While we're waiting on the jury, what -- what are those
21 Number s?

22 MR. LUGINBILL: So one through 16 and 17 to 143.

23 (Jury enters courtroom.)

24 THE COURT: Excuse me. You all had an opportunity to
25 review that? Maybe not?

1 MS. FLUMIAN: Briefly.

2 THE COURT: I'm sorry ladies and gentlemen, bear with
3 me one moment.

4 (Bench conference.)

5 THE COURT: Madam Court Reporter for Plaintiff's 17
6 through 124 is admitted without objection. And 131 through
7 143 is admitted without objection. All right. Swear the in
8 witness please.

9 (Plaintiff's Exhibit 17 through 124 and 131 through 143
10 admitted into evidence.)

11 THE CLERK: Please raise your right hand, place your
12 left hand on the Bible.

13 STANFORD H. DAVNE,

14 being duly sworn, testified as follows:

15 THE CLERK: Please be seated. Please state your full
16 name, spelling your last name directly in the microphone.

17 THE WITNESS: Stanford Davne, D-A-V-N-E.

18 THE COURT: Do you have a middle initial, sir?

19 MR. LUGINBILL: Do you have a middle initial?

20 THE WITNESS: I do. H.

21 THE COURT: Thank you. You may proceed.

22 DIRECT EXAMINATION

23 BY MR. LUGINBILL:

24 Q. Good morning, Dr. Davne.

25 A. Good morning.

1 Q. If you would please tell the jury a little bit
2 about your education that led up in the medical school.

3 A. Yes. Well, I graduated from La Salle College,
4 which is in Philadelphia in 1970. After that I obtained a --
5 I initially didn't get into medical school at that time, and
6 I obtained a master's degree in pharmacology at Hahnemann
7 Medical College in Philadelphia. It's a research science of
8 pharmacology.

9 And then I started medical school in -- at the
10 University of Guadalajara in Mexico in 1972. And I then
11 completed part one of the National Board of Medical
12 Examination, which is what you take after two years of
13 medical school here in the United States. And I got high
14 marks on that and I transferred back to Temple University
15 School of Medicine, also in Philadelphia.

16 When that was completed, medical school was completed
17 in 1976. I obtained a first year general surgical residency
18 and four-year orthopedic residency at Thomas Jefferson
19 University Hospital, also in Philadelphia. Jefferson is a
20 very large medical university.

21 And when that was completed in 1981, I obtained a
22 fellowship in spinal cord injury surgery at Northwestern
23 Memorial Hospital in Chicago. When that was completed, I
24 came back to begin practice at Thomas Jefferson University
25 Hospital in 1982.

1 Q. Just can -- just for purposes of the jury may I
2 know, what is they residency? What does that mean?

3 A. Well, residency -- so after medical school, you've
4 had a lot of basic knowledge and some clinical knowledge you
5 have to have before you can even be licensed, at least one
6 year of residency. It used to be called an internship, but
7 it's just a residency and you learn in -- in that case
8 general surgery and then a four year residency in orthopedic
9 surgery. So you learn all aspects of orthopedic surgery, how
10 to treat all types of orthopedic problems. And then after
11 that is a fellowship in spinal. In this case it was spinal
12 cord injury surgery.

13 And I also did spine surgery at the same time. So
14 Thomas Jefferson University Hospitals, one of the regional
15 spinal cord injury centers in the United States. Mass
16 General, NYU Jefferson, Johns Hopkins, Emory, Grady, Emory in
17 Atlanta, University of Miami, there's 18 of them. So I knew
18 I was coming back to Jefferson and I wanted that fellowship
19 to -- to learn how to treat spinal cord injury patients. And
20 then I started practice in 1982 at Jefferson.

21 Q. Were you directly employed by the hospital or did
22 you have a practice with other doctors?

23 A. I was in private practice initially just by
24 myself. And eventually, a few years later my partner was a
25 neurosurgeon and we practiced together.

1 Q. Now, when did you stop doing active surgery?

2 A. I stopped doing active surgery in 1998.

3 Q. Did you stay in the field of spinal surgery?

4 A. Yes, I did. I took four years off. So by way of
5 explanation, I was 50 years old in 1998, but I had previously
6 had multiple myeloma and I was satisfactorily in remission
7 and healthy. But at age 50, I decided to take it a little
8 easier, so to speak, "Smell the roses", if you would. And I
9 gave up the clinical practice of orthopedic surgery.

10 I was restoring an old house in -- in Pennsylvania.
11 And I got bored after four years and so I decided to come
12 back into practice and I didn't want to return to the
13 operating room and the stress of that. So I practiced
14 nonoperative orthopedic surgery.

15 And then I returned eventually to another university
16 hospital, a Cooper University Hospital, which is in Camden,
17 New Jersey, right across the Delaware River from
18 Philadelphia. And I practice there nonoperatively, again,
19 seeing patients part time one to three days a week. And then
20 in 19 -- in 2021 I retired. So I -- I continued to do some
21 of this type of work which I had done in the past, which is
22 expert testimony and providing expert opinions, but I'm no
23 longer clinically practicing. I'm -- I'm 75.

24 Q. So Doctor, a little back, once you started the
25 private practice did you become board-certified?

1 A. Yes. So in order to take your board examination,
2 you -- at the -- that time you had to be in private practice
3 for two years after completing your fellowship, and then you
4 could sit at that time for both a written and oral
5 examination. And I passed that the first time that I took
6 that and -- when I was first eligible in 1984. And I've
7 continued to be board-certified since that time.

8 Q. Are you board-certified now?

9 A. Yes, I am. So at that time in 1984, board
10 certification was for life. Subsequently, a few years later,
11 they changed it to every 10 years. So you had to sit for a
12 reexamination every 10 years, but my board examination in
13 1984 was for life.

14 Q. Okay. And what active licenses do you currently
15 hold?

16 A. I have an active license in Pennsylvania. I have
17 an inactive license in New Jersey.

18 Q. I guess you should clarify. What do you -- what
19 do you hold board and what -- what does, "hold board" mean?

20 A. I'm boarded in orthopedic surgery.

21 Q. Now, at some point were you teaching residents as
22 well?

23 A. Yes, during the entire time at Jefferson, I taught
24 both orthopedic residents, neurosurgical residents, and
25 medical students. Subsequently, when I was at Cooper, I also

1 taught -- although I wasn't in the operating room at that
2 time, I also taught and attended grand rounds and taught
3 residents and medical students. But at Jefferson it was, you
4 would have residents that would make rounds with you, seeing
5 patients going to the operating room with you. And also I --
6 I would give lectures to the residents and to the students.

7 Q. Doctor, when you were -- as part of your teaching
8 duty, what did you do to stay current in the field of
9 orthopedic surgery?

10 A. Well, I attended various meetings and I also
11 lectured. I -- I gave various lectures around various
12 meetings, the American Academy of Orthopedic Surgeons and
13 other organizations. And I published and I was fortunate
14 enough to be a guest surgeon outside the United States. I --
15 I had the opportunity to be a guest surgeon in Japan and
16 Italy and France. So I -- I was pretty -- I was a very busy
17 spine surgeon back in that time period.

18 Q. Fair to say that keeping up with the journals and
19 all of that is part and parcel to meeting your yearly
20 requirements and staying certified?

21 A. Yes, of course you have a requirement, but I far
22 exceeded the -- the basic requirement was 100 hours, I think
23 of particular what they call, "Type one credits." And I did
24 that, but I was very active reading and attending meetings
25 and giving lectures.

1 Q. Was your literature review really different after
2 surgery than it was before?

3 A. No, it was the same. I kept current with the
4 literature.

5 Q. You were doing grand rounds and things like that.
6 Did that bring you into discussions with colleagues who are
7 actively concerned?

8 A. Yes. So grand rounds is what we would do once a
9 week, whether it be Jefferson or Cooper. And you would --
10 there would be various types of problems and cases presented
11 to discuss the management of patients. And then usually once
12 a month there was something called mortality and morbidity
13 conference where you discussed serious problems that had
14 occurred with patients. And so, I attended those meetings
15 and participated in those regarding the management of
16 patients.

17 MR. LUGINBILL: Your Honor, just want to offer
18 Dr. Davne as an expert in the field of orthopaedic surgery.

19 THE COURT: Any questions or objections?

20 MR. HOOD: No questions at this time, your Honor.

21 MR. SMYTH: Nothing, your Honor.

22 THE COURT: So admitted without objection.

23 You may proceed.

24 BY MR. LUGINBILL:

25 Q. Doctor, you're now -- since you've qualified as an

1 expert -- allowed to give opinions in the field orthopedic
2 surgery. Will all of your opinions today be true within a
3 reasonable degree of medical certainty?

4 A. Yes.

5 Q. And does that reasonable degree of medical
6 certainty acknowledge that nothing in medicine, they're very
7 detailed in medicine that 100 percent certain?

8 A. That's correct.

9 Q. And so when we say reasonable degree, probably
10 true, it's more likely than not?

11 A. That's correct. More likely than not.

12 Q. You mentioned that you've been doing expert work.
13 Just in general, what do you charge for coming here today?

14 A. My fee for trial testimony is \$10,000.

15 Q. And when did you leave home to come here?

16 A. I'm sorry.

17 Q. When did you leave home to come here and be with
18 us?

19 A. I left home yesterday 12:30.

20 Q. And will you get home tonight sometime?

21 A. Sometime this evening. Yes. That's okay.

22 Q. Why do you still do expert work?

23 A. Well, I -- I find it interesting and I believe
24 that it's helpful for people to get opinions from -- from --
25 from physicians like myself who have a lot of experience and

1 have done a -- a -- treated a lot of patients. And so I was
2 basically, for example, I was the first fellowship trained
3 spine surgeon in Philadelphia. So spine surgery is a new
4 area within -- within orthopedic surgery. And if you go back
5 to 1981, when I completed my residency and took my fellowship
6 there were really very few people that were specifically
7 trained in spinal surgery. So I have this vast experience
8 starting early on in spine surgery.

9 Q. Did you always testify for Plaintiffs?

10 A. No. Although in these medical negligence cases,
11 most of my testimony has been on behalf of the patient, but I
12 have testified and I have reviewed matters on behalf of the
13 doctors.

14 Q. When you're reviewing a case, how do you ensure
15 that the bias of knowing something bad has already happened,
16 how do you ensure that doesn't leak into your analysis?

17 A. Well, you know, you're -- you're always looking
18 retrospectively, so you have that -- that advantage of
19 everything has happened over a long period of time, and now
20 you have to look at the records and you have to look at the
21 records objectively, whether it be on behalf of the patient
22 or on behalf of the doctor. And there are many cases that I
23 have felt that were not meritorious, so to speak, and that I
24 -- I didn't agree to offer an opinion about them. So I only
25 -- although I've been asked to review many cases, I don't

1 have many that I actually choose.

2 Q. Now, in this case particular, what have you
3 reviewed?

4 A. Well, I reviewed a lot of medical records, the
5 office and hospital records regarding her care and treatment,
6 and multiple deposition testimonies, and her subsequent
7 medical care. So there -- there have been a lot of medical
8 records that I did review and -- and imaging studies. I
9 reviewed MRI scans.

10 Q. Specifically, have you reviewed the records from
11 Southeastern Spine?

12 A. Yes, I did. I reviewed those records.

13 Q. Have you reviewed the inpatient records from East
14 Cooper Medical Center?

15 A. I did.

16 Q. Have you seen her PCP records from Dr. Harkins?

17 A. From who?

18 Q. Dr. Harkins?

19 A. Yeah. The primary care doctor, yes.

20 Q. Okay. And have you reviewed any of the due
21 orthopedic records?

22 A. Yes, I reviewed. I think that was Dr. Annie who
23 subsequently treated her.

24 Q. In general, every surgery has risks; is that fair?

25 A. That's correct.

1 Q. What are the big risks that you're worried about
2 in a spine surgery?

3 A. Well, the way I would explain it to patients is
4 there are different categories of risks. There's certainly
5 the risk of any major operation, loss of life, pulmonary
6 embolism, stroke, infection. These are normal risks that --
7 that everybody faces when they undergo a major operation.
8 And then there are risks that are specific to spinal surgery:
9 paralysis, nerve injury.

10 And then -- then there are another associated group of
11 risks that relate to when we use an orthopedic implant
12 screws, or rods, or plates or whatever we're implanting, they
13 have a separate set of risks. So although that isn't
14 pertinent in this case, those are the types of risks that you
15 explain to a patient that's going to undergo surgery.

16 Q. If you're confronted that of a situation where
17 there are some unusually high risk or unusual risks, patients
18 still benefit from the surgery, how does the surgeon go about
19 weighing risks with benefits?

20 A. Well -- well, that's exactly what you have to do.
21 You have to weigh the risks and the benefits. So sometimes
22 the risks outweigh the benefits: Somebody's too ill, too sick
23 to undergo a surgical procedure. And I mean, in spine
24 surgery a lot of people are older because you have
25 degenerative changes that occur in the spine over a long

1 period of time. So sometimes in elderly people, we have to
2 be very careful because they -- it's -- they have much
3 greater risk. They do not have the capacity to withstand
4 complications. A younger, healthier 20, 30, 40-year-old
5 person can withstand these risks and complications in a much
6 different way. So you have to balance what you're going to
7 do to a patient with the benefit that they're going to gain.
8 And sometimes you say, "No, it's too risky."

9 Q. Can a surgeon ever subject a patient to a -- a
10 risk that is unnecessary or that is just so outweighed by the
11 benefit that you so off weight by the risk that you
12 personally would not do?

13 A. Yes, that -- that oftentimes is the case, and
14 sometimes you just have to tell the patient that -- sometimes
15 patients actually come in and say, "I want surgery to fix
16 this problem." And maybe the benefit of doing surgery isn't
17 as good as it would be. So sometimes you have to say, no, I
18 won't do this surgery because the benefits are not as great
19 as the risks. And sometimes the risk with some patients that
20 have pulmonary disease or -- or they're just too great to
21 operate.

22 Q. Whose responsibility is it to make sure that
23 patient is aware of both the risks and the benefit of doing
24 the surgery?

25 A. It -- it's the physician that's going to operate

1 on the patient. It's your responsibility to explain those
2 risks and complications to the patient and the benefits, risk
3 benefits, and complications.

4 Q. All right. So turning to Ms. McGougan's case,
5 what's your understanding of what brought her into
6 Southeastern Spine to be seen by Dr. Frisch?

7 A. I -- if I recall correctly, she was lifting
8 something groceries or something like that and she developed
9 back and leg pain. And the MRI showed that there was a disc
10 herniation and the decision was made to perform what we call
11 a microdiscectomy or a limited incision, take out the disc
12 herniation, and try to take the pressure off of the nerve.

13 Q. Was there any imaging done as part of the process?

14 A. Yes, there was an MRI scan done in -- in -- in
15 July of 2016.

16 Q. And what did that MRI show?

17 A. It showed a disc herniation at the L4-5 level,
18 more towards the left side.

19 Q. In the simplest terms, what is a disc herniation?

20 A. So the vertebrae in your back which come from the
21 neck, the cervical and the thoracic, and then in the lumbar
22 are separated by the intervertebral discs. We just commonly
23 call them discs. And so these discs are sort of the shock
24 absorbers and they allow flexibility. If it was one solid
25 bone every time you step on something, it -- it would be a

1 shock wave of going up to your brain.

2 So in a sense, this allows flexibility and shock
3 absorbers to allow you to move. So the discs are part of, at
4 every level in the spine, in the cervical, thoracic, and
5 lumbar spine.

6 So there are seven cervical -- cervical vertebrae, 12
7 thoracic vertebrae, which support the rib cage and five
8 lumbar vertebrae. And they're attached to the sacrum, which
9 is attached to the pelvis. And the sacrum has sort of
10 vertebra also, although they're -- they're semi fused
11 together.

12 Q. Okay. There (inaudible) the July of 2016 for
13 itself. I want to make sure I refer to it correctly. So
14 this would be Plaintiff's 131. And, Doctor, probably the
15 easiest -- if you can just -- to turn around and have a look
16 at it that way. Can you show us where the L4 L5 disc is?

17 THE COURT: He can do that on that monitor.

18 MR. LUGINBILL: Okay.

19 THE COURT: You'll be able to hear him.

20 THE WITNESS: Oh, great.

21 THE COURT: He can draw on it. So you can draw
22 directly on that monitor.

23 THE WITNESS: Just pointing to it?

24 THE COURT: You can draw right on it.

25 THE WITNESS: Oh, okay.

1 THE COURT: Uh-huh. Yes, sir.

2 THE WITNESS: So this is the sacrum. Okay? And then
3 this becomes L5 and L4 and L3 and L2 and L1. And what you
4 see dark in between are intervertebral discs. So a disc has
5 two Number s, the vertebrae above and the vertebrae below.
6 So each disc in this case, this is the L5-S1 disc, this one.
7 And this is the L4-5 disc. Now here the white is cerebral
8 spinal fluid, that which bathes the spinal cord. And then
9 the spinal cord ends up here at L1, 5, 4, 3, 2, 1. And this
10 is the spinal cord up here.

11 And it comes to an -- an end and it's called the cauda
12 equina, which are the bundle of nerves. And cauda equina
13 means the horse's tail. Because they're -- that's what it's
14 like. And it's bathed. The -- the white is a cerebral
15 spinal filling. So those nodes come down. Now, here at L4-
16 5, you can see that disc is bulging back on this particular
17 image. And that's a --

18 Q. Doctor, again, I -- I (inaudible) it a little hard
19 to kind of dark on that?

20 A. Yeah, that's -- that's very dark. My --

21 Q. You have to explain to the jury if you had an
22 exhibit or demonstrative that was clarified a little bit.

23 A. Yes.

24 MR. LUGINBILL: Your Honor, permission? I'd like to
25 show a colorized image of this slide, as a demonstrative it

1 is not being admitted into evidence. It's just
2 demonstrative.

3 THE COURT: Any exception?

4 MR. HOOD: Not for demonstrative use, your Honor.

5 MR. SMYTH: No exception, your Honor.

6 THE COURT: You may proceed.

7 THE WITNESS: So again, the -- the vertebrae are Number
8 ed here. You can see L5 and S1, and then L4. So it's the
9 L4-5 disc. And the artist has colorized and shown the disc
10 which is pushed back. Sometimes people call it, "A slipped-
11 disc." That's not a typical doctor's term. We call it,
12 "Herniated disc." Okay. Sometimes it's a protruding disc.
13 But the -- the bottom line about the disc is it's pushed back
14 and putting pressure on the nerve. And typically you may
15 hear people refer to that as sciatica, which is the pain that
16 goes down your leg.

17 So this is another complicated point when people
18 complain that they have leg pain or sciatic pain -- pain is
19 not really in their leg. So from the time you're born, you
20 -- the brain learns where the nerves go. So the brain has
21 learned that if you step on something hot, that -- that's a
22 particular nerve path that's coming up from your foot up
23 through your leg into the spinal cord and up to the brain.

24 Now, it -- it's instantaneous. Because there's a step
25 on something hot. Your brain says pick your foot up. So it

1 instantaneously sends a signal back down through the spinal
2 cord to move your foot.

3 So when people experience sciatic pain, the pain is not
4 in the leg. They feel it as though it's in the leg, but it's
5 that nerve that's being tweaked in their spine. So the
6 spine, you're tweaking the same nerve the brain has learned
7 since birth, that that one goes to your leg. And so there's
8 really nothing wrong with your leg, it's all coming from the
9 disc herniation in your spine.

10 BY MR. LUGINBILL:

11 Q. Based on what you see here, was she an appropriate
12 candidate?

13 A. Yes.

14 Q. Roughly a candidate. What would she be a
15 candidate for?

16 A. Exactly what was done a microdiscectomy a limited
17 incision. Some, I did it under a microscope. Other doctors
18 do it with loops. Sometimes doctors do it with the naked eye
19 limited incision removing that -- that portion of the disc.

20 Q. Compared to other types of spinal surgery. How
21 invasive is a microdiscectomy?

22 A. Well, they're all invasive when you're getting
23 down that far into the disc, but it's not as much dissection
24 or moving muscle as it would be if you were doing a large
25 instrumented spinal fusion where you're putting in screws and

1 rods. That's a much different, more involved -- longer
2 procedure that requires a lot more dissection. So here the
3 concept is to try to do it as minimally invasive as you can
4 to take -- to not disrupt as much muscle tissue. And that's
5 what was done here.

6 Q. How big of an incision are we talking about?

7 A. Well, generally an inch. Sometimes it's -- the
8 lengths I always explain to residents. It's not exactly the
9 lengths of the incision that's what's most important is
10 because it -- it will heal, but making sure you get to the
11 right spot.

12 Q. And so if you can't just -- using this model,
13 where would the incision go? And then what would be the path
14 that the surgery would take to get to the disc?

15 A. So the incision would go right here -- excuse me,
16 this is a (inaudible) back here white, but the incision would
17 be in this area. And then you go through, so water or shows
18 up as white on some of these images, the -- the MRI images
19 and so the cerebral spinal fluid here can show up as white.
20 It's been colorized, but here it's white and here it's white
21 and that means there's more water content in -- in the -- in
22 the tissues.

23 Q. Then once you get through the -- the fatty tissue
24 and the muscles, did you see what you -- how did you get to
25 the disc itself?

1 A. Well, to get to the disc itself, when you come
2 down through the tissues again in a small incision and you
3 come down onto the bone, the lamina of the spine. Lamina
4 means roof in Latin. And you come down onto the lamina and
5 then you have to almost always remove a small portion of the
6 lamina so you can see where you're working and you have to
7 pull the nerve aside a little bit in order to get to the disc
8 and remove the disc. So you're handling the nerve at the
9 same time you're doing the surgery.

10 MS. FLUMIAN: Do you want him to read or you want
11 (inaudible)?

12 MR. LUGINBILL: (Inaudible).

13 THE COURT: He can just go over to the side, sir, and
14 just swipe. And there's a place for you to just hit "clear"
15 on that monitor.

16 MR. LUGINBILL: On -- on your monitor, do you see
17 (crosstalk) over here on the right?

18 THE COURT: Yeah. Just hit the top and it'll come up
19 and then you just hit "clear".

20 THE WITNESS: Oh, okay. Thank you.

21 THE COURT: You're welcome.

22 BY MR. LUGINBILL:

23 Q. Thank you. What does the surgeon need to do in
24 preparing you for these surgeries to manage the known risk of
25 infection?

1 A. Well, for different types of surgery, you give
2 what we call prophylactic antibiotics. So that's to prevent
3 against infection. And in spine surgery, it's the norm to
4 protect against infection. And at a minimum what's
5 recommended is to give a dose of an intravenous antibiotic
6 right before the surgery stops. And in a longer surgery,
7 sometimes after a few hours a second dose. And then
8 postoperatively, depending on the circumstances and the type
9 of surgery, you may also give intravenous and oral -- and/or
10 oral antibiotics during a period of time.

11 So it depends on the circumstance for how much longer.
12 But the basic requirement is at a minimum to give an
13 intravenous dose of antibiotics when the anesthesiologist is
14 putting the patient to sleep. So before you make your
15 incision, that antibiotic has had a half an hour to circulate
16 and make sure that you have high levels of antibiotics to
17 protect against infection.

18 So it is unfortunately a problem that patients get
19 infected in the operating room, even though we're very
20 careful and you provide careful draping and all the
21 instruments are sterilized. Bacteria are not only floating
22 around in the air, but they're on the patient's skin. Okay.
23 So it -- you -- you scrub the skin real well, but you can't
24 remove all bacteria. So that's why we give a dose of
25 antibiotic right before this incision.

1 Q. Now, doctor, in your review of the records, do you
2 have any critiques at all of how the surgery was performed?

3 A. No, it was fine. There's no -- everything was
4 done right at that point in time.

5 Q. Any criticisms at all of Dr. Frisch's immediate
6 postoperative antibiotic choice?

7 A. No, postoperatively she was prescribed one week of
8 doxycycline, which is a tetracycline antibiotic to take. And
9 that was appropriate. That was fine.

10 Q. Is tetracycline -- that group, is that considered
11 a broad-spectrum?

12 A. It is.

13 Q. We want to turn now to just a couple of things
14 that may affect how a surgeon goes about treating this
15 particular patient, Pat. How would a surgeon have to factor
16 in her RA positive status?

17 A. So she's got rheumatoid arthritis and had been
18 treated for -- with immunosuppressant drugs. So
19 immunosuppressants to treat rheumatoid arthritis suppress
20 your immune system, your ability to fight infections. So
21 someone's more susceptible to an infection. So you just have
22 to be aware of that. And of course generally, you have a
23 medical consultation and the patient sees their
24 rheumatologists ahead of time, but you have to be aware that
25 that's the case.

1 Q. Even once the suppressive medications gets up, our
2 RA patients generally somewhat of a common problem?

3 A. Yes, nobody knows exactly how long. I mean, just
4 because it's not like an aspirin where you take an aspirin
5 and four hours later or five hours later, the effects of the
6 aspirin are gone. With immunosuppressive drugs, the effects
7 can last for a month or two months. Nobody knows exactly how
8 long they last, but immunosuppression drugs to suppress your
9 immune system.

10 Q. Does -- does the disease itself affect your immune
11 system?

12 A. Yes.

13 Q. And would a surgeon -- would an orthopedic surgeon
14 -- spinal surgeon be aware of that and have to consider that?

15 A. Yes. That's -- that's normal that you -- when you
16 operate on somebody with a -- that has been immunosuppressed,
17 whether it be for rheumatoid arthritis or various cancers or
18 HIV, any of these kinds of things that we operate on patients
19 for you, you have to be aware of that.

20 Q. Now, she also has something called malabsorption
21 syndrome. How would that impact, or what would you have to
22 consider there?

23 A. So in malabsorption syndrome, you don't absorb
24 things as properly and you may not get an administration of
25 an oral antibiotic might not cross into the bloodstream

1 normally because you don't absorb things properly.

2 Q. Is that again this something that you have to take
3 in mind when you're developing a post-surgical treatment
4 plan?

5 A. Yes.

6 Q. All right. I'm going to turn out to Plaintiff's
7 Exhibit 4. Davne, this is the August 23rd and this
8 Plaintiff's Exhibit 3. And this is the August 16, first
9 postoperative visit?

10 A. Yes.

11 Q. How'd she look here from your orthopedic
12 standpoint?

13 A. She seemed to be doing fine. Her incision looked
14 good. There were no problems at that point in time. And
15 basically it says, "Overall she's doing well and reports
16 significant relief of her preoperative symptoms." On
17 examination there was no erythema or it's redness, more the
18 drainage or swelling, no signs of infection. And
19 neurologically, her strength was 5/5, which means normal
20 motor strength. We're always checking. We've operated next
21 to nerves or pull -- we pulled the side nerves in order to
22 get to the disc. So that's important I think to check.

23 Q. In looking at the treatment plan, is it unusual to
24 use oral antibiotics two weeks after an open surgery? I'm
25 sorry, not oral antibiotics for steroids.

1 A. Well, there's -- she was -- she had received seven
2 days of oral antibiotics after the surgery, which was 8/2,
3 and this is 8/16. And so she's off of antibiotics at this
4 point.

5 Q. And I misled you with my bad question. She was
6 given a Medrol Dosepak. What is that?

7 A. So that's a steroid. It's a very powerful steroid
8 and you give it a decreasing dose. It's five days and the
9 dose decreases each day for five days.

10 Q. What would be the benefit of it to this patient at
11 this time?

12 A. I'm not sure exactly. It -- it -- it may be to
13 help relieve pain because it's a very powerful agent, but I
14 -- I don't know exactly why it was given.

15 Q. And she was rating one out of 10; is that right?

16 A. I'm sorry, what?

17 Q. That I think she reported a one out of 10 on the
18 HPI?

19 A. I -- I'm -- I didn't hear you clearly.

20 Q. Okay. On the third line down on the HPI, she
21 starting on the end of the second line, where did she rate
22 her pain at?

23 A. Back and leg pain on the left side.

24 Q. What -- what pain scale rate did she deal with?

25 A. One out of 10.

1 Q. Do you find it unusual to prescribe a Medrol
2 Dosepak to an RA patient who's only having one out of 10
3 pain?

4 A. Yes, but I -- I -- I don't know why it was
5 prescribed.

6 Q. What would be the risk of a steroid there?

7 A. Well, it's -- it is an immunosuppressant also
8 suppresses the immune system.

9 Q. All right. And then going to the next, this is
10 Plaintiff Exhibit 4. It's too small to drive a little bit
11 (inaudible). Is there anything concerning happening here at
12 Plaintiff's Exhibit 4?

13 A. Well, her -- her incision started to drain so
14 spontaneously now the incision was closed and now there's
15 drainage coming from the incision.

16 Q. What do you, as a spine surgeon, when you've seen
17 thousands of patients post-surgery, what's going through your
18 mind this patient comes in and she's had -- and just kind of
19 walk us through from eight to, what's happened and why this
20 is a concern?

21 A. So when patients drain postoperatively, there are
22 various reasons. It could be just accumulation of blood or
23 it could be infection or it could be just what we call serous
24 fluid. And I think you don't know exactly what the cause is.
25 You have to be very concerned when it's three weeks after

1 surgery that it could be infection. So that's one of the
2 first things that you -- you have to be concerned that this
3 is an infection. From my perspective, when I see a patient
4 that's three weeks fine following surgery, and I've had this
5 happen as well, that you have to think that this is possibly
6 a deep infection that all of us -- the -- the -- the
7 infection is deep in the wound and now has worked its way
8 out, but you don't know at that point in time. And what was
9 done was she was started on an oral antibiotic a Bactrim at
10 that point in time and she was going to be seen back in one
11 week.

12 Q. I want to come down just a little bit to the
13 physical exam portion.

14 A. Yes.

15 Q. What are the positive straight leg test and what
16 does it tell you?

17 A. Well, it just tells you -- it may tell you that
18 there's a little irritation of the nerve root. So when you
19 raise the leg up, it stretches the sciatic nerve and that's a
20 sign that there may be a little irritation of the nerve.

21 Q. Can it tell you where it's being irritated?

22 A. It can't tell you specifically where. No.

23 Q. And then just above that, it indicates a restrain
24 of the lower extremity on the left with Pat, although
25 slightly diminish, left knee extension, what does knee

1 responding extension tell you?

2 A. The knee extension -- well, actually that's the
3 nerves at L2, 3, and 4, but it -- it doesn't -- it doesn't
4 tell you a lot. It's just some information. I -- I wouldn't
5 be as alarmed about that specifically.

6 Q. In a patient that's coming in one week after she
7 was told could follow-up for four weeks. So she's coming
8 back sooner than schedule. You've got odd straight leg test
9 on the left where you operated, that was the disc that was
10 involved. And then you've got the zero signals drainage,
11 help the jury or help us understand how you're putting those
12 together. All those little pieces of information, how do you
13 read those together into what should I do next?

14 A. Well, you have to rule out the potential causes of
15 this drainage. So in this case, the physician's assistant
16 made the decision that let's try to protect against an
17 infection and let's give an oral antibiotic, in this case it
18 was Bactrim. And watch the wound and see her back in a week
19 which was her plan. And -- and I think that was reasonable
20 to make that plan. I might have done things a little
21 differently, but I think that was --

22 MR. HOOD: Objection, your Honor.

23 THE COURT: Basis?

24 MR. HOOD: Improper standard.

25 THE COURT: He's an expert. He's done these types of

1 surgeries. He can opine as to how he would've handled the
2 situation. Overruled. You can address the matter in
3 cross-examination.

4 BY MR. LUGINBILL:

5 Q. That -- that one of the things that came up in the
6 course of this case is whether or not this fluid should have
7 been swapped. Do you recall that?

8 A. Yes.

9 Q. What information can you gain and how solid is
10 that information?

11 A. So if you want to culture a wound to see what
12 antibiotic you might use and what -- what bacteria is growing
13 so you can -- you can culture the wound. That wasn't done.
14 The decision was just made to try to suppress whatever
15 infection was done at this point in time with an antibiotic.

16 Q. She was told to go back in one week. Are you --
17 do you have any criticism of that follow-up time?

18 A. No, I have no criticism of -- at that point. It
19 was reasonable on 8/23.

20 Q. All right. Any criticisms of the choice of
21 antibiotic?

22 A. No. It was -- Bactrim was a reasonable
23 antibiotic. I -- I might have chosen a different antibiotic,
24 but it was reasonable.

25 Q. All right. Let's look at Plaintiff's Exhibit 5.

1 This should be the August 30th -- Pat back in as destructive
2 on August 30th. And what is observed here?

3 A. Well, here -- there's still drainage from the
4 wound and she reported that she was only able to tolerate the
5 Bactrim. She -- she had some reaction to it, so she stopped
6 it after four days. So now you have a continued draining
7 wound. She had received an intraoperative dose of vancomycin
8 to protect against the infection and seven days of
9 doxycycline following the surgery. And now it opened and
10 started to drain and you've now got four days of more
11 antibiotic and it's still draining.

12 So I believe that this is a deep wound infection until
13 proven otherwise. And I believe that at this point in time
14 the requirement is to return the patient to the operating
15 room, explore the wound, make sure that it is or isn't a deep
16 wound as you open up a wound. If it's superficial, it will
17 stop above the fascia with that, you know, layer surrounding
18 muscles. And if it's deep, it goes -- it's down at the site
19 of surgery at where the bone was removed and where the disc
20 was removed, so --

21 Q. Let me ask this. In the prior visit on 8/23,
22 there was some talk about whether or not to do an MRI.
23 During MRI three weeks out from microdiscectomy, would you
24 expect to see some fluid in the wound this area?

25 A. I -- well, you might see a small fluid collection.

1 It's -- it's entirely possible. So I wouldn't fault anybody
2 for not obtaining an MRI at three weeks out. I -- it -- it
3 is -- it's reasonable to do one way or another. You have to
4 -- you have to know what it's -- you have to interpret the
5 MRI and put it in context with -- with the patient in their
6 clinical situation, but it wasn't done right at that time.

7 Q. Fair to say then that not doing on the right
8 period would've changed your course of treatment at that
9 point?

10 A. No.

11 Q. When we get to the 30th, would an MRI -- would be
12 useful here?

13 A. Yes, but I think the most important thing would be
14 to open up the wound and take the patient to the operating
15 room under sterile conditions to explore the wounds and to
16 see why it's still draining, and then put the patient on
17 appropriate antibiotics if it is a deep infection. Okay?
18 What was done here was that was not done. She was given a
19 prescription for doxycycline again which was the same
20 antibiotic that was given following the initial surgery for
21 seven days. So she was given a prescription for doxycycline
22 on 8/30. And she was seen back the following day to check on
23 her.

24 Q. And now, she's -- the follow-up was in one week?

25 A. Well, she actually had a follow-up on 9/1 and then

1 she had a follow-up on 9/8.

2 Q. Look, I want to ask it this way, did -- what was
3 she -- what was the anticipated return?

4 A. In one week.

5 Q. And then as you said, when -- when did she
6 actually come back?

7 A. She actually came back the next day. She was
8 having drainage and pain and she came back the next day.

9 Q. Showing you what's marked as Plaintiff's Exhibit
10 6. Plaintiff's 6. And I'll quibble with you a little bit
11 because there is an August 31st, so this will be two days
12 later?

13 A. Yes. Correct.

14 Q. What --

15 A. So again, there was still drainage. It was noted
16 as a small area in the center of the incision. And she was
17 encouraged to continue with the oral antibiotic doxycycline
18 and just to be seen back in a week. And then she returned on
19 9/8.

20 Q. The fact that she's still drained a week later or,
21 you know, two days later. You already said you wanted her
22 back in the OR I assume she still, in your opinion, she
23 should go back to OR here?

24 A. Yes. So in my opinion, she should have been
25 returned to the operating room on 8/30. Now it's 9/1, I -- I

1 still think she should have been returned to the operating
2 room. I think that would be the standard of care. This is
3 four weeks after the initial surgery. She's already been
4 treated with antibiotics. She's and we don't know what the
5 organism is and it's draining.

6 Q. Doctor, the fact that she's not complaining of any
7 significant pain, does that rule out a deep surgical site
8 infection?

9 A. No, not at all.

10 Q. And why not?

11 A. Because patients especially when -- when they
12 drain that helps get rid of pain associated with pressure
13 that can be associated. So when the wound is healed over and
14 pressure can build up from fluid from infection, they can
15 experience more pain.

16 Q. Just back seem like an overly simple pressure, but
17 -- does bacteria as it grows create pus?

18 A. Yes.

19 Q. All right. I'll show you Plaintiff's Exhibit 7.
20 This is the September the 8th.

21 A. And just explain that. So as bacteria multiply,
22 the white cells in your body are coming in to try to fight
23 the infection and they create -- they create fluid and
24 debris. So that's pus, that's what pus is.

25 Q. Again, this is Ms. Aprill PA, no pain walking

1 through tolerance. It's closing up. You interpret that to
2 be not closed?

3 A. It's not closed. It's -- there's no increased
4 drainage, but it -- it was still draining.

5 Q. So for all the reasons you were concerned before,
6 are you just saying it's the same?

7 A. Yes. The same 8/30, 9/1, 9/8 the wound should
8 have -- she should have been returned to the operating room.

9 Q. Let's talk about this treatment plan. follow-up
10 with one to two weeks or sooner. Was there any further
11 antibiotic order?

12 A. No, no further antibiotics order. So there was no
13 ongoing treatment.

14 Q. Is there any way to tell you were just looking at
15 that wound that the antibiotics are effectively eradicating
16 any infection?

17 A. No, I mean, just because the wound is closing that
18 suggests that there's some healing of the skin, but that
19 doesn't mean there's healing down below. Okay.

20 Q. Is a one -- to two-week follow-up here
21 appropriate?

22 A. Well, again, I would've -- I think she should have
23 been returned to the operating room. I -- I think that was a
24 poor decision, but that's what occurred.

25 Q. Now, PAs are used in surgical practices across the

1 country by (inaudible)?

2 A. Yes.

3 Q. What is the surgeon's responsibility in
4 supervising those PAs who are operating the (inaudible)?

5 A. Well, the -- the surgeon is the supervising
6 physician for the PA, the physician's assistant. To the
7 extent that you delegate responsibility. I -- I used to have
8 physician's assistants in my practice or nurse practitioners
9 or both. And your responsibility is to supervise them. And
10 you're responsible -- you're responsible for their actions.

11 Q. It's part of that supervising, making sure that --
12 that those folks are your extensions is what they have on the
13 position the same, they know when you expect being brought
14 in?

15 A. Yes. There -- I mean, they are trained and you're
16 giving them responsibility in your -- while you're not there,
17 you're -- you're delegating responsibility to -- to them as a
18 physician extender.

19 Q. Is this a situation where a PA would be expected
20 to come back to the surgeon and tell them, make sure that
21 they know what's going on?

22 A. Yes. I think right along, whether it be 8/30 or
23 8/23, 8/30, 9/1, 9/8 that this is a wound -- a wound
24 infection until proven otherwise. And you're giving the
25 patient an antibiotic and you're making a decision. This is

1 also the same antibiotic now that's that was given
2 immediately for seven days postoperatively. So you have to
3 be concerned about the same antibiotic. The patient got
4 infected on that same antibiotic. Despite taking that
5 antibiotic, an infection continued. The -- the assumption is
6 the infection occurs intraoperatively. Okay? Not
7 postoperatively.

8 In this case the wound is closed the assumption in my
9 experience and the experience of many others if it -- it's an
10 intraoperative infection. The wound got contaminated,
11 whether it's off the patient's skin or bacteria or in the air
12 or on an instrument, even though it's been sterilized.

13 Q. The next visit would be -- and this should be
14 Plaintiff's Exhibit 9. Yes. Now, who sees the patient on
15 this day?

16 A. Dr. Frisch sees the patient at this time.

17 Q. What does he find in his exam?

18 A. Well, he found that there was a wound dehiscence,
19 meaning, dehiscence is a fancy word for separation of the
20 wound, but --

21 Q. Stop there. Isn't that what's been happening the
22 whole time?

23 A. Yes, the wound has opened up. It's dehiscence so
24 it's a fancier word for the wound has opened.

25 Q. All right. What else did he find?

1 A. He didn't see any active drainage. He noted that
2 she has been having fevers and an increase in pain.

3 Q. And now in fairness to -- to everybody in
4 Southeastern Spine prior to this day, the increasing pain is
5 a new symptom, as is the low grade fever, correct?

6 A. Yes.

7 Q. Appropriate choice at this point is to do what?

8 A. Take her back -- admit her to the hospital, which
9 she wanted to do at that time like get cultures and get an
10 MRI. There were all appropriate choices right at that time.

11 Q. Nothing here in problem?

12 A. No.

13 Q. It's just 20 days too late or later than it should
14 have been?

15 A. Yeah, it's a month later than it should been.
16 Remember that the infection first manifest itself on 8/23
17 when the wound opened up or dehiscence you don't have it.

18 Q. All right. Tell us when she gets to the hospital,
19 how is her wound or how do they work her off when she gets
20 there?

21 A. Well, she gets an MRI scan. She gets some
22 laboratory studies and she's taken to the operating room.

23 Q. What would the laboratory studies do?

24 A. Well, the way we follow infections, we get a -- a
25 white blood count. CBC gives you the type of white blood

1 cells. White blood cells are the ones that fight infection.
2 You get that kind of account to see if it's elevated and the
3 type of distribution of the white blood cells. And you get a
4 test called an ESR, Erythrocyte sedimentation rate, which is
5 a -- a more general concept that may show you -- it gives you
6 a sense that there's an infection. And then you get
7 C-reactive protein, which is another more specific test to
8 help guideline -- give you a guideline if there's an
9 infection.

10 Q. So this is a way -- they're not investigating
11 whether they're infection using blood tests; is that fair?

12 A. Right. You're using blood and of course you're
13 taking her back to the operating room and going to perform
14 culture. So it's all being done at that time on -- in 9/20.

15 Q. Now, the CRP and involved separate white blood
16 cell test, is that something that a surgical practice or the
17 PA or a surgeon is comfortable doing?

18 A. Yes. You just order the test and you don't -- you
19 don't actually -- I don't know how to perform it myself,
20 although I -- I understand it -- it's sent to the laboratory.
21 It's a blood test. You get the blood drawn from a vein and
22 it's sent to the laboratory. The laboratory does that test
23 and you get a result back.

24 Q. Should all of the PAs and Dr. Frisch know that
25 they have these tools in their toolbox?

1 A. Yes. Just these are standard tests.

2 Q. Once the drain started and -- and the patient that
3 Pat was and what was there looked at factoring or the
4 absorption syndrome (inaudible) A, is this a patient for the
5 surgeon should have to have a high index of suspicion for the
6 infection?

7 A. Yes. This is an infection until proven otherwise.
8 And I -- it's my opinion that it was an infection when it
9 first opened up three weeks after, but here now we're two
10 months, seven weeks, I guess down -- down the line since
11 surgery this is an infection until proven otherwise. And the
12 decision at that time to open up the wound, get cultures
13 that's appropriate. It was a -- it should have been done
14 before, but it was certainly appropriate on 9/20.

15 Q. And is that just opinion or is that the standard
16 of care?

17 A. That's the standard of care.

18 Q. So why is it a standard of care?

19 A. Well, the standard of care requires if you have a
20 high suspicion of an infection in a -- in a surgical -- a
21 post-op surgical patient, in this case, you -- you know, it's
22 more likely than not a deep infection because it didn't -- it
23 stayed hidden for three weeks and -- and it was -- and she
24 was given it protecting antibiotics for seven days following
25 the surgery, should have protected against a superficial

1 infection on the skin. And then she's given Bactrim, didn't
2 solve for four days, that didn't change the infection. So
3 this is a deep infection.

4 So starting on 8/23, it's my opinion that the standard
5 of care required the wound to be open. Now, it doesn't
6 happen until 9/20 and that was now within the standard of
7 care to open this wound to get cultures, find out what the
8 organism is and to properly treat it.

9 Q. You just said, "The whole goal here is to properly
10 treat", right?

11 A. Right. Is to -- to arrest the infection. To stop
12 the infection because left unchecked it can cause serious
13 damage.

14 Q. And -- and that was my next question. What's the
15 benefit? Why is the standard of care here a safety rule that
16 detects, or how does it detect the patient?

17 A. Well, an infection left unchecked in the spine can
18 lead to paralysis of the nerves. So you don't want to not --
19 you want to arrest the infection as quickly as you can. So
20 you want to know the organism so you can have the proper
21 antibiotics to treat that -- that bacterial infection.

22 Q. Now, once we get into her inpatient, you talk
23 about all of the -- the tests that were run. Was she also
24 given her nasal swab?

25 A. Yes, she was.

1 Q. Tell the jury what that means.

2 A. So she was a nurse. She worked in a hospital. So
3 a nasal swab was also to check to see people that work in
4 hospitals sometimes have bacteria -- not sometimes they have
5 bacteria in their nose. And the one that we're always
6 concerned about is MRSA -- MRSA, Methicillin-Resistant
7 Staphylococcus aureus. So the most common deep infection is
8 Staphylococcus aureus, and a variant of that is
9 methicillin-resistant. So methicillin was the Number one
10 drug to treat basic Staphylococcus -- Staphylococcus aureus.
11 And methicillin-resistant means that now this isn't -- this
12 is a hospital-acquired type of infection. That's what the
13 culture showed, that this was MRSA, methicillin-resistant
14 Staphylococcus aureus. So it's a hospital-acquired
15 infection. And they were also looking to see if she had it
16 on her nose -- in her nose as many hospital workers do. And
17 again, one of the ways that -- as I said before infection can
18 occur because the patient's carrying the organism. Okay?

19 Q. These swabs are relatively easy to do without
20 risky procedure, why aren't they done all the time? Why
21 isn't every surgery made basic swab?

22 A. Well, it's because the incident -- the -- I mean,
23 they've studied it. Okay. And written papers on it. The
24 incidence is too low to -- to -- to subject every patient to
25 a test which might not provide any useful information.

1 Q. If your patient is an RA patient and susceptible
2 -- more susceptible to infection because left does it start
3 to get to be more of a better idea?

4 A. Well, it's information that -- that is useful.

5 Q. Still not the standard of care --

6 A. It is not the standard of care, no.

7 Q. Now, when she's in the hospital, do you have any
8 criticisms at all about how she was followed or managed by
9 Southeastern Spine?

10 A. Yes.

11 Q. Well, in the hospital itself?

12 A. Oh, in the hospital, no. She -- her care and
13 treatment in the hospital is -- is fine, but it's after that
14 then I object.

15 Q. And that brings us to our expert. So what was her
16 discharge plan from an orthopedic standpoint from MRSA?

17 A. So after the wound is washed out, it was closed,
18 sutured closed, and she was started on intravenous
19 vancomycin. She received seven or eight doses of intravenous
20 vancomycin, and then she was switched to oral doxycycline.
21 Again, that's the same antibiotic that she was given after
22 the initial surgery on 8/2. And after she was seen back on
23 8/30 when the Bactrim didn't work, she was given a week of
24 doxycycline. So again, she's being prescribed. I -- I may
25 have gotten that wrong. She's prescribed a different

1 antibiotic at that point. She was prescribed minocycline,
2 but -- but she was prescribed an oral antibiotic. Four days
3 of vancomycin intravenous followed by oral antibiotic.

4 Q. And -- well, first of all, who set that discharge
5 plan?

6 A. Dr. West, the infectious disease doctor.

7 Q. What -- do you have a deep space surgical
8 infection? Is a surgeon always going to bring in an
9 infectious disease specialist?

10 A. I -- I think most of the time that you have a deep
11 infection, you do bring in an infectious disease doctor
12 because of their area of expertise. However, in MRSA -- MRSA
13 infections you always bring in. If you don't bring it in,
14 the hospital brings it in because it's a hospital acquired
15 infection. So there's always an infectious disease doctor
16 that comes in when it's an MRSA infection.

17 Q. Is there anything about those discharge notes from
18 a -- that you looking at it as a surgeon jumped out at you
19 (inaudible)?

20 A. Yeah, she should have been sent home on
21 intravenous antibiotics. The reason we give intravenous
22 antibiotics is because you get a high level, a known level of
23 antibiotic being disseminated through the body, getting to
24 the infected area. Whereas when you give oral antibiotics,
25 you can't control the level of -- of the antibiotic. So

1 certain infections you give a -- a prolonged period of
2 intravenous antibiotics.

3 And in this case, I believe it's my opinion that the
4 standard of care required at a minimum seven to 10 days of
5 intravenous antibiotics. You could have been sent home --
6 should have been sent home on intravenous antibiotics at that
7 time before being switched to -- and -- and -- and seen and
8 -- and made a decision after seven to 10 days of intravenous
9 antibiotics, whether you're going to continue that or switch
10 to oral antibiotics for a deep wound infection, especially
11 MRSA in an immunocompromised patient.

12 And one other thing, there's open bone. When they
13 opened the wound up, it went right down to the laminectomy
14 site where they had removed the lamina and there's open bone
15 and where the disc was removed. So this infection just
16 tracks all the way to that area. So you want to -- you want
17 to protect against the continued infection. You want a high
18 level of intravenous antibiotics at a -- a minimum of seven
19 to 10 days.

20 At -- at seven days, you can reassess. That would be
21 double the Number of doses that she received. She received
22 four days worth and or -- or seven doses. And seven days
23 would've been 14 doses. Vancomycin is twice a day, be given
24 every 12 hours intravenously.

25 Q. And you always just stop at seven to 10 days. Why

1 is there a range?

2 A. Well, you want to look at assess the patients, you
3 make sure they don't have fever. Look at laboratory studies
4 if you want it after seven days. The laboratory studies
5 could be variable, but you want to know what their blood
6 count is. You can get an ESR, erythrocyte sedimentation
7 rate, you can get a CRP, you can get these tests, but you
8 have to -- after seven days, they still are likely to be
9 elevated. Okay. But you can make a decision based upon
10 factors at a minimum of seven to 10 days of intravenous
11 antibiotics, whether you want to continue intravenous or not.

12 Q. What's more important for you as a surgeon at that
13 point when you're looking at the CRP as the separate? Is it
14 the actual value or are you looking to establish a trend?

15 A. You're -- you're looking to establish trends. So
16 you want to see those Number s coming down and that gives you
17 an idea of whether the infection is being eradicated. The
18 absolute Number is not critical. It's the trend.

19 Q. And if you have a trend that starts to come down
20 and then turns around and starts to go back up again, how do
21 you interpret that?

22 A. Well, you interpret it that the infection is still
23 going on.

24 Q. Who is going to be doing that blood work
25 generally?

1 A. Well, it could be either the surgeon or the
2 infectious disease doctor. Either or somebody has to follow
3 the wound. The surgeon generally follows the wound. And
4 decisions about antibiotics in -- are typically made in
5 discussion between the surgeon and the infectious disease
6 doctor because the infectious disease doctor wasn't in the
7 operating room. So they have -- they don't have an
8 understanding of -- they -- they can read the operative
9 report, but the -- the surgeon has to talk to the infectious
10 disease doctor to -- to make a decision about the -- the
11 antibiotics. The -- the specific antibiotic you would rely
12 on the judgment in general of the infectious disease doctor
13 as to what antibiotic would be chosen, because they have a
14 greater level of expertise in treating MRSA infections as to
15 what -- which antibiotic you would choose.

16 Q. Regardless, it's going to be physically the person
17 to seeing the patient drawing the blood, but the standard of
18 care require there to be some collaboration there so that
19 someone do?

20 A. Yes.

21 Q. Was that done in this case?

22 A. No, it was not.

23 Q. I'm going to show you Plaintiff's Exhibit 61.

24 This is Dr. Frisch's discharge summary from 9/20, including
25 9/20 admission. She was discharged on 9/26 obviously. You

1 taught a lot of residents in your day?

2 A. I'm sorry.

3 Q. You said you've taught a lot of residents in your
4 day, correct?

5 A. Yes.

6 Q. Would this discharge summary receive a passing
7 grade?

8 A. I -- I'm sorry, I couldn't hear you. I'm a little
9 hard of hearing.

10 Q. Fair enough. With this discharge instruction
11 received a passing grade with one of your records?

12 A. It -- it -- it's -- you would really want to be
13 more specific.

14 Q. The discharge summaries help other surgeons or
15 other practitioners who may come behind you?

16 A. Yes.

17 Q. Going back to the concept of the seven doses of IV
18 antibiotics versus the 14 doses that says there, in your
19 review of this case in research you've done, in your
20 experience as a surgeon in the field for 40-plus years, have
21 you -- are you aware of any study or any scientific outcome
22 that would suggest that in a RA patient specifically or more
23 -- in any patient, we'll start there. In any patient who had
24 deep wound infection where we know tearing left material was
25 in contact with bone. You -- have you been able to find

1 anything that have justified seven doses?

2 A. No. I think that in this case and in my
3 experience, MRSA infection in a patient that's had spine
4 surgery, that's had disc surgery where it's a deep wound
5 infection, that seven doses of vancomycin or intravenous
6 antibiotic is inadequate. And the -- the standard of care
7 would be seven to 10 days at a minimum of intravenous
8 antibiotics.

9 The -- the -- you're -- you're -- so the question might
10 be, well, how do you know three more days or four more days?
11 Why do you know that? Well, the same thing is true. Why --
12 why not just one day? And it's because if you're trying to
13 treat a deep infection in the spine and you need to give
14 intravenous antibiotics for a long enough period of time to
15 wipe out that infection and other types of infections when
16 you get into the bone, it's six weeks or more of intravenous
17 antibiotics.

18 It's not four weeks, it's not five weeks, it's six
19 weeks or more of intravenous antibiotics. So that's the
20 standard of care. It's -- and these are through experience
21 and one or two weeks of intravenous antibiotics in a -- in an
22 infection in the spine, in the bone is not long enough. And
23 we know that from experience.

24 THE COURT: Let me interrupt you, please.

25 Ms. Mass (ph), Mr. Foreman, ladies and gentlemen, we're

1 going to take a brief comfort break. During the break,
2 please do not discuss the case. Please leave your notepads
3 on your seats. Let us know when you're done.

4 (Jury exits courtroom.)

5 THE COURT: A jury requested a comfort break. So I --
6 I guess it'll take five, maybe 10 minutes.

7 Sir, you can walk around if you'd like. Just please
8 don't discuss your testimony with anyone.

9 THE WITNESS: Okay.

10 THE COURT: And I'll just remind you again, if you're
11 not speaking into that mic, it's not picking up what you're
12 saying. So if you want an inaudible record speak from the
13 mic, if you want audible record speak into the mic.

14 (Off the record.)

15 THE COURT: Plaintiff ready to proceed?

16 MR. LUGINBILL: Yes, your Honor.

17 THE COURT: Defense ready to proceed?

18 MR. HOOD: Yes, ma'am.

19 THE COURT: The witness will retake the stand. It
20 should be right behind you.

21 (Jury enters courtroom.)

22 THE BAILIFF: All jurors present, Your Honor.

23 THE COURT: You may be seated. Ladies and gentlemen,
24 now resume testimony.

25 You may proceed.

1 MR. LUGINBILL: Thank you, your Honor.

2 THE COURT: You are welcome.

3 BY MR. LUGINBILL:

4 Q. All right. I want to pick back up with the -- a
5 little bit of the discharge part. When she left the hospital
6 the 26th of September, who was responsible for making the
7 decision of when she could restart her RA as you understand
8 that?

9 A. Her rheumatologist and -- would be the one that
10 would ultimately be responsible.

11 Q. You recall seeing the records that initially, that
12 the RA meds for help (inaudible) Dr. Frisch.

13 A. Would help her what?

14 Q. Would help her, Dr. Frisch, do you recall?

15 A. I don't recall.

16 Q. Very well. In looking at the Southeastern Spine
17 records from 26th forward, are there any consult notes or
18 telephone call documentation or anything that would indicate
19 that anyone from the Southeastern Spine spoke to Pat's
20 rheumatologist?

21 A. I didn't see anything.

22 Q. In the period of time, 9/26 when she was
23 discharged until she was readmitted in December in the
24 Southeastern Spine notes, did you see any evidence of blood
25 work orders?

1 A. No.

2 Q. Any results?

3 A. No.

4 Q. Any reference to any other doctor doing those,
5 that blood work?

6 A. No.

7 Q. Based on the evidence that you've seen in the
8 record, was any blood work done from 9/26 until Pat was
9 readmitted on December the 19th?

10 A. No.

11 Q. Is that within the standards of care?

12 MR. HOOD: Objection, your Honor.

13 THE COURT: Basis?

14 MR. HOOD: Previously undisclosed opinion.

15 THE COURT: Overruled. You may answer the question,
16 sir. Do you recall the question? Do you need it repeated?

17 THE WITNESS: I understand. I believe that the
18 standard of care required follow-up blood work to ascertain
19 whether there was adequate treatment of the infection.

20 BY MR. LUGINBILL:

21 Q. Somebody had to do it?

22 A. Yes.

23 Q. The standard of care for a spinal surgeon and his
24 practice to why they do it themselves will coordinate with
25 some more member or the patient's care team to ensure it's

1 done?

2 A. That's correct.

3 Q. I'm showing Plaintiff's Exhibit 8. How did she
4 look here?

5 A. Well, she wasn't having any drainage from her
6 incision. I -- I think that's the main thing that she didn't
7 have. Her wound looked okay.

8 Q. Nothing to do here other than we don't have any
9 blood work results or orders?

10 A. That's correct. There her sutures were removed at
11 that point.

12 Q. Moving on to Plaintiff 10, this is November 28?

13 A. Yes.

14 Q. How was she looking now?

15 A. Well, she was having a lot more pain. She -- it
16 was predominantly in her back and it was rated 8/10, so it
17 was fairly significant pain.

18 Q. Is this what you would've expected from the -- in
19 the normal course of (inaudible) healing from the incision
20 drainage?

21 A. No, it's more than you would expect -- much more.

22 Q. Would this be considered pain out of proportion?

23 A. It could be. I -- I mean it -- it -- it's hard.
24 She was having a lot of pain at that point. It's something
25 that needed to be considered.

1 Q. The record reflects that she resumed on her -- it
2 says, "Kariva", but it should be Arava.

3 A. Right.

4 Q. And she's finished searching prednisone?

5 A. Yes.

6 Q. What effect would that have on -- on her immune
7 system?

8 A. Well, if -- they're immunosuppressives.

9 Q. Now, if we stop just at the physical exams and
10 they factoring in the -- the point of X-rays that were done,
11 would a reasonable surgeon have a return of the infection on
12 the different diagnosis of what's causing that infection?

13 A. Yes. You're always worried after you open a wound
14 up, debride it and treat with antibiotics. You're always
15 worried that you didn't eradicate the infection. So it
16 should be at the -- the front of your mind and that's why you
17 should get blood work.

18 Q. How does the positive straight leg test at
19 reproducing low back pain at 90 degrees and slight dimension
20 of straight L4-5 on the left, how does that factor into
21 moving the infection either up or down you're different --

22 A. It -- it's nonspecific. It -- it wouldn't --
23 that's there -- that would not be a factor to me.

24 Q. Would you consider this to be nerve involvement
25 for a neurologic sign?

1 A. Not necessarily of any -- I mean, no, I would not.

2 Q. I want to go down to the follow-up -- gave her a
3 prescription for ibuprofen over the MRI section and come back
4 at here ibuprofen and have her come back four to six weeks or
5 sooner. Is that appropriate?

6 A. No.

7 Q. Now, there's going to be some -- I'm not asking
8 you to decide who is right or wrong, looking at an MRI on
9 this date, how do you get the MRI with a return to the office
10 of four to six weeks?

11 A. Well, you're looking for any signs of possible
12 return of infection, and it was very reasonable to recommend
13 an updated MRI at that point in time.

14 Q. Is one of the things that the MRI will show you
15 that you would be looking for is signs of a return of the
16 infection?

17 A. That's correct. An abscess accumulation of fluid
18 involving another disc.

19 Q. So help me understand how you would then, if -- if
20 you're not going to take a look and you don't get to
21 investigate to see what's going on, why would you wait --
22 have the patient wait another four to six weeks before seeing
23 them?

24 A. I think the standard of care required follow-up
25 blood work at that point in time. And I think that -- that

1 should have been done.

2 Q. Not having that information here, six weeks
3 post-surgery from the incision of drainage, did it prevent
4 the ultimate infection that we know happened from being
5 detected on this case?

6 A. Yes. It -- there was an opportunity to see that
7 there was an infection at that tape at that time.

8 Q. And depending on what an MRI did at that point, if
9 you really suspect that you have an infection, you get the
10 MRI and depending on what it shows, if you intervened there
11 in -- in whatever that intervention looks like, we don't know
12 what it would show. Do you believe you could have stopped
13 the infection at that point?

14 A. Well, yes, you could have stopped it at that
15 point. I don't -- I would say this, that even if you stop it
16 at that point, it's, you know, getting to it a month later, I
17 don't think that would've changed the ultimate outcome. But
18 you would've started the treatment sooner and she would've
19 gotten better sooner.

20 Q. When you say, "To change the ultimate outcome", at
21 this point in November, is there anything to -- to base on
22 that physical exam that she's got disguidance or oral
23 antibiotic on it?

24 A. No, you can't approve that she has it at that
25 point in time.

1 Q. And if you -- you eradicate the infection before
2 it gets to the disc of the bones, she has a better option; is
3 that fair?

4 A. Well, I -- I would say in my opinion, the
5 infection was at that point already in the disc in bone
6 because it takes a long time for it to show up on MRI. So I
7 would say that by 11/28 -- and that's why I said even if you
8 intervened at that time, which I think should have happened,
9 I don't think it would've changed the ultimate outcome of
10 requiring six weeks or three months of intravenous
11 antibiotics and the subsequent bone damage that was done.

12 Q. I want to look at the MRI from November the 20th,
13 or sorry December 20th. Okay. I think you reviewed this in
14 your -- (inaudible) of the case for (inaudible). What are we
15 looking at here?

16 A. Well, you're looking at the L4-5 disc level and
17 what you see here is I'm going to just point right at it.

18 Q. I do look at --

19 A. Oh, okay.

20 Q. It doesn't help you. It's there.

21 A. It did, but I'm going to clear this because I
22 think I have obstructed vision. If you look at the -- I'm
23 just going to put my finger here. If you follow that -- that
24 along, you'll see that the bone has been disrupted. I'm
25 going to point below it. If you look up from that point,

1 you'll see now the bone has been carved out at that level
2 that -- so if you -- if you're looking at -- this is L4-L5,
3 if you're looking, the bone has been eaten away right there
4 maybe eaten away is a bad terminology, but it's been
5 dissolved or affected. Okay.

6 Q. And then again, it may also help, we do have the
7 August 24.

8 A. Yeah, so this is a -- the MRI is a different
9 image. Okay. So here you can --

10 Q. I -- I -- I'm misleading report, but that is in
11 September 1. There you go.

12 A. Right. So here, this is a -- the same date, this
13 is December 24th.

14 Q. Twenty four.

15 A. Okay. But it's a different way. The MRI is
16 looking a little differently. And what you see, what's been
17 circled is that the disc is involved and you can now see
18 where the artist has drawn in here, the disruption of the
19 bone, okay? Both in L4 and L5. So it's a disc space
20 infection that has gotten into the bone, and we call that
21 osteomyelitis.

22 And so that's what has happened at this point in time.
23 You now have a full-blown disc and bone infection that you
24 can prove on MRI. It takes a long time radiologically,
25 radiographically to see the disruption of the resorption we

1 call it, of the bone. It -- it takes a period of time before
2 it shows up on a study. So an MRI done one week after the
3 wound was surgically treated in -- on 9/20. You wouldn't see
4 that, but progressively you'll see the changes and that's why
5 you get progressive blood studies. And here now you -- you
6 have proof that it is a discitis and osteomyelitis based upon
7 the MRI scan.

8 Q. And then the last one that I want to go to is --

9 A. And -- and I would say this, it's not draining.
10 See it's -- it's hidden, it's deep, but it's not -- not
11 broken through. Okay. And that's very typical.

12 Q. As part of her long-term care she's -- she's not
13 been seated to -- this is a January the 17th, I believe.

14 A. January 29, 2019.

15 Q. What are we looking at?

16 A. Well, we're looking at the aftereffect of the
17 osteomyelitis where the disc has collapsed and the bone has
18 collapsed. So now the L4-5, instead of being like this is
19 tilted like this and I think if you have another view, you
20 can see it's also collapsed. And this is -- this is a -- a
21 slice taken this way. So if you're -- we -- we -- this is
22 called a coronal slice, and that's what you're looking at
23 taken this way. And we also take slices this way.

24 We -- we put it together on our minds, but this would
25 be the sagittal slice. I -- I don't remember if you have

1 one, but this is pretty demonstrative of the collapse that
2 has occurred.

3 Q. Okay.

4 A. So again, so we're making slices this way versus
5 you previously looking at slices that were made this way, the
6 MRI makes sequential slices, and you're just taking a
7 snapshot here, but we look at multiple slices. The MRI has
8 multiple slices that we look at. Okay.

9 Q. When these two discs collapse down on the cells
10 that we see here, and they -- do they fuse together, that
11 bone grow together?

12 A. It -- it may grow together. And it also, not only
13 does it grow together, it affects the -- the -- the vertebrae
14 above. So you -- you tend to get -- when one -- when it
15 collapses this way over time, you get what we call a
16 compensatory scoliosis. It's not here, but if you're -- if
17 this is angled this way, the body wants to keep the head
18 straight, so the vertebrae have a compensatory scoliosis that
19 it will tilt back in the other direction.

20 Q. Absent putting rods in there, is there any way to
21 stop that?

22 A. No. Absent doing a major spinal fusion, there's
23 no way to stop that. That -- that's what occurs over time.

24 Q. How does this repositioning of the disc affect the
25 nerve roots that we talked about before at L4 above?

1 A. Well, sometimes it pinches the nerve roots because
2 it's collapsed down. So this is the neural foramen where the
3 nerve roots come out. So here's at L4-5, and let me just do
4 it on this side. So when this collapses down, this space,
5 the neural foramen where the nerve goes through, it's the
6 tunnel is made up in part from the L4 vertebrae and in part
7 from the L5 vertebrae. So that hole where the disc comes
8 through, we call that the neural foramen is now much smaller
9 and it can pinch the nerve root and give you sciatic leg
10 pain.

11 Q. Based on your --

12 A. And weakness. It can do -- you can get weakness
13 from it too.

14 Q. Based on your review of the due records, Pat
15 suffering from pain, permanent pain associated with this
16 permanent change?

17 A. Yes, she is.

18 Q. And is that likely to continue the rest of her
19 life?

20 A. Yes.

21 Q. All right. Doctor, the last couple of things I
22 want to touch base on are unfortunately about you.

23 A. Okay.

24 Q. You have been a Defendant in court; is that true?

25 A. I have.

1 Q. I want you to tell me a little bit about this
2 multi-district litigation you were involved in that had to do
3 with pedicle screws.

4 A. So today, the way spinal fusions are done is what
5 we call a pedicle screw. The screws are placed into the
6 spine and you connect them with rods. So that surgery was
7 first started in 1986, and I actually helped pioneer the
8 development of that surgery back in 1986. I was a busy spine
9 surgeon at a big university hospital, and I saw the value in
10 that.

11 And what happened was the FDA said that these screws
12 were not specifically approved for the use in the spine.
13 Now, as often happens, the FDA was very wrong, and ultimately
14 they were approved. But during that time period, the earlier
15 screws that we were using were made out of stainless steel
16 and subsequently metal -- the use of titanium, which is much
17 stronger and different metal became available and it wasn't
18 available back in 1980 -- in the late 1980s. So we were
19 using stainless steel, which was a common -- common metal
20 that we used throughout all of orthopedic surgery.

21 And some of the screws were breaking and they were
22 breaking for various complex reasons. But generally because
23 the spine wasn't fusing together, this led to a lot of
24 litigation. There were seven to 10,000 lawsuits in the
25 United States at that time. It started in the late 1980s

1 into the early 1990s. And it's called multi-district
2 litigation. It's in federal court. And multi-district just
3 means that it involved different areas of the country because
4 there are seven to 10,000 lawsuits.

5 And actually they put it all together in the Eastern
6 District of Pennsylvania, which happens to be Philadelphia.
7 Because I helped pioneer this I had done a lot of this
8 surgery and there was a lot of litigation and I was named in
9 a lot of lawsuits. In fact, a little over 200. And so this
10 was something that I went through and I was a Defendant.
11 Ultimately, the case is the FDA eventually years later
12 approved it.

13 All spine surgeons today do spinal fusions with this
14 device. It is the standard of care, but I sort of had my
15 nose out in front and I got hit with a lot of Plaintiff
16 litigation at that time, and I sort of weathered the storm,
17 but that's something that -- that I went through in my career
18 in the -- in the early 1990s.

19 Q. Were there also a few state court cases that
20 stayed out of the MDL?

21 A. Well, that's right. So it was it's complicated,
22 but in medical negligence, most times it's a state court
23 thing, like this is a state court. And so the federal
24 issues, which were mostly related to the manufacturer were in
25 federal court and the state issues were in state court. It

1 -- it's complicated. I'm not a -- an attorney. I -- but I
2 -- I learned a lot about it.

3 So it was all about the FDA saying that it wasn't
4 technically approved and ultimately it was. And -- and
5 because of my work with the manufacturer I -- I guess after I
6 had been doing this surgery for a few years, the manufacturer
7 and came to me and asked me to be on their medical advisory
8 panel.

9 And that's how I wound up operating in other countries
10 because I -- I really was an expert in the -- in pioneering
11 this surgery. And as a -- as a -- in payment, so to speak,
12 for my work with the manufacturer, I was given stock options.
13 So eventually the company was sold and I -- I received money
14 for that.

15 Q. Despite being sued a hundred times then, why do
16 you do this work for Plaintiffs?

17 A. Well, I -- I think that --

18 MR. HOOD: Objection, relevance.

19 THE COURT: Overruled.

20 THE WITNESS: I think it's important. I -- I mean, I
21 have this vast experience. I was in the beginning of a lot
22 of the development of a lot of present day spinal surgery.
23 And in many respects, I was ahead of the curve, so to speak,
24 because the surgeons are still doing what I was doing in the
25 mid-1980s today.

1 The newest developments are, you know, some -- some
2 techniques of minimally invasive surgery that I wasn't
3 performing, but basically most -- most of spinal fusion
4 surgery is exactly the same as today as it was in the -- when
5 we started to do this in the 1980s, 40 years later. It's --
6 BY MR. LUGINBILL:

7 Q. Let me ask you, are the principles of treating
8 those patients after surgery and managing infections any
9 different?

10 A. No, what's changed is some availability of some
11 different antibiotics, but the basic treatment for
12 infections, whether it be osteomyelitis or deep wound
13 infections, is the same when I was a resident, when I was an
14 attending and what I taught residents today as it was 40-plus
15 years ago.

16 So in 1980, or '81, or '82, we treated -- osteomyelitis
17 was six weeks of IV antibiotics, just as we do today. We
18 followed it with the Erythrocyte sedimentation rate, ESR. We
19 didn't have CP -- the CRP at that time. That wasn't a test,
20 but we -- and we didn't have MRIs, and we didn't have CT
21 scans back at that time. We just had X-rays, but at the end
22 of --

23 Q. At the end of the day -- let me ask you, at the
24 end of the day, if Pat had been brought back to the surgery
25 room to the surgery earlier for the washout and had gotten

1 broken down by that time, could that image of her collapsed
2 disc collapse toward the individual disc?

3 A. Yes.

4 MR. LUGINBILL: Please answer any questions the Defense
5 may have.

6 THE COURT: You may proceed.

7 MR. HOOD: May I please the Court?

8 THE COURT: Yes, sir.

9 CROSS-EXAMINATION

10 BY MR. HOOD:

11 Q. All right. Good afternoon, Dr. Davne. My name is
12 Jamie Hood.

13 A. Good afternoon.

14 Q. We met by Zoom. Remember that?

15 A. Forgive me, but I don't, but there could have
16 been.

17 Q. I'm easily forgotten. You got a copy of your
18 deposition in case we need it.

19 A. Okay.

20 Q. And I do want to talk about the timeline for a
21 minute. The surgery that we've been talking about was in
22 2016, right?

23 A. Correct.

24 Q. And your involvement in this case started roughly
25 2018?

1 A. That's correct.

2 Q. And then, I took your deposition over Zoom in
3 2020?

4 A. Correct.

5 Q. And you're here today in 2024?

6 A. That's right. It's taken a long time.

7 Q. So -- so you've been involved in this over the
8 course of eight years?

9 A. That's correct.

10 Q. And you obviously have an extensive litigation
11 experience that you just described with your Counsel?

12 A. Yes, I do.

13 Q. And so in terms of being an expert witness, you've
14 done this hundreds of times?

15 A. Well, I haven't appeared in court hundreds of
16 times, but I have probably close to a hundred times appeared
17 in court.

18 Q. Okay. You've given hundreds of depositions?

19 A. Certainly, I have.

20 Q. Reviewed hundreds of cases?

21 A. I have.

22 Q. And -- and really your only source of your primary
23 source of income from 1998 up until 2021 when you fully
24 retired with your consulting work?

25 A. That's correct.

1 Q. All right. And -- and you understand that the
2 purpose of the discovery or the deposition when I got to ask
3 you questions, was for me to inquire to you what the opinions
4 that you formulated in this case were?

5 A. That's correct.

6 Q. And you agreed to be under oath and answer those
7 questions?

8 A. I did.

9 Q. And you were -- fully disclosed all of your
10 opinions?

11 A. Yes.

12 Q. In 2020, you had no criticisms of Dr. Frisch or
13 South -- Southeastern Spine after September 26, 2016, true?

14 A. I'm sorry.

15 Q. In your deposition back in 2020.

16 A. Yes.

17 Q. Your last criticism of Dr. Frisch in Southeastern
18 Spine had to do with the discharge on 9/26/2016, true?

19 A. That's true.

20 Q. All these other opinions are new. Everything
21 after that day is a new opinion, is it not?

22 A. Well, I wouldn't say they're new. I would say
23 that my opinion in 20 -- at that point in time was the wound
24 that should have been opened and cultured and -- and treated.
25 So I did say that, but I -- I wasn't offering opinions. And

1 I gave you opinions about the length of antibiotic treatment
2 back at that time as well.

3 Q. And you actually explicitly promised in your
4 deposition if you formulated new opinions that you would let
5 Counsel know so that they could be disclosed to us and then
6 we could kind of ask you questions about it?

7 A. Well, I'm not sure what a new opinion is.

8 Q. Well, you offered opinions about Dr. Frisch in
9 Southeastern Spine that are after the date of September 26,
10 2016. You just did. So when did you formulate those
11 opinions?

12 A. Well, I'm -- I'm not sure I -- I don't want to
13 argue with you, but my opinion was that the wound should have
14 been open and treated beginning 8/30. I said that back in
15 that -- and -- and it continued until the wound was
16 eventually opened and treated. But I gave you my opinion
17 that it should have been treated. Now, what I've said today
18 is I amplified some aspects of that treatment, but I didn't
19 give you new opinions. I don't believe I did.

20 Q. All right. So let's -- let me then be clear
21 because if -- if we're miscommunicating, or maybe I didn't
22 understand you then -- then maybe we can speed this up. Your
23 first opinion with respect to Dr. Frisch in Southeastern
24 Spine, was that on -- on August 30, 2016, you believe at that
25 date they should have taken the patient back to surgery?

1 A. That's correct.

2 Q. And that would continue on until eventually they
3 were taken back to surgery on September 21st?

4 A. That's correct.

5 Q. And your only other opinion that I understood
6 previously you to have with respect to Dr. Frisch in
7 Southeastern Spine was that he should have opposed Dr. West's
8 decision to send the patient home on oral antibiotics instead
9 of IV?

10 A. That's correct.

11 Q. And is -- as you sit here today, are those the two
12 opinions that you have with respect to Dr. Frisch and
13 Southeastern Spine?

14 A. Yes. All I amplified today was more information
15 about the treatment. I -- I said that the wound had to be
16 opened and cultured and that she had to be treated.

17 Q. All right.

18 A. That's all I've done.

19 Q. So then if -- we're in agreement. So the jury is
20 clear then in terms of your testimony as an orthopedic
21 surgeon about deviations from the standard of care they have
22 to do with August 30th, and that point should have gone back
23 to surgery, and then on September 26th he should have
24 insisted on IV antibiotics?

25 A. That's correct.

1 Q. And that's it?

2 A. That is.

3 Q. Okay. I'm going to turn my back to you just a
4 second. I'm going to --

5 A. That's okay.

6 Q. -- flip chart. Do you by chance know any of the
7 doctors or participants in this case?

8 A. No.

9 Q. All right. I'm going to use this flip chart to
10 demonstrate to Dr. West and his wife, who was my computer
11 science teacher in eighth grade that we don't need computers
12 for everything. Okay. 8/30 and 9/26 those are the two dates
13 with the opinions that you have; is that correct?

14 A. Yes. But I want to clarify. Starting at 8/30, I
15 believe the wound should have been opened and that continued
16 until it eventually was. I -- I -- I'm --

17 Q. I got you. So I drew an hour down, so 8/30 all
18 the way to 26th shooting up.

19 A. Right.

20 Q. I got you. All right. I jumped right in and I
21 didn't because I wanted to get some clarity on this so I can
22 figure out what all I needed to cover with you. I was
23 confused for a moment. You were talking about the MDL
24 litigation and the pedicle screw?

25 A. Yes.

1 Q. You were a named Defendant in that?

2 A. Yes.

3 Q. So you were actually a Defendant in hundreds or
4 thousands of lawsuits?

5 A. No, the MDL -- well, I was named in the MDL
6 litigation. I -- I was named.

7 Q. Okay.

8 A. And -- but it -- it -- you -- you're going to get
9 me involved in things that I -- they're -- they're federal
10 court legal issues that I -- I don't have enough knowledge
11 about, but yes, I was named in the federal litigation.

12 Q. Okay. And I'm just trying to make sense of what
13 you all just talked about. It sounded like there were
14 pedicle screws which are used in orthopedic surgery that --
15 that you and some colleagues were using before the FDA
16 approved it?

17 A. Well, everybody, the entire spine community was
18 using them, but I had -- yes.

19 Q. Okay.

20 A. It wasn't just some colleagues, all the spine
21 surgeons at Jefferson and in Philadelphia and around the
22 country were using them.

23 Q. Let me be more specific. You were sued in that
24 litigation because you were using pedicle screws before they
25 updated?

1 A. Correct.

2 Q. And the issue was that some of the screws that
3 would be put in would actually break?

4 A. That -- that was one of the issues.

5 Q. And that over time the technology for the
6 materials used for the screws improved.

7 A. Well, the design of the screws were -- were --
8 were improved.

9 Q. Right.

10 A. And then -- then -- then the metal titanium became
11 available.

12 Q. Right. So you had improvements in the materials
13 and improvements in the design, correct?

14 A. Yes. And -- and that's what I helped participate
15 in.

16 Q. Okay. And then the FDA approved the use of those?

17 A. They didn't approve the use of it because of the
18 design changes. They approved the use of it because it
19 became apparent that this was the right way to do it.

20 Q. And as I understand it, you were some kind of
21 proctor or some kind of a spokesperson for one of the
22 manufacturers?

23 A. Well, initially I started having courses and then
24 the -- the manufacturer asked me to be a part of their
25 medical advisory panel and I was.

1 Q. Okay.

2 A. Not a spokesperson for them per se, but helped to
3 teach the type of surgery.

4 Q. Got it.

5 A. And it -- it's -- it is really pretty complicated
6 because the FDA-approved the use of the spine and the -- the
7 screws in the sacrum, but they didn't approve it for the use
8 in these bones. So this is the FDA, a lot of bureaucrats and
9 they -- they were wrong, but it led to a lot of litigation.

10 Q. Right. And the theory at least that was espoused
11 against you was that you were used as were other physicians
12 to go teach other people how to use these screws. And so
13 there were more surgeons using the screws around the country?

14 A. In part, yes.

15 Q. And -- and in part, the other part of this case
16 was that because the FDA had not approved these -- these
17 weren't FDA-approved surgeries, true?

18 A. That's correct. Well, FDA doesn't really approve
19 surgery. FDA just approve -- this is such complicated stuff,
20 but the FDA only approves -- only approves the device. So
21 here's the device. They -- they didn't -- they -- they
22 didn't agree with the way the label on the device was. It --
23 it's very complicated.

24 Q. Okay. I don't want to get into it. I mean, the
25 gist of it was the MDL settled for like a \$100,000,000?

1 A. Yes. It -- it did settle that -- that was the one
2 manufacturer settled for \$100,000,000, but there were more --
3 there were 15 different manufacturers.

4 Q. Okay. I got you. I just -- I mean, I think we
5 understand the magnitude though. Let's -- let's move on to
6 this case. So in terms of your active surgical practice that
7 ended in 1998, true?

8 A. Yes.

9 Q. And from 1998, all the way until 2021, at the time
10 you retired, you were not treating surgery, but you weren't
11 performing surgery?

12 A. That's correct.

13 Q. You were basically having in-office visits one or
14 two days a week?

15 A. That's correct.

16 Q. So with respect to following a postoperative
17 patient, like the Plaintiff here, you weren't doing that from
18 1998 forward?

19 A. Correct. I did not see patients that were
20 immediately postoperative. I -- I did see patients who had
21 been operated upon, but not in the immediate postoperative
22 period during three -- three months or so following surgery.

23 Q. And as I understand it, that from 1998 after that
24 point, you never went back into the operating room?

25 A. That's correct.

1 Q. And so the surgery that you talked about earlier
2 that would've been something that you were doing, but that
3 was back -- back in the 90s?

4 A. Correct.

5 Q. The same surgery that Dr. Frisch did?

6 A. Correct. The same -- the same surgery.

7 Q. So in terms of working with infectious disease, in
8 terms of working with PAs, in terms of managing patients like
9 that, they -- like Ms. McGougan, the Plaintiff, that was your
10 folks back in the 90s and after 2 -- 1998, you went to an
11 office practice?

12 A. Yes.

13 Q. Okay. Now, you talked about the surgery that
14 Dr. Frisch performed. What was the name of that?

15 A. He did a microdiscectomy.

16 Q. And I think if I remember correctly, you said that
17 that was appropriate surgery to do?

18 A. Yes.

19 Q. And it was a minimal type of a surgery?

20 A. Yes.

21 Q. And there are more radical or aggressive ways to
22 treat that condition, are there not?

23 A. Yes, you could. There are. You could have been
24 more aggressive and done a fusion.

25 Q. Okay. And so a fusion then would've done what?

1 A. Would've fused the two bones together. The -- the
2 concept is that if you take out the disc and put bone in
3 where the disc was that you -- you -- you get one bone to
4 grow into the next, it's sort of tricking the -- the body
5 where there was a disc to make it bone. And that is a
6 concept to alleviate pain and also prevent collapse, so.

7 Q. But in this case, a more conservative approach was
8 taken, right?

9 A. Yes. I -- I agree with the surgery.

10 Q. Right.

11 A. I would've done that myself.

12 Q. And -- and in fact, while there are maybe more
13 aggressive options, sometimes a more conservative approach
14 like this is better?

15 A. Well, yes, you have -- it's -- it was appropriate
16 surgery.

17 Q. Technically, you have no criticisms of the surgery
18 itself?

19 A. That's correct.

20 Q. You all talking about informed consent earlier,
21 that you're aware that's not an issue in this case?

22 A. I didn't talk about it.

23 Q. You were asked questions by Counsel about talking
24 about the risk associated with surgery?

25 A. Oh, yes. But I didn't specifically speak about

1 informed consent.

2 Q. And to be clear, you're not offering any opinions
3 that Dr. Frisch failed to properly inform the patient.
4 You're not offering that opinion, are you?

5 A. No.

6 Q. And you saw the Plaintiff's deposition when you
7 were reviewing the materials that -- that she's not certified
8 that as well?

9 A. That's correct.

10 Q. You're not certified as an infectious disease
11 consultant, true?

12 A. True.

13 Q. You do not read infectious disease journals?

14 A. True.

15 Q. You're not an infectious disease expert?

16 A. True.

17 Q. You've never testified as an expert in an
18 infectious disease?

19 A. True.

20 Q. You are -- and you didn't perform any research in
21 this case on infectious disease or orthopedic surgery prior
22 to formulating your opinions, true?

23 A. That's correct.

24 Q. So you were provided the materials, you reviewed
25 them and you offered your opinions, and that's what we

1 discussed in 2020. And that's what you discussed today?

2 A. That's correct.

3 Q. So when you were asked that question about
4 awareness of any literature, things of that nature, that's
5 just as you sit here today, you don't have something on the
6 front of your mind versus you've gone and exhaustively
7 researched the issues?

8 A. That's correct.

9 Q. Okay. So it would be misleading for the jury to
10 think that you went to look for those articles and they don't
11 exist. It's just you're not aware it didn't exist?

12 A. No. I -- I -- I kept current with the literature,
13 but I didn't do a search to find all kinds of various
14 articles that I could quote today.

15 Q. Okay. And -- and to be clear, just provide a
16 little more context. I think you and Mr. Luginbill were
17 talking about whether you were familiar with any literature
18 that supported vancomycin for four days and then switching
19 into an oral medication. I believe your testimony was you
20 weren't aware of it.

21 A. That's correct.

22 Q. I just wanted to provide some clarity here that
23 you didn't actually undertake some kind of research to
24 determine whether there is or isn't that literature, true?

25 A. That's true.

1 Q. But -- and as you sit here, you're just not aware
2 of it one way or the other?

3 A. No. So I've kept current with the literature. I
4 do not believe that there is a substantial body of medical
5 literature from my reading that would support the use of only
6 four days or seven doses of vancomycin in a patient who is
7 immunocompromised with a deep wound infection.

8 Q. Okay. But we'll come back to that. The
9 immunocompromised vancomycin, because we talked about that
10 previously, but let me -- let me go chronologically and then
11 we get to -- that we'll cover, okay?

12 A. Okay.

13 Q. So we know that the surgery is performed on August
14 2, and you have no criticisms, right?

15 A. That's correct.

16 Q. You have no criticisms of the medications that
17 were prescribed, no criticisms of the discharge, no
18 criticisms of the follow-up on August the 16th?

19 A. Right. My first criticism is 8/30.

20 Q. Okay. So a patient then comes back in the 23rd,
21 and you talked about she was prescribed Bactrim that you
22 thought was reasonable?

23 A. Correct.

24 Q. Now, you also mentioned that the patient stopped
25 the Bactrim after four days?

1 A. Correct.

2 Q. And then the patient was resumed for a new
3 medication starting on 8/30?

4 A. Right. On doxycycline.

5 Q. So the patient didn't complete the Bactrim course
6 on the 23rd through the 30th, true?

7 A. That's correct.

8 Q. And in order to have the effect desired, we all
9 know that you got to take your antibiotics even if you're not
10 sick anymore, right?

11 A. Yes.

12 Q. So in terms of whether that Bactrim had a chance
13 to do what it was trying to do, it did?

14 A. That's correct.

15 Q. So if we're trying to figure out whether the
16 Bactrim actually was able to prevent an infection, it wasn't
17 completed, so it didn't?

18 A. That's correct.

19 Q. Okay. So then she comes back in on the 30th, and
20 at this point she hasn't had a -- of course, postoperative
21 antibiotics from the 23rd to -- to completion, and they just
22 prescribed doxycycline?

23 A. Right.

24 Q. Doxycycline happens to be effective for the
25 treatment of MRSA too, right?

1 A. It can be.

2 Q. Do you know whether it was effective for this
3 particular bug that's off on the ground?

4 A. It doesn't appear to have been since she was given
5 it. In -- in reality, she was given seven days of
6 doxycycline on two occasions. First, immediately following
7 the surgery, and second for seven days following on -- on
8 8/30 for seven days. So it doesn't appear that in -- in
9 reality, maybe in the laboratory it would've shown up as
10 being sensitive, but it didn't work on her.

11 Q. So we get to August 30th, and you believe at that
12 point the patient should have been taken back to the
13 operating room?

14 A. I do.

15 Q. Obviously going back to the operating room, that's
16 what happened on September 21st, right?

17 A. Yes.

18 Q. You would -- that's the same procedure you would
19 want to have performed?

20 A. Correct.

21 Q. Now, for August 30th, the patient did -- did not
22 have a full course of antibiotics since the first signs of
23 drainage, true?

24 A. On August the 30th?

25 Q. Yes, sir.

1 A. Well, that's -- she had four -- she had four days
2 of oral Bactrim.

3 Q. And I think we just covered that, right?

4 A. Yeah. From the -- from the 30th from the -- the
5 -- the 23rd to the 27th.

6 Q. And that's not a full course?

7 A. No.

8 Q. So my question is, when she was seen with the
9 30th, at that point in time she had not had a full course of
10 antibiotics?

11 A. I agree.

12 Q. Okay.

13 A. But -- but -- but she wasn't being treated for a
14 deep wound infection.

15 Q. Understood.

16 A. Okay.

17 Q. So now we get to August the 30th, and from that
18 point forward, you believe she should have gone back in for
19 the incision and drainage?

20 A. Absolutely.

21 Q. All right. Now, you saw the records from August
22 30th, of September 1st, September 8th, and again on September
23 the 20th, true?

24 A. Correct.

25 Q. In -- in those descriptions, I don't want to go

1 through them all now. We're -- I'm standing between us at
2 lunch, but there was no indication of redness, puffiness,
3 anything on the wound itself in those office visits that
4 would be indicative in and of themselves of an infection. Do
5 you agree with that, true?

6 A. The wound was draining during that time period.
7 It was open and draining.

8 Q. All right. Let's --

9 A. That's indicative of an infection.

10 Q. Okay. Let's do it this way then. If we could
11 pull up please Exhibit Number -- Defense Exhibit 23, please.
12 And if we could blow up as large as possible, the middle
13 paragraph about physical examination. So when September 9th,
14 or -- excuse me, September 8, 2016, when Ms. Ryan Aprill who
15 examined the patient -- this is the physical description that
16 -- that you observed in the record, true?

17 A. Yes.

18 Q. And it's recorded -- it says, "Well developed,
19 well-nourished 61-year-old female alert, oriented times
20 three, and no acute distress strength is five out of five
21 symmetric. I inspected her posterior incision site. There
22 is no erythema, no swelling, no flushness. Her incision
23 looks as it did two days ago. There is minimal amount of
24 drainage on the bandage and there is a small area in the
25 center of the incision where the drainage appears to be

1 coming from." See that?

2 A. Yes.

3 Q. So the erythema, tell us what that is.

4 A. Redness.

5 Q. Okay. So she's reporting no -- no redness, true?

6 A. True.

7 Q. No swelling?

8 A. That's true.

9 Q. No flushness?

10 A. That's true.

11 Q. And she's talking about minimal amount of drainage
12 on the bandage, right?

13 A. Correct.

14 Q. So she would -- patients on her -- on her side or
15 her tummy, and she's got a bandage on the back and the PA
16 actually removes the bandage, the physically examined?

17 A. Yes.

18 Q. And when she removes it, she sees what she's
19 describing is minimal amount of drainage on the bandage?

20 A. Correct.

21 Q. All right. Do you know whether that's the
22 serosanguineous fluid or whether that's purulent or does it
23 matter?

24 A. It doesn't matter.

25 Q. Fair enough.

1 A. At this point in time.

2 Q. You know which one it is?

3 A. Well, I don't, but it doesn't matter. It's an
4 open draining wound four weeks after surgery.

5 Q. Okay. So let's look then if we could, at the next
6 visit, which is Exhibit Number 25, please. No, 3rd. And if
7 you could blow up the first paragraph, please. All right.
8 And orient us. This is September the 20th at Southeastern
9 Spine visit with Dr. Frisch; is that right?

10 A. Yes.

11 Q. All right. And here it says that, "We had a
12 61-year-old female who is now approximately six weeks status
13 post L4-5 HMP." Okay. Sort of cut off there. "She had
14 complete resolution of her preoperative symptoms, but over
15 the last two weeks has had an increase in pain and does have
16 a wound dehiscence in the middle portion of her incision, but
17 no active drainage. However, she has noticed that she has
18 been having fevers and increased -- increase in pain. I
19 would like to get an updated MRI, she's very concerned about
20 her fevers." Can you see that?

21 A. Yes.

22 Q. Prior to this visit, were there any complaints of
23 fevers?

24 A. Not to my knowledge.

25 Q. And what's the significance of a -- of a fever?

1 A. Well, a fever can mean that you -- it's a -- can
2 be a sign of an infection.

3 Q. Okay. And --

4 A. It's a -- it's a sign of an inflammatory response
5 I should say.

6 Q. And what about pain?

7 A. Pain can be a sign of infection, inflammation.

8 Q. And what about a description that she has had an
9 increase in pain over two weeks?

10 A. Well, that's a concern.

11 Q. And -- and we know from the -- the prior exam was
12 basically two weeks before this?

13 A. Correct.

14 Q. And so she comes back in and Dr. Frisch sees her
15 and he takes her back to the hospital, has her admitted and
16 does the procedure?

17 A. Correct.

18 Q. Okay. So during the -- the course of this time,
19 the Southeastern Spine, did you ever see where the wound was
20 described as red or swollen or any of those descriptions?

21 A. No, but it was open and draining. That's the
22 point.

23 Q. Okay. That -- I understand that's your point.
24 I'm trying to understand the totality of pictures because you
25 keep focusing on one data point and I want to make sure we're

1 looking at them all. And so --

2 A. So -- so in all fairness, sometimes you will see
3 localized redness, sometimes you will see active drainage,
4 sometimes you'll see it's swollen, but this was a deep
5 infection. So the swelling and the accumulation of fluid as
6 seen on the MRI is deep. And you may not see that on the
7 surface. The most important issue is that it was open and
8 draining.

9 Q. Let's talk about the surgery then that was also
10 being performed on September 26th or September 21st. You
11 believe it should have been performed sooner --

12 A. That's correct.

13 Q. That surgery carries with it risk, true?

14 A. Yes.

15 Q. And if this wound does not have a deep wound
16 infection and you open it up, what are the potential problems
17 for the patient?

18 A. Well, when you open up a wound, you open it up
19 slowly and you see if it's getting beneath the fascia or it's
20 just superficial. So if it's superficial, you clean it up
21 and suture it up and -- and treat the patient with some
22 antibiotics and you should be fine. It's a superficial wound
23 infection. If it's a deep wound infection, the best thing
24 you can do is open it up and let it drain and get cultures
25 and treat the patient with antibiotics.

1 Q. Okay. Doctor, I don't think we're communicating.
2 My question is what are the risks of the patient when you do
3 the surgery?

4 A. Well, the same risks of any surgery have the risk
5 of death paralysis, blood transfusion, all additional
6 infection. You have all of those risks that I outlined
7 before that occur with any spinal surgery.

8 Q. Isn't that why you -- you as a surgeon to be
9 judicious when you do and when you don't do surgery?

10 A. Yes. You have to balance the risks. So here on
11 one hand you have a patient that -- what's the harm in taking
12 her back to the operating room? You have all those risks.
13 What's the good is that you could eradicate the infection at
14 an earlier date.

15 Q. All right. So the -- you had a standard risk of
16 infection, bleeding, death?

17 A. Correct.

18 Q. None of those are good. It's not good.

19 A. Well, it's not good to take somebody to the
20 operating room if you don't need to take them to the
21 operating room. I agree with that.

22 Q. I think we -- I think that's the point. We all --

23 A. Right. For sure.

24 Q. -- when they need it.

25 A. We just agree or disagree on when she should have

1 been returned to the operating room.

2 Q. Right. And so basically it comes down to the --
3 the disagreement of making a medical judgment of when it's
4 appropriate to pursue a surgery?

5 A. Right. And my position is that the standard of
6 care required it at a much -- so sooner point in time.

7 Q. Let's look at the -- you already talked about
8 surgery. All right. So back to surgery, open the wound for
9 -- making that decision whether to do the surgery or not.
10 You look at the clinical presentation, right?

11 A. Yes.

12 Q. You see what the wound looks like?

13 A. Yes.

14 Q. You look for drainage, right?

15 A. Yes.

16 Q. You look for the type of drainage, whether it's
17 purulent or serosanguineous?

18 A. Well, that may be helpful, but the fact that it's
19 open and draining obviously now on 9/26, this is almost two
20 months following the surgery, you're very concerned that it's
21 a deep wound and that's why he took her back to surgery that
22 day on 9/20 rather.

23 Q. I understand. I'm just trying to work through the
24 things that you look at here and we keep getting into this
25 refrain about you had drainage, you needed surgery. So I'm

1 just trying to understand what the other factors are. So I
2 was just going through a list that I thought you gave me the
3 deposition and if we need to, we can go to the deposition.

4 A. Sure. No.

5 Q. But you look for drainage?

6 A. Yes. Always.

7 Q. You look for the type of drainage?

8 A. You do.

9 Q. You look for the quantity of drainage?

10 A. Yes. That can be, it's informative. That's
11 right.

12 Q. And you look at how much drainage there's over
13 time?

14 A. That's correct.

15 Q. And you look at how the patient is responding to
16 the medications that she's been given -- that she hasn't been
17 given?

18 A. That's correct.

19 Q. And you look at the pain?

20 A. That's correct.

21 Q. You look at the pain as it compares to over time?

22 A. Yes. These are all things that you look at.

23 Q. And those are all things that were considered in
24 the evaluations that you saw as well, true? All of those
25 same factors.

1 A. Yes. They -- they were considered.

2 Q. You mentioned a few times this idea of
3 immunocompromised and I said -- we've come back to it. And
4 so I want to revisit that. Is it your understanding that the
5 patient had held off of her rheumatoid arthritis medicines
6 starting in July before surgery?

7 A. Yes. Right before surgery she stopped them.

8 Q. So by this point in time, she is two months
9 without any medication?

10 A. Yes.

11 Q. And I think if I remember hearing you said, "One
12 to two months" and, you know, is that in the system?

13 A. Well, I don't think we know. That I -- I may -- I
14 may have -- so it's not certain. I think I clarified that or
15 I said that it's not exactly sure when immuno -- when these
16 drugs complete their effects, but generally in the
17 neighborhood of one to two months, they're less, you're less
18 immunocompromised than you are on day one.

19 Q. All right. So in 2020 when we met for the first
20 time, we talked about immunocompromised. Do you remember
21 that?

22 A. I -- I don't remember the conversation exactly,
23 but go ahead.

24 Q. Did you review your deposition in preparation of
25 your testimony?

1 A. I did a few days ago, but I didn't memorize it.

2 Q. I understand.

3 A. If you have a -- I'll I'm happy to answer your
4 question.

5 Q. So let me just ask a question first and let me
6 refresh your memory. The -- at the time of your deposition
7 2020, you were under the impression that the patient was
8 still taking Enbrel at this time?

9 A. That's correct. Because of the discharge note had
10 said to resume Enbrel and I subsequently learned that no, her
11 Enbrel had stopped in July right before the surgery.

12 Q. So on November -- or excuse me, in September 26th,
13 back in 2020, when you were talking about how
14 immunocompromised the patient was. It was your understanding
15 and belief in formulating that opinion that it was based upon
16 her continued use of Enbrel?

17 A. That's correct.

18 Q. True? Okay. We know that's not the case?

19 A. That's correct. I didn't have records that -- I
20 didn't have pharmacy records or the complete records at that
21 time, and I based it upon her discharge summary, which
22 indicated she would resume Enbrel.

23 Q. Okay. Well, you did have a deposition and her
24 deposition clearly says she had Enbrel?

25 A. Yes.

1 Q. Okay.

2 A. But I didn't have a medical record.

3 Q. Either way, whether -- whether you dismissed it or
4 it was in the record or what, she wasn't taking Enbrel, true?

5 A. That's correct.

6 Q. So that's not a basis for being immunosuppressed?

7 A. Well, she was immunosuppressed during -- from the
8 time of surgery up until at some point a month or two later
9 approximately.

10 Q. So let's talk --

11 A. There's no definite time. I -- there's no
12 knowledge of when the immunosuppressant effects of Enbrel
13 absolutely stop.

14 Q. All right. So what did -- we're talking about
15 immunosuppressant again for clarification. That just means
16 that your -- your body's not able to fend off infections like
17 it typically would?

18 A. That's correct.

19 Q. And you got post-conditions or medicines, or
20 whatever it may be?

21 A. That's correct.

22 Q. Is it your opinion that rheumatoid arthritis, the
23 disease itself, causes immunosuppression?

24 A. I don't -- I don't know that it's my opinion of
25 that, but there have been people who suggest that the --

1 Q. To be clear, I like --

2 A. I don't.

3 Q. We're -- we're here to talk about Dr. Davne in
4 your opinion. So let me ask it this way. Are you able to
5 say to a reasonable degree of medical certainty that
6 rheumatoid arthritis itself causes immunosuppression?

7 A. No.

8 Q. Okay. So we should not focus on the rheumatoid
9 arthritis then we should be focusing on the medicine?

10 A. That's correct.

11 Q. In the medicine, the Enbrel, for example, what is
12 a half-life Enbrel?

13 A. I don't -- I don't know exactly.

14 Q. Can you tell -- tell us what a half-life is? Do
15 you know half-life concept?

16 A. Well, a half-life concept is when you administer a
17 drug, when half of it is gone. What -- what is the
18 half-life? So if you -- if you looked at aspirin, what's the
19 half-life of aspirin? It might be two hours.

20 Q. Did you use that example earlier?

21 A. Well, I'm giving it, I -- I purposely use the same
22 example.

23 Q. So -- so when you were formulating this opinion
24 that Enbrel could take one to two months, what -- what was
25 the basis for that?

1 A. Because it can -- from my reading, I understand
2 that these drugs have an effect that can last one to two
3 months. It's a decreasing amount.

4 Q. Okay. So as you sit here today, can you offer
5 opinions or a reasonable degree of medical certainty that the
6 effects of Enbrel can any (inaudible) a patient up to two
7 months after they're stopped?

8 A. Yes.

9 Q. And that's your opinion to a reasonable degree of
10 medical certainty?

11 A. Yes.

12 Q. And that is based upon what?

13 A. It's based upon my knowledge and experience and
14 reading. So obviously --

15 Q. Reading what?

16 A. Reading literature. Can I finish my -- so it is
17 true that the day you stop Enbrel, you're, you know,
18 compromised to the fullest extent and each successive day
19 that decreases. But these are powerful drugs and they don't
20 -- their effects don't disappear in a week. Their effects
21 continue the exact length of time that their effects of
22 immunosuppression is unknown from my reading.

23 Q. Would you agree that the immunosuppression, if
24 any, is diminishing from the point of the last administration
25 of Enbrel?

1 A. Yes, that's what I said.

2 Q. And if I was just -- I hear what you're saying
3 because it's your opinion and it's literature, but you're
4 asking us to state your word for it. So all I'm saying is
5 that when you say the literature, is there a literature that
6 we need to say, oh yeah Jamie, when you go read this that's
7 what it says.

8 A. Well, I don't have a specific article, but I
9 understand that immunosuppressive drugs don't stop their
10 effect like an aspirin in two hours.

11 Q. Right.

12 A. It is a period of time that can be a month or two
13 and it's unknown.

14 Q. All right. You -- you mentioned that there's some
15 confusion based on the records about whether she was on
16 Enbrel or not. So I want to pull up one other record. I
17 don't think we talked about it yet. We could look at Exhibit
18 Number 15, please -- Defense's Exhibit 15. All right. Who
19 is -- blow at the top just to help where (inaudible) in his
20 hand, please?

21 A. I can't read it.

22 Q. Yeah, we're going to try to blow it up so everyone
23 can see it together.

24 A. It's blurry.

25 Q. All right. So what we're looking at here in

1 Exhibit 15, is the consultation note in conjunction with the
2 surgery that Dr. Frisch did back in August, the original
3 visit.

4 A. Okay.

5 Q. And you recognize the name Dr. Whirrett down
6 there?

7 A. Yes.

8 Q. That's an internal medicine doctor who came to see
9 the patient to evaluate her condition, her medical condition,
10 her medicines, all of that kind of stuff before surgery?

11 A. Yes.

12 Q. Okay. And that's a good idea, right?

13 A. Yes.

14 Q. All right. And if we look at the last page in
15 terms of assessment plan from the consultant, Dr. Whirrett on
16 page one, on page three of that document. And under
17 assessment plan Number two there it says rheumatoid
18 arthritis, it says, "Her Enbrel medic are on hold very
19 operatively to locate with Dr. Frisch." You see that?

20 A. Yes.

21 Q. Certainly here and then in the Southeastern Spine
22 records and elsewhere, you saw the medical references to
23 these Enbrel drugs being helped, true?

24 A. Yes, I understand that.

25 Q. So the surgical team in the Southeastern Spine

1 folks were aware of a rheumatoid arthritis, true?

2 A. Yes.

3 Q. They're aware of her treatment for it, true?

4 A. Yes.

5 Q. They're aware of how that treatment might affect
6 her recovery, true?

7 A. Yes.

8 Q. He made a plan about what to do to minimize that,
9 true?

10 A. Hold on.

11 Q. To hold those medicines?

12 A. I -- I, yes. To hold the medicine. That's right.

13 Q. That's true?

14 A. That's appropriate. I have no objection to her
15 care and treatment at that point in time.

16 Q. Understood. But your original opinions about
17 immunosuppression was premised on the idea that she had
18 continued to take Enbrel all at this time?

19 A. Yes, but as I said to you before in 2020, I didn't
20 have all the information and I -- I said in my testimony at
21 that time it was my understanding based upon the discharge
22 summary, which indicated she was going to continue with
23 Enbrel and I didn't have all the information I subsequently
24 have learned. She -- despite what the discharge summary said
25 she didn't take -- she didn't continue with Enbrel.

1 Q. All right. So anything else, and I mean it sounds
2 to me like for the immunosuppression at least as it relates
3 to your opinions, the only thing that we're talking about is
4 Enbrel. Is there anything else?

5 A. No, she -- I mean significantly, that's the main
6 thing. She did get some steroids, but that's not, it is an
7 immunosuppressant, but the main issue was the Enbrel.

8 Q. And as you sit here today, you can't offer an
9 opinion to a reasonable degree of medical certainty whether
10 her treatment, rheumatoid arthritis before surgery in fact
11 had an immunosuppressant effect that causes infection, true?

12 A. I can -- I -- I -- let me break that apart. So
13 the immunosuppression, there was an effect from
14 immunosuppression, but I am not saying that the
15 immunosuppressant is what caused the infection. She got an
16 infection in the operating room unfortunately which happens,
17 but she was immunosuppressed at the time to some degree at
18 the time she underwent the surgery. So yes, she was
19 immunosuppressed to some degree, but I'm not saying that it
20 was the immunosuppressant that caused the infection.

21 Q. Understood. So then I think we're agreeing with
22 the question.

23 A. We are.

24 Q. Whether the immunosuppression, if any, caused this
25 infection, your answer is no?

1 A. So the immunosuppressant by itself didn't cause
2 the infection, but she was immunosuppressed which created a
3 -- she made -- it made her more susceptible to an infection,
4 but that wasn't -- I have no objection to the way she was
5 being treated at that time.

6 Q. All right. Let's jump to September 20th
7 timeframe. You looked at that MRI?

8 A. I did.

9 Q. Right. And that you agreed that the MRI's proper
10 diagnostic tool for looking up the osteomyelitis?

11 A. Yes.

12 Q. And September 20th, at that time that's when -- or
13 September 21st when the IND the surgical procedure to clean
14 up the wound was performed. Dr. Frisch did that and also was
15 able to directly visualize the surgical procedure performed?

16 A. That's correct.

17 Q. So between the MRI and the surgeon's eyes, those
18 are the tools that you would use to see if there is evidence
19 of bone involved?

20 A. Yes. But the surgeon's eyes, he didn't go back in
21 and explore the disc space and the bone at that point. He
22 just opened up the wound. He wouldn't have been able to see
23 into the disc space at that time.

24 Q. Nor would you want it to be looking in there?

25 A. That's correct.

1 Q. Right?

2 A. That's correct.

3 Q. So and we can agree then the MRI that Dr. Frisch
4 ordered in September of 2016 did not show evidence of
5 osteomyelitis?

6 A. That's correct.

7 Q. You agree that Ms. McGougan's infection was
8 contained within an abscess and involved no bone or disc at
9 that time was September 20, 2016?

10 A. No, I -- I wouldn't agree with that. I believe
11 that the -- there was no way of demonstrating it by MRI, but
12 I believe it would've been the -- the disc in the bone
13 would've been infected by that time.

14 Q. So is your opinion that the bone was infected by
15 September 20 of 2016?

16 A. Yes, but we just couldn't -- we -- this is a -- a
17 typical problem. We oftentimes don't see the evidence on
18 studies on MRI for two or -- two or three months after the
19 bone infection is there because not enough destruction has
20 occurred to be visualized.

21 Q. All right. So then maybe the better question was
22 there was no evidence of disc or bone involvement as of
23 September 20 of 2016?

24 A. And that's what I said.

25 Q. So let's then jump forward to the discharge. You

1 talked about the vancomycin with Mr. Luginbill, that was a
2 recommendation by Dr. West obviously, right?

3 A. Yes.

4 Q. Do -- do you have any idea who Dr. West is or?

5 A. Well, he is an infectious disease doctor.

6 Q. And do you know sort of anything about the
7 standing in the medical community?

8 A. I don't have anything negative.

9 Q. All right. So do you know why Dr. West thought
10 that the four days of IV was sufficient with 14 days of oral
11 antibiotics of?

12 A. No.

13 Q. Okay. So in terms of his thought process for the
14 rationale that -- that he used to reach that decision, you're
15 not aware of what it is?

16 A. No. I -- I believe she was having some trouble
17 with IVs, but there was some note to that effect, but I don't
18 know for a fact.

19 Q. Do you agree that if she had stopped taking her
20 rheumatoid arthritis medications in July 2016 that she would
21 not be considered immunocompromised during this treatment
22 period?

23 A. No.

24 MR. HOOD: Again, your Honor, can I hand this
25 deposition?

1 THE COURT: Handed you. Uh-huh. Thank you.

2 BY MR. HOOD:

3 Q. All right. Dr. Davne, we have handed to you a
4 copy of the original of your deposition transcript from
5 September -- excuse me, April 20, 2020. Do you have that
6 with you?

7 A. I do.

8 Q. And at this time you're under oath and free. Does
9 it testify just like if you're in the court, true?

10 A. Yes.

11 Q. All right. Let's go to page 93. If we could go
12 there together in line 15.

13 A. Okay.

14 Q. Are you there with me?

15 A. Yes.

16 Q. All right. My question to you: "All right." --

17 A. What -- what line?

18 Q. Line 15.

19 A. Line 15.

20 Q. You there?

21 A. Yes.

22 Q. All right. My question to you. "All right. If
23 in fact the records indicate that she was not taking her
24 rheumatoid arthritis medicines during that period from July
25 through September."

1 A. I'm sorry -- I'm sorry. I must be on you --
2 you're line 15 you said to me on page 93.

3 Q. No, we're definitely not communicating. Let's go
4 to page -- I'm -- I'm sorry, I think I said 93. It's 94 line
5 15.

6 A. Line 15. Okay. Go ahead.

7 Q. Starts with: "All right." Do you see that?

8 A. Right.

9 Q. Okay. Here we go. Try again. My question, "All
10 right. If in fact the records indicate that she was not
11 taking her rheumatoid arthritis medicines during that period
12 from July through September, would that change your opinions
13 in this case?"

14 Your answer, "Well, it would eliminate the issue of
15 immunosuppression which I had spoken about that she wasn't
16 immunosuppressed during that time period. But that was not
17 what I had seen, what I had saw on the medical records. If
18 you want to point something to me to make me doubt that, I'm
19 happy to look at it." Did I read that correctly?

20 A. You did.

21 Q. And Doctor, you agree that if she was not
22 immunocompromised then the combination of Dr. Frisch's
23 surgery on September 21st, four days of IV vancomycin in the
24 hospital and 14 days of oral minocycline after being
25 discharged was appropriate, correct?

1 A. What line are you on now?

2 Q. I'm asking you a question first.

3 A. Oh, so I want to finish to your previous question.

4 Q. We are.

5 A. Because what you did was, I was referring when you
6 asked me that question to the 9/20 time period above that, so
7 I was talking about 9/20, the immunosuppression. That --
8 that's the line right above when you asked me line 15, line
9 13 says admission on 9/20. So I was talking about the
10 admission on 9/20. Now -- now, go ahead with your question.

11 Q. I'm sorry, I'm going to have to read that back
12 because my question specifically set a period from July
13 through September. So let's look at this question together
14 and see how you answered it under oath at the time. "If in
15 fact the records indicate she was not taking her rheumatoid
16 arthritis medicine during that period from July through
17 September, would that change your opinions in this case?"
18 Your answer, "Well, it would eliminate the issue of
19 immunosuppression, which I have talked about or spoken about
20 that she wasn't immunosuppressed during that time period.
21 But that's not what I had seen, what I saw in medical
22 records. If you want to point something to me to make me
23 doubt that, I'm happy to look at that." Did I read that
24 correctly?

25 A. You did, but again, July, September, but the next

1 sentence is -- in -- in my answer, I talked about the
2 admission of 9/20. So I was focused on the 9/20 when I was
3 answering it and maybe I was confused.

4 Q. Well, Doctor, you did have the opportunity to
5 receive your transcripts, true?

6 A. Well, I -- yes, but yes, that's correct.

7 Q. Okay. And you get the transcript after all these
8 questions and answers are typed up, right?

9 A. Yes. I didn't see anything incorrect about my
10 answer.

11 Q. And if you wanted to change or clarify, you have
12 the ability to do that. You know that?

13 A. That's correct.

14 Q. And you didn't choose to clarify or change this
15 testimony, did you?

16 A. Look, I don't want to argue with you about this,
17 but there is some confusion here and it's matter of
18 interpretation. I was talking about 9/20, and what I've
19 explained is the immunosuppression by that time would largely
20 have been gone because it's a month or two after the -- the
21 she had stopped the Enbrel. I agree with that.

22 Q. You agree with this statement?

23 A. I agreed that by 9/20 there was no effect of
24 immunosuppression.

25 Q. Okay.

1 A. That's what I agree with.

2 Q. All right. Well, I think we can move on then. No
3 immunosuppression as of '19?

4 A. That's correct.

5 MR. LUGINBILL: Objection, Your Honor. That misstates
6 the testimony and misstates the records.

7 THE COURT: Is there any objection?

8 MR. LUGINBILL: It's basically the objection misstate
9 your testimony.

10 THE COURT: I think your objection it's inconsistent
11 with your witness's answer.

12 MR. HOOD: Thank you, your Honor.

13 BY MR. HOOD:

14 Q. Okay. I -- I'm not trying to muddy the waters,
15 I'm ready to move on. I think we're aligned here, but
16 apparently not.

17 A. What I said and what my testimony -- what my
18 testimony is, is that Enbrel has a decreasing effect of
19 immunosuppression. That's what I've made perfectly clear.
20 And that by 9/20, which is two months later, it should -- she
21 should not have had any significant immunosuppressive effect.

22 Q. Right.

23 A. That is consistent with what I've been saying.

24 Q. All right. Let's get this written down here.

25 Anybody saying you didn't want to, 9/20 is not equal and you

1 know it's fresh. Do you agree with that?

2 A. Yeah.

3 Q. Okay. Let's move on. And, doctor, do you agree
4 that if she was not immunosuppressed on 9/20, then the
5 combination of Dr. Frisch's surgery on September 21st --

6 A. Where are you reading from?

7 Q. I'm asking a question first.

8 A. Oh, okay.

9 Q. Okay. I'm reading from my outline. You with me?

10 A. Yes.

11 Q. Doctor?

12 A. Yes, I'm listening.

13 Q. Okay. I don't just take the deposition back. I
14 want to make sure we finish this.

15 A. Okay.

16 Q. All right. I'll leave it right here. My question
17 to you, doctor, you agreed that if Ms. McGougan was not
18 immunocompromised then the combination of Dr. Frisch's
19 surgery on September 21st, four days of IV vancomycin in the
20 hospital and 14 days of oral minocycline after being
21 discharged was appropriate?

22 A. I think that she should have had seven to 10 days
23 of intravenous antibiotics that seven doses was not
24 appropriate of intravenous antibiotics. That's my opinion.

25 Q. I hand you your deposition again, if we could

1 together go to page 100 of your transcript, sir.

2 A. Okay.

3 Q. Line Number 12.

4 A. Okay.

5 Q. Here is my question, "From April 20, 2020, and you
6 agree that if she was not immunocompromised then the
7 combination of irritation and debridement four days of IV
8 antibiotics, and 14 days of oral antibiotics that was all
9 appropriate and meets the standard of care?" Your answer,
10 "Yes."

11 A. Yes.

12 Q. Did I read that correct?

13 A. You did.

14 Q. And we know she wasn't immunosuppressed?

15 A. That's correct.

16 Q. All right. I want to shift gears on the
17 osteomyelitis then. I think we testified earlier we in
18 agreement there was no medical evidence of osteomyelitis at
19 the September, late November?

20 A. That's correct.

21 Q. And you believe the earliest it might have been
22 diagnosed was sometime late November?

23 A. Yes. It -- it -- it frequently can't be diagnosed
24 until it's very common that it can't be diagnosed until three
25 months.

1 Q. Okay. Is this particular case, doctor, isn't it
2 true that you believe the earliest it might have been able to
3 be diagnosed was sometime in late November?

4 A. I would agree that's three months.

5 Q. And in between those dates, the September and
6 November dates, she was feeling better and the infection was
7 not apparent, correct?

8 A. In between what dates?

9 Q. Date she was discharged from the hospital.

10 A. On which day?

11 Q. September 26th.

12 A. Correct. There was no -- it was not apparent.

13 Q. So we have this --

14 A. Except for increasing pain.

15 Q. So we have a September 26th to November 28th --
16 the two-month period?

17 A. Right.

18 Q. And during that period of time, she wasn't
19 exhibiting signs of infection until her pain came up?

20 A. That's -- that's correct.

21 Q. Okay.

22 A. And she developed a fever.

23 Q. And is -- as I understand your testimony you
24 believe, sir, it should have been earlier. Despite that,
25 you're unable to quantify how earlier intervention on August

1 30 would've ultimately changed your outcome, true?

2 A. I can't quantify it, but the earlier you intervene
3 and treat the deep wound infection, the more likely that
4 you'll have a good -- a better result. I can't quantify it
5 though.

6 Q. Meaning that you can't provide an opinion to a
7 reasonable degree of medical certainty that a surgical
8 intervention on August 30th would've eliminated the
9 osteomyelitis that was (inaudible)?

10 A. That's not what I said. What I said is that
11 earlier intervention by quantify, I -- we're putting a Number
12 , a percentage Number that -- or -- and, but what I can say
13 is the earlier you intervene, the more likely that you
14 would've treated the osteomyelitis before significant damage
15 had occurred. It -- it's a continuum. So if you get to this
16 infection earlier and you treat it earlier, it's more likely
17 you would've resolved the osteomyelitis.

18 Q. And you're -- you're not able to find that even if
19 the steps that you recommend have been taken, were taken, did
20 -- the osteomyelitis might not occur?

21 A. That's correct.

22 Q. And in terms of the increased -- her risk for
23 developing osteomyelitis, that's not something you can
24 quantify?

25 A. That's correct. That's what I was implying. I

1 can't quantify it, but there's an increased risk. The longer
2 the infection is allowed to be present before you treat it --

3 Q. Right.

4 A. -- the more likely that the -- you -- you can't
5 eradicate it.

6 Q. Okay. And so when we're talking about that, you
7 can't say that she had a 10 percent more likely chance or 50
8 percent?

9 A. That's correct.

10 Q. Anything like that?

11 A. That's correct. That's what I said.

12 Q. You offered some testimony about Duke records not
13 fast-forwarding?

14 A. Okay.

15 Q. Have you -- have you interviewed or examined the
16 patient?

17 A. No.

18 Q. So in terms of the Duke records, and you -- you
19 just look at them to see if -- what current status was,
20 things like that?

21 A. That's correct.

22 Q. And I -- I presume from your review of the Duke
23 records, you -- you saw the notes by doctor -- is it Grassy,
24 Grossy?

25 A. I -- I don't -- I just don't remember, but I

1 looked at the Duke records.

2 Q. Okay. He was a surgeon up there who identified
3 the significant hip pain?

4 A. I -- I don't remember exactly.

5 Q. Okay. Do you remember from the Duke records that
6 there was a hip issue and also a -- a low back issue?

7 A. I don't remember exactly. I remember the low back
8 issue.

9 Q. Okay. Let me -- let me pull up Exhibit Number 89
10 to see if this helps refresh your memory. If we could go to
11 the assessment plan, which is on page five, please. And then
12 that's hard to read. See we can do the page five one. All
13 right. And if we just pull out that assessment claim would
14 be great. All right. Hopefully that helps read a little bit
15 there. And for orientation here, this is a visit in June or
16 July 25, 2017. It says, "Ms. McGougan, 62-year-old female
17 with a history of rheumatoid arthritis (inaudible)
18 microscopic discectomy in South Carolina August 2016." So
19 that's the history, right?

20 A. Yes.

21 Q. And I -- we can read the whole thing. "After
22 approximately two weeks after surgery, developed infection,
23 which was sought to be discitis osteomyelitis prognosis
24 sepsis, was treated with IV antibiotics from MRSA sepsis
25 discitis osteomyelitis. She is a (inaudible) at times.

1 She's actually now has fairly mild back pain and left-sided
2 leg pain. She's no longer taking antibiotics. She's here
3 today to establish carrier, her referral recommendation for
4 rheumatologist." Do you see that?

5 A. Yes.

6 Q. Okay. So then beneath that, if we could scroll
7 down on the exam section. Again, I really don't want to have
8 to read this whole paragraph to you. What I'm trying to get
9 you to focus in on is about halfway down. The sentence
10 begins, "Obviously in the middle there." Do you see that?
11 "Obviously --

12 A. Yes. I see it.

13 Q. -- since she's doing fairly well at this point, I
14 would not recommend any surgical intervention. I do think we
15 need to keep an eye on her sagittal balance. I explained to
16 her hopefully that this will collapse down in auto-fuse in a
17 position where she has no significant compression, either
18 health work, or eye nerve roots. I talked to her about what
19 to look for with respect to this." And is that -- as an
20 orthopedic surgeon, you are hoping that's going to fuse now.
21 Is that --

22 A. Yes.

23 Q. -- that's normal. And the alternative would be to
24 go in and do hardware to fuse it?

25 A. Correct.

1 Q. And so you'd rather keep the hardware out than let
2 the body do itself?

3 A. Yes.

4 Q. All right. So you saw this record, right?

5 A. Yes.

6 Q. All right. Then let's look at -- there's one
7 more. Do pull up Exhibit Number 100, and this is another
8 visit from March 5, 2019. We're going to go to the sixth
9 page of this visit. And I just want to pull up the first
10 large paragraph. You can pull up that first large paragraph
11 please.

12 All right. So do you recall in your review of the Duke
13 records where her treating physicians there indicated that
14 they discussed in 2019 her current sentence exam findings?
15 She has chronic back and buttock and hip pain region. I
16 agree with Dr. Grossy that about all the possibilities. See
17 that her left hip joint itself is what's driving this pain by
18 the possibilities include her pain for lower left, the set
19 joints or upper radiculopathy on the left, although I think
20 it is less likely overall. Do you see that?

21 A. Yes.

22 Q. Did you do any of your own assessments whether you
23 have these complaints, that are being talked about, were
24 actually hip related versus back?

25 A. No, I -- I don't have any medical information

1 about that.

2 Q. Okay. So in terms of, you know, whether all of
3 her current situations, current complaints today are related
4 with all fusion or not, that's just not something that you've
5 gone through to look at you make a determination all her
6 (inaudible)?

7 A. No, but she -- the -- the most prominent symptom
8 has been her chronic back pain, which I believe is related to
9 her back.

10 Q. Understood. But, for example, this thing here,
11 talking about left hip joint pain?

12 A. I don't recall that they worked -- they evaluated
13 any further. I just don't remember that they evaluated her
14 hip.

15 Q. You -- you don't know whether -- let me just get
16 some clarification in terms of what you did look at, you
17 looked at all the Duke records?

18 A. Well, then I had, yes, I think up through 2019.

19 Q. And did you look at any records after that?

20 A. No.

21 Q. Did you look at any -- any of her treating primary
22 care doctor records?

23 A. I don't remember anything after 2019.

24 Q. Rheumatology?

25 A. I just don't remember anything after 2019.

1 Q. So in terms of the snapshot, the snapshot ends in
2 2019?

3 A. That's right.

4 Q. Bear with me just a second, please. All right.
5 Doctor. All right. So, Doctor, as I'm getting ready to sit
6 down, I just want to make sure we're clear. We have two
7 days, 30th and the 26th?

8 A. Right.

9 Q. We're also clear that as of the 20th of September,
10 patient was not immunosuppressed?

11 A. That's correct.

12 MR. HOOD: Thank you.

13 THE COURT: Mr. Foreman, ladies and gentlemen, we're
14 going to take advantage of this break in testimony to take
15 our lunch recess. We'll break until 2:15. During the break,
16 please do not discuss the case in any manner whatsoever.
17 Please leave your notepads on your seats. Again, avoid any
18 contact with anyone or about the courthouse you do not
19 recognize to be a fellow juror and return directly to your
20 jury room at which time we will resume testimony. Have a
21 good lunch.

22 (Jury exits courtroom.)

23 THE COURT: Doctor, you may step down. I would just
24 ask that you return by 2:15 and please don't discuss your
25 testimony. Thank you.

1 Is there anything forward right for lunch from
2 Plaintiff?

3 MR. LUGINBILL: No, ma'am.

4 THE COURT: From the Defense?

5 MR. HOOD: No, your Honor.

6 THE COURT: Have a good lunch. See you at 2:15.

7 (Off the record.)

8

9 **CERTIFICATE OF TRANSCRIBER**

10

11 I, MARY RAGSDALE, a court-approved transcriber, do
12 hereby certify that the foregoing is a true, accurate, and
13 complete Transcript of Record of the proceedings had and
14 evidence introduced in the trial of the captioned case,
15 relative to appeal, in the South Carolina Circuit Court 9 of
16 Charleston County, South Carolina, on the September 9, 2024.

17

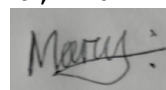
18 I do further certify that I am neither of kin, Counsel,
19 nor interest to any party hereto.

20

21

22 September 9, 2024

23



24

MARY RAGSDALE

25

Transcriber

1 CONTINUATION OF PROCEEDINGS - SEPTEMBER 11, 2024

2 THE COURT: Please be seated. Good morning everybody.

3 All right. Everyone ready to proceed?

4 MR. LUGINBILL: We are, your Honor.

5 MR. HOOD: We are, your Honor.

6 THE COURT: And who is your next witness?

7 MR. LUGINBILL: Your Honor, we would call Ms. Dula Ann
8 Leggette to the stand.

9 THE COURT: Okay. And then who's going to be your --
10 I'm trying to determine how many more witnesses you're going
11 to need to call in your case.

12 MR. LUGINBILL: Your Honor, I think we have five live
13 witnesses and then we have the one --

14 THE COURT: With the deposition?

15 MR. LUGINBILL: The deposition.

16 THE COURT: And how long do you anticipate those
17 witnesses will take to complete?

18 MR. LUGINBILL: It is my goal that we should be able to
19 finish shortly after lunch.

20 THE COURT: And then how many witnesses do you have,
21 Mr. Hood?

22 MR. HOOD: Five.

23 THE COURT: And then how many do you have, Mr. Smyth?

24 MR. SMYTH: Two, your Honor.

25 THE COURT: Okay. They should be right behind me. Is

1 your witness in the courtroom?

2 MR. LUGINBILL: Yes, ma'am.

3 THE COURT: You need to go ahead and have him stand by
4 the witness stand, please. If you all have any requests for
5 instruction, I would ask that you all get those to me by the
6 lunch. Unless you have them now. That would be helpful.
7 They may need to be in writing. Please don't email them to
8 me.

9 MS. FLUMIAN: Your Honor, we're prepared to tender
10 ours.

11 THE COURT: I'm sorry, I can't hear you.

12 MS. FLUMIAN: We're prepared to tender ours at this
13 time.

14 THE COURT: Thank you. That would be great. I just
15 need to make sure your colleagues have copies.

16 MS. FLUMIAN: Thank you.

17 THE COURT: Thank you, ma'am. Appreciate it.

18 (Jury enters courtroom.)

19 THE BAILIFF: All jurors present, your Honor.

20 THE COURT: You may be seated. Good morning, ladies
21 and gentlemen, I hope everybody had a pleasant and restful
22 evening. We're now going to resume testimony.

23 Plaintiff may call their next witness.

24 MR. LUGINBILL: Thank you, your Honor.

25 Plaintiff calls Ms. Dula Ann Leggette.

1 THE COURT: You can swear the witness, please.

2 THE CLERK: Please raise your right hand and place your
3 right hand on the Bible.

4 DULA MCGOUGAN LEGGETTE,

5 being duly sworn, testified as follows:

6 THE CLERK: Please be seated. Please state your full
7 name, spelling your last name directly in the microphone.

8 THE WITNESS: Dula McGougan Leggette, L-E-G-G-E-T-T-E.

9 MR. LUGINBILL: (Inaudible).

10 THE WITNESS: Thank you so much.

11 THE COURT: Ma'am, can you spell your first name as
12 well?

13 THE WITNESS: D-U-L-A.

14 THE COURT: Thank you.

15 You may proceed.

16 DIRECT EXAMINATION

17 BY MR. LUGINBILL:

18 Q. Good morning, Ms. Dula. How are you today?

19 A. Good morning.

20 Q. Where are you from?

21 A. I live in Belmont, North Carolina.

22 Q. Where is that in relation to Tabor City?

23 A. It's about three and a half hours. It is west of
24 Charlotte.

25 Q. Okay.

1 A. Just west of -- just across the top of the river
2 from Charlotte.

3 Q. Tell the jury a little bit about how you know
4 Ms. Pat.

5 A. I officially met Pat when she started dating my
6 brother in 2005. So she's my sister-in-law. And we have a
7 lot of family connections, a lot of friends in common because
8 I grew up in the area which she did and -- and -- I know her
9 well from the years of her being my sister-in-law.

10 Q. Have you all been closer?

11 A. Pardon?

12 Q. Have you all become close?

13 A. Yes, we have become very close. We talk on the
14 phone frequently.

15 Q. Now, obviously you're three hours apart, you're
16 not having coffee every day, but how often do you two spend
17 time together?

18 A. It varies. Sometimes we see each other once a
19 month or so. Sometimes we may go several months. It just
20 depends on family situations and our time schedules.

21 Q. No one here, like, you -- how important is family
22 to you?

23 A. Oh, extremely important.

24 Q. Give me some examples.

25 A. Well, Pat comes from a large family, so she

1 understands what our family was like when she married into
2 our family. We have 20-some first cousins on just my
3 mother's side, and we get together on a regular basis. And
4 she's always been very gracious in helping plan and take part
5 in family events and -- and things that we do. She always,
6 you know, was welcoming to have us at her home.

7 She loves to cook and it makes -- nothing makes her
8 happier than to cook a big meal and have a lot of family fill
9 her house with, you know, with love and laughter. And she's
10 always -- keeps up with, you know, what's going on with, you
11 know, the different cousins and -- and relatives.

12 Q. But is there a sense of service in the way she
13 treats her family?

14 A. Oh, certainly. If she says come over for a light
15 lunch, come over for a Thanksgiving feast type of lunch
16 because she is more than happy to -- you know, to do things.
17 And she's always been the one that when we just sort of came
18 through wedding season with several cousins, you know,
19 getting married and she was always the first to say, I want
20 to give a shower, I want to do a baby shower, I want to help
21 out with this. And the -- the -- the family always feels
22 very welcomed, you know, in her home and she's very easy to
23 talk to and -- and -- and is close to a lot of our family
24 members. Yes.

25 Q. Before her initial injury in 2016, how would you

1 describe her as far as an active person being able to get out
2 and do what she wanted to do?

3 A. Pat is a -- a very kind and -- person and -- and
4 caring. And she's always been very active in her church and
5 in her community, and it was something that she was
6 constantly on the go. And in -- in participating in events
7 in the community, in the church it was very common for her to
8 take meals to families for somebody that had been sick if
9 there was a new baby. She sang in the church choir. She was
10 just active in a lot of activities as -- as well as working
11 full time at that point.

12 Q. When was the first time you guys actually see her
13 after she had July surgery done?

14 A. The -- the first -- the first surgery was in
15 August.

16 Q. I called July surgery, "July", but yeah, she had
17 it on August 2nd. Did you see her between the August the 2nd
18 surgery and the September surgery?

19 A. August surgery and September surgery. I don't
20 think so. I think we just talked on the phone during that
21 time.

22 Q. And were you able to see her between September and
23 December?

24 A. Yes.

25 Q. So tell us about when you first saw her after the

1 September surgery.

2 A. I know for sure I saw her in early November. One
3 of our uncles had passed away and after the service that his
4 -- at the cemetery, the family went to her house and she
5 welcomed everyone in -- you know, in the home. And she was
6 -- she was not feeling well at that point. And that was
7 probably the second week in November.

8 And then, I saw her again early December and there had
9 been a marked change in her ability to do things at that
10 point. The visit in December, she was not doing well at all
11 and it was getting time to start preparing for Christmas, so
12 I went down to help put up a Christmas tree.

13 Q. How important is Christmas and family?

14 A. Oh, family and Christmas is -- is a big thing. I
15 mean, just you have large families and extended families and
16 you are accustomed to Christmas get togethers and -- and --
17 and it's -- it's a very significant holiday because of the
18 actual true meaning of it, as well as the fact that it's an
19 important time to be with family.

20 Q. When you were there in December, did she talk
21 about having Christmas with her grandkids first son boy?

22 A. Oh, yes. Yeah. And that was part of the reason
23 that she wanted to get the Christmas tree up because she
24 wanted the house decorated and she was not able to do that at
25 that point.

1 Q. Give us some examples when you say she wasn't
2 able, just -- what was she -- what could she do?

3 A. At that point she couldn't even get in and out of
4 a chair by herself. She had to have help sitting down and
5 standing up. While we were getting -- it was an artificial
6 tree while we're getting it down from the attic, my bro Edgar
7 brought a chair and sat it down where she could see and talk
8 to us, but he had to help her in and out of that chair.

9 And so we got things down and took it around to the
10 living room and -- and he moved and she was able to -- to
11 walk in the living room and she was able to -- he was able to
12 help her sit down and she watched while we decorated the
13 tree.

14 And then later, you know, as we were visiting and
15 things after the tree was decorated, she wanted to sit in the
16 recliner and there again, she had to have help getting in and
17 out of -- of the chair.

18 Q. Did you observe anything on her face or how she
19 moved that made -- made you think she was in pain?

20 A. Yes, definitely. I mean, it was very obvious that
21 she was having difficulty, you know, moving almost any part
22 of her body.

23 Q. Obviously, you know, she was treated with
24 antibiotic and all of that. Did you get to see her
25 (inaudible) a lot of times now gone down and she's gone

1 through all the treatments issues recovered to the extent
2 that she is who she is today. In your observation, has she
3 ever gotten back to where she was?

4 A. Not --

5 Q. Not being able to move?

6 A. Not totally, no.

7 Q. What have you observed are her limitations now?

8 A. She has more difficulty doing steps, more
9 difficulty in lifting things and just in the -- the just
10 general movement is -- is slower than what it was before.

11 Q. Now, had you just stopped her and she gets quit
12 living in her life?

13 A. No, no. She still -- she still goes and does, you
14 know, she pushes through and you don't always realize that
15 she's in as much pain until you sort of get close to her and
16 talk to her a little bit and you'll find out that she is
17 doing things because it's what she wants to do. And she
18 feels very much the need to -- to go forward with helping or
19 doing whatever she wants to, you know, to do. But she is
20 uncomfortable in doing it pain-wise.

21 Q. Based on your knowledge of her going all these
22 years, did she share her personal burden with other people?

23 A. No, very rarely do you. No.

24 Q. Are you one of those inner circle?

25 A. Yes. Yes.

1 Q. How hard has it been on her emotionally to go
2 through this?

3 A. It's hard because she's a person that -- she's
4 very caring. It is her nature, you know, just in meeting
5 someone, you know, on the first time you meet her, the first
6 time I met her, I felt like I had known her for years just
7 because that's just the personality she has and just the
8 caring attitude that she has when she speaks to people. And
9 it's been hard that she can't go and do as -- as much as she
10 would -- would like to do.

11 Q. How's it affected Edgar?

12 A. It's been hard. He -- he had to really step up
13 and -- and -- and do a lot of things in taking care of her
14 hands-on things when she was so sick, he had to help her go
15 to the bathroom -- go into the bathroom to get up and down on
16 the toilet and help tend to her needs and that was hard, you
17 know, that was something. And then just -- just the day-to-
18 day things that -- that he's had to help with and -- and her
19 not being able to do the things that -- that they had been
20 doing before her surgery.

21 MR. LUGINBILL: Ms. Dula, please answer any questions
22 Defense may have.

23 THE WITNESS: Okay. Thank you.

24 THE COURT: Mr. Hood?

25 MR. HOOD: Good morning, ma'am.

1 THE WITNESS: Good morning.

2 MR. HOOD: I don't have any questions for you.

3 THE WITNESS: Thank you.

4 THE COURT: Ms. Maples?

5 MS. MAPLES: No questions, your Honor.

6 THE COURT: Any exception to the witness being excused?

7 MR. LUGINBILL: Not from the Plaintiff.

8 THE COURT: Plaintiff?

9 MR. HOOD: No, your Honor.

10 MS. MAPLES: No, your Honor.

11 THE COURT: Ma'am, you're excused.

12 MS. DULA: Thank you.

13 THE COURT: Call your next witness.

14 MR. LUGINBILL: Plaintiff calls Edgar McGougan to the
15 stand.

16 THE CLERK: Please raise your right hand and place your
17 left hand on the Bible.

18 EDGAR LEE MCGOUGAN,
19 being duly sworn, testified as follows:

20 THE CLERK: Please be seated. Please state your full
21 name, spelling your last name directly in the microphone.

22 THE WITNESS: Edgar Lee McGougan, Junior.

23 THE COURT: If you could spell your last name please,
24 sir.

25 THE WITNESS: M-C-G-O-U-G-A-N.

1 THE COURT: You may proceed.

2 MR. LUGINBILL: Thank you, your Honor.

3 THE COURT: You're welcome.

4 DIRECT EXAMINATION

5 BY MR. LUGINBILL:

6 Q. Edgar, tell the jury a little bit about where
7 you're from.

8 A. Right now we live in a little farming community
9 called Sandy Plains, North Carolina, about seven miles
10 outside of Tabor City.

11 Q. That's where you are now. Tell us a little bit
12 about where you grew up.

13 A. I grew up in Green Sea, which is in South
14 Carolina, but again, it's a little small farming community.
15 Just like six or seven miles from Tabor.

16 Q. That imaginary line that divides the two states
17 really didn't divide that community too much?

18 A. Not so much we're -- we consider ourselves twin
19 communities.

20 Q. Okay. Were you a -- a city boy growing up or a
21 country boy?

22 A. Country boy.

23 Q. Tell me about that.

24 A. Well, it just, you know, all the benefits of being
25 in the country, you can get out and, you know, hunt and fish.

1 You're not regulated in a lot of things that you can't do. I
2 just enjoy being out in that kind of setting.

3 Q. Did you know Ms. Pat growing up?

4 A. No, I didn't.

5 Q. Did you know her family at all? Mr. Prince or
6 Mr. (Inaudible)?

7 A. No, I didn't.

8 Q. Okay. What do you do for a living?

9 A. I worked for Horry County School District. I did
10 HVAC worked for them.

11 Q. What's that entail?

12 A. We fix air conditioners, install them, keep them
13 up, do the maintenance of home.

14 Q. Now how many schools are there in the Horry County
15 school district?

16 A. When I retired, about 55.

17 Q. You got busy?

18 A. Very busy, yes.

19 Q. You enjoy it?

20 A. I did. It was a challenge. I liked
21 troubleshooting and -- and fixing things.

22 Q. Now, tell us how you met Pat.

23 A. I have an aunt who is a matchmaker and she gave me
24 Pat's phone Number, and I called Pat and the first time that
25 I talked to her, we talked almost two hours, so we had -- we

1 hit it off right off the bat.

2 Q. Now, at that point, how old were you?

3 A. When I first met Pat?

4 Q. Yes.

5 A. Fifty two or three, somewhere in there.

6 Q. Okay. And that means she was how old?

7 A. Fifty two or three -- we're three days difference.

8 I was born on the November 24, and she was born on the of

9 November 27, in the same year.

10 Q. Had you had a family you were married prior to?

11 A. I had -- a -- I was married before I met Pat, and
12 I have one son.

13 Q. And how old was he?

14 A. He's 30 right now. He was 11 when me and Pat got
15 married.

16 Q. How was Pat as a -- as a mom to your son?

17 A. She very -- very good. Did a very good job. Her
18 and Robert got along real well from the beginning. She was,
19 you know, a second mother to him. She played a large part in
20 making Robert the man he is today. She's a -- a -- a strong
21 Christian and her values are, you know, had very high -- very
22 high values, very high standards.

23 Q. Where did you all -- well, get one thing out to --
24 where did you go when you got married?

25 A. When --

1 Q. (Inaudible). When did you all get married?

2 A. St. Patrick's Day in 2006.

3 Q. Okay. (Inaudible) getting married on a holiday.

4 How you can't forget your Number s.

5 A. That's right. That helps.

6 Q. She was from Tabor City. You're from Green Sea?

7 A. That's correct.

8 Q. Where did you all live once you got married?

9 A. We originally she had a house in Tabor City and we
10 lived there, but we sold that house about two years after we
11 were married. And we moved to my mother's house in Green
12 Sea. My mother had passed away. No, that sound right.

13 Q. Okay.

14 A. Okay.

15 Q. So is that the house you grew up in?

16 A. It is.

17 Q. So you and Pat, your son were living in Green Sea
18 in old family place?

19 A. That's right.

20 Q. Did your son go to college?

21 A. He did.

22 Q. Were you all able to pay for it or to help?

23 A. Well, I told him I would see that he got educated
24 and we had to -- to completely pay his college off and all we
25 went out -- we had to sell the house in -- in Green Sea.

1 Q. All right. Before we get to that, let me ask you
2 this, did you all have a plan in place on how long you were
3 going to work, how long she was going to work, and whether or
4 not you would've had what you needed to get him to school?

5 A. I had retired in -- in 2013, and Pat was going to
6 work on another so much years. And our goal was to --
7 between the two incomes pay off college debt and a few other
8 things.

9 Q. Okay. How did this injury and the long recovery
10 and not being able to go back to work change that?

11 A. Whenever she got hurt, that ended her career, she
12 unable to continue to work. She was a -- a nursing
13 supervisor at -- at McLeod hospital in Loris. And as part of
14 her duties, she would be required to do CPR at times and
15 maybe help move a patient at times and she just couldn't --
16 after she was hurt, she couldn't do that anymore.

17 Q. Were you able to stay in your family's place?

18 A. We were for a while, but we sold the house and
19 bought a double-wide and moved Sandy Plains along the --
20 about the same time her father, Mr. Billy was getting up in
21 age and he was beginning to slow down and so we had to move
22 to be closer to him.

23 Q. Were the two of you helping to take care of him?

24 A. We were along with -- with John his son.

25 Q. Now, when you say, "Sandy Plains", is that her

1 family farm?

2 A. That is.

3 Q. Before the injury and treatment, what kind of
4 things did you and Pat like to do?

5 A. Well, she -- we both enjoyed outdoors, you know,
6 she would fish with me some, that kind of thing. We're very
7 active in our church. We had -- we both taught Sunday
8 school, that type of thing. We traveled a little bit, not a
9 lot. We went -- Robert, my son got -- when he got -- when he
10 graduated he moved to Chattanooga and so we would try to go
11 up and see him a couple times a year.

12 Q. Was there anything about Pat's physical condition
13 after RA or anything that kept you off you going where you
14 wanted to go or do what you wanted?

15 A. No, it didn't, nothing whatsoever.

16 Q. Did she ever have problems not being able to go to
17 work because of her RA?

18 A. No, she meant -- her RA was pretty much controlled
19 before -- before the surgery and she was able to do anything
20 she wanted to.

21 Q. How would you describe you all's life at that
22 time?

23 A. It was good. I mean, like I said, I was retired.
24 That's retirement's hard to be and so she still enjoyed
25 working and so it was, you know, things were good.

1 Q. You all happy?

2 A. Yeah, we were happy.

3 Q. Had a plan?

4 A. Had a plan.

5 Q. Just real briefly, how bad was her back?

6 A. It had all started with a loaf of bread. We had
7 stopped in Marion to go by Walmart pick up a few things and
8 we got her out of the (inaudible) checking out she leaned
9 over the shopping cart to pick up a loaf of bread and I heard
10 a little pop and she kind of said, "Oy". And apparently
11 that's whenever the injury occurred. And it -- it took a
12 while to get -- saw several different doctors before they
13 were diagnosed, what the problem was, but that's how it
14 started.

15 Q. Now, as she was going through trying to -- to
16 figure out what was wrong, what was going to happen were you
17 able to go with her to most of her doctors?

18 A. I -- I went to most of her visits (inaudible).

19 Q. Okay. Were you there for the initial visit with
20 Dr. Frisch?

21 A. I was.

22 Q. What was your understanding of what needed to be
23 done?

24 A. They had, I think, had taken an X-ray and saw that
25 she had a -- a -- a chip out of one of her vertebrae. And

1 that he could, Dr. Frisch said it would be no problem to go
2 in and surgically remove that chip and get that out of the --
3 out of the way.

4 Q. In that discussion with Dr. Frisch, he -- he tell
5 you that he had any concerns that her RA would be something
6 that had to be dealt with or was a problem with the surgery?

7 A. I don't remember. I don't (inaudible) discuss RA
8 or not.

9 Q. Okay. And what was your expectation? We all have
10 expectations on how long she'd be out or she be able to go
11 back to work?

12 A. I think she'd be about eight weeks and she should
13 be able to go -- go back to work after that.

14 Q. Everything still going to plan?

15 A. Still going to plan.

16 Q. After that first meeting with Dr. Frisch, did you
17 have confidence that everything would be good?

18 A. Everything seemed to be -- I was, you know, I was
19 impressed, but you know, what he had told us.

20 Q. How did you all, of all of the doctors, let me ask
21 you, how far is it from where you all living in Green Sea to
22 Mount Pleasant in Southeastern Spine?

23 A. It's around three hours.

24 Q. Once you drove by a few -- few doctor's offices
25 between Green Sea and Mount Pleasant.

1 A. Yeah.

2 Q. Why -- why Southeastern?

3 A. I -- I think Patty talked with a couple of -- of
4 doctors that she knew and they recommended Southeastern Spine
5 and they were also at that time they were doing a lot of
6 advertising. Every time you turned on the TV you saw
7 Southeastern Spine advertisement.

8 Q. Did those TV ads give you confidence?

9 A. Sure, yeah, they were.

10 Q. She comes down, she has the surgery. How'd that
11 go?

12 A. Went well.

13 Q. Take her home?

14 A. We went home.

15 Q. How'd you do that first week?

16 A. The first week? Well, she had, you know, right
17 after operations, she was a little slow moving around, but
18 she seemed to be on meeting higher expectations for what we
19 would say. She was on track of getting better.

20 Q. Was she able to do most of what she needed to do
21 for herself by herself?

22 A. For the most part, yes.

23 Q. You weren't having to help her bathe or anything
24 like that?

25 A. Not at that point, no, sir.

1 Q. Okay. How about -- well, did you go with her to
2 that first visit follow-up?

3 A. I did.

4 Q. All right. How did that go?

5 A. It went -- went all right.

6 Q. Is there anything that was discussed in that one
7 that gave you any concern -- excuse any concern or any pause?

8 A. Not in the first visit.

9 Q. Okay. We all come -- come home. Do you remember
10 when you were supposed to come back after that first visit?

11 A. I really don't. Probably about two weeks, I
12 guess. I'm not sure.

13 Q. Do you remember why you came back earlier than
14 original day?

15 A. I don't.

16 Q. Tell us a -- a little bit about how her conditions
17 started to change between that first visit and then the
18 second visit.

19 A. She began having a pain and just wasn't moving
20 well.

21 Q. Do you remember an event with the bandage on her
22 back?

23 A. Yes, I do.

24 Q. Tell jury about that.

25 A. I had to help change her bandages because had been

1 on her back, she couldn't reach them and we had changed or
2 she went and -- and laid on the bed and when we -- I looked
3 at her, changed the dressing, it was real wet.

4 Q. There was a spot on it?

5 A. A spot on it. Probably that big around on the --

6 Q. So -- so there's --

7 A. Well -- yeah, spot that size on -- on the bed.

8 Q. Okay. And where did all that wetness come from?

9 A. It come from the surgery site. Where had an
10 incision.

11 Q. Did you see where it was coming from?

12 A. Yes.

13 Q. When you were changing those bandages initially,
14 was the incision closed?

15 A. It was. For the most part, I think it was a
16 little place at the top that might've been draining.

17 Q. And then once the fluid started coming out, had it
18 started to open up?

19 A. It -- it was -- you could tell it was coming from
20 the place at the top.

21 Q. Okay. After that happened, did you go with her to
22 that next appointment?

23 A. I did.

24 Q. All right. What was the conversation about there
25 in terms of what they were worried about?

1 A. Well, they -- because of the wound hadn't healed.
2 I think they were worried about infection at that point.

3 Q. Well, I'm going to back up. One thing that I -- I
4 forgot to ask you about. Did you fill the prescription and
5 go get it and bring it back for the Medrol Dosepak after that
6 first? Where did Pat do?

7 A. I think I probably would've, but I don't remember
8 exactly.

9 Q. But you remember having it?

10 A. I -- I do.

11 Q. Okay. So now you're home, you've gone down, you
12 -- you're meeting, sorry, you're at Southeastern Spine
13 they're worried about infection.

14 MR. KERN: Object to the form, your Honor. Leading.

15 THE COURT: Please rephrase the question. Sustained.

16 BY MR. LUGINBILL:

17 Q. When you were at the visit, what was their
18 concern?

19 A. Concerned that she might have an infection.

20 Q. Did they give her any special instructions or
21 precautions of what she was supposed to do to manage the
22 infection?

23 A. I don't recall.

24 Q. Do you recall being offered an MRI that day?

25 A. That was on the 28th of August when left.

1 Q. Yes, sir.

2 A. I don't.

3 Q. Did you and Pat talk about medical decisions for
4 her, or she'd make the decision what she wanted?

5 A. Well, she, you know, she -- we discussed some
6 things, but she was in charge of, you know, taking care of
7 herself.

8 Q. Knowing Pat had to do as her husband. Did she
9 ever not do what doctor told her to do?

10 A. Never. As best we could tell she always followed
11 doctor's instructions.

12 Q. That have (inaudible). Did you get to see
13 Dr. Frisch that day?

14 A. On the 2nd.

15 Q. The 2nd?

16 A. I don't think so.

17 Q. When you all left, what was your understanding of
18 what you all needed to do in terms of the infection and the
19 pain that was coming back?

20 A. Just keep changing the dressing.

21 Q. Okay. And so let's talk about the dressing. How
22 often were you changing the dressings?

23 A. It was three or four times a day, a good bit of
24 drainage.

25 Q. And how long did that last?

1 A. I don't recall.

2 Q. When you were first seeing those wet bandages,
3 what did it look like?

4 A. It -- it would have a clear or maybe a yellowish
5 tint. Didn't look particularly, you know, bad.

6 Q. Did you see blood?

7 A. I did not, no.

8 Q. Okay. So just a yellowish-tinted fluid?

9 A. Right.

10 Q. But -- but you're talking about a bandage. Just
11 make sure we -- we're all on the same page with what the
12 doctor --

13 A. Right.

14 Q. Is this a Scooby-Doo Band-Aid or are we talking
15 about?

16 A. It was about a four by four.

17 Q. Okay.

18 A. Pretty close.

19 Q. And did you have to, like, put a tape and do all
20 that?

21 A. Just --

22 Q. Stick on.

23 A. Just stuck on.

24 Q. You're being her -- her nurse maid to the nurse?

25 A. Correct.

1 Q. We're doing all this?

2 A. Right.

3 Q. She getting any better after the second visit?

4 A. She was initially things seemed to be going good
5 about like the first surgery. Everything seemed to be
6 progressing, like it's supposed to.

7 Q. Tell me about the problem she had after taking
8 Bactrim. Do you remember that?

9 A. At one point she had a reaction to some drug and
10 she had a -- a rash.

11 Q. Where -- where was the rash?

12 A. I think it was pretty much all over.

13 Q. Which looked like -- did you see it?

14 A. I -- I did. It was a -- a -- a rash not a --
15 wasn't really big rash. It was a -- just a small rash.

16 Q. Okay. Itchy?

17 A. I -- I'm not sure.

18 Q. Did she complain about itching or anything?

19 A. I'm not sure.

20 Q. Were you with her on the next visit?

21 A. I was.

22 Q. What was Pat's concern then?

23 A. I -- I don't recall.

24 Q. The wound was still draining at that point?

25 A. I'm not sure.

1 Q. To the best of your recollection, what were you
2 worried about?

3 A. Well, we were -- I was still concerned that it
4 might be an infection.

5 Q. Do you recall whether that wound healed over at
6 that point?

7 A. I don't recall exactly what point it did -- it did
8 heal over, but I don't recall when.

9 Q. At any of these postoperative visits, once the
10 drainage had started, do you recall when you were going with
11 her whether or not they ever did any blood work?

12 A. No, they never did any blood work that I saw.

13 Q. Did they ever ask her to go somewhere else with
14 family doctors, get Labcorp, or anything at all to go get
15 blood work done?

16 A. No.

17 Q. Did they ever ask you all to go get records from
18 anywhere else and have those documents (inaudible)?

19 A. No.

20 Q. Tell us about how her physical condition was doing
21 during this period.

22 A. As the further away we got from the -- the second
23 surgery, she was beginning to have trouble moving. I was
24 having to do more things for her.

25 Q. Now, when you say, "Trouble moving", give me some

1 examples of things she was having trouble moving?

2 A. Getting in and out of chairs that type of thing.

3 Q. How did you help that?

4 A. Well, at -- at one point, it got to where I had to
5 physically put her in and out of a chair.

6 Q. Was she able to get in and out of the shower
7 without help?

8 A. No, I had to help her with that too.

9 Q. Were you with her on this next visit? One minute.
10 Back in one minute. So she had to follow-up the visit. Did
11 you drive her to the visit with Dr. Frisch before she went
12 back from home?

13 A. Oh, yeah, I drove her every time I went.

14 Q. Okay. How was that drive down?

15 A. It was a very long drive for her every time. I
16 don't know how many ever come from Georgetown, but it was a
17 rough, very rough road and every time we hit a bump it hurt.

18 Q. Did those visits -- being up to the time when you
19 met with Dr. Frisch, did the PA seem to be listening to your
20 concerns?

21 MR. KERN: Objection, your Honor.

22 THE COURT: Basis?

23 MR. KERN: Speculation.

24 THE COURT: Please repeat the question. I didn't hear
25 you. Go ahead.

1 BY MR. LUGINBILL:

2 Q. In those visits at Southeastern Spine with the PAs
3 before you got to see Dr. Frisch based on your observation,
4 did those PAs seem like they were listening and concerned or
5 taking your concerns serious?

6 A. They seem to, yes, sir.

7 THE COURT: Objections overruled. I'm going to give
8 you some latitude that you need to feel with more careful in
9 phrasing and remember if you're not speaking into that
10 microphone, nothing you say is being recorded. Thank you.

11 BY MR. LUGINBILL:

12 Q. Tell us about the visit with Dr. Frisch?

13 A. I don't recall.

14 Q. Were you with her?

15 A. I was in the room, yes.

16 Q. Okay. When Dr. Frisch came in, did he look at the
17 wound?

18 A. This is which visit? I mean, I've lost track.

19 MR. KERN: Just testified he didn't know.

20 THE COURT: I'm sorry, can't hear you.

21 MR. KERN: Just testified he didn't know.

22 MR. HOOD: Leading.

23 MR. KERN: It's leading.

24 THE COURT: Sustained. Leading. Rephrase.

25 BY MR. LUGINBILL:

1 Q. Okay. Do you recall being in the room with
2 Dr. Frisch, when you visited her right before you all went
3 into the hospital?

4 A. I do.

5 Q. When you came to my (inaudible) that day, was the
6 plan as far as you had --

7 MR. KERN: Objection.

8 MR. LUGINBILL: -- going into the hospital that day?

9 MR. KERN: Objection.

10 THE COURT: You stand addressing the Court, is there
11 any objection?

12 MR. KERN: It's leading, your Honor.

13 THE COURT: Sustained. Leading. Rephrase.

14 BY MR. LUGINBILL:

15 Q. What was your intention when you left Green Sea at
16 that moment?

17 A. Well, we were just going make a simple doctor's
18 visit. We -- we had no idea we would be staying. So we
19 hadn't made any plans at all to stay in a hospital or stay in
20 Charleston.

21 Q. When Dr. Frisch came in, what do you recall about
22 what he did in his examination?

23 A. I don't recall.

24 Q. What is your understanding of why you had to go to
25 the hospital?

1 A. Had an infection that had gotten worse. And, you
2 know, Pat was in a lot of pain and they were going to admit
3 her to the hospital asking if we could -- they wanted,
4 Dr. Frisch wanted to admit him -- admit her on Friday
5 afternoon, and I asked you -- you know, if we could wait and
6 come back on Monday.

7 Q. I -- I don't think you're -- we're on the same
8 page. In September.

9 A. Oh, I'm sorry. I asked you about --

10 Q. In September, do you -- what was his concern about
11 why he was sending her over 8/2?

12 A. That was before the second surgery. I'm -- I
13 don't -- he -- he wanted -- he wanted to do a -- a -- a
14 second surgery and go in and clean out the wound. They had a
15 -- a -- a pus pocket in the room or he -- he suspected
16 something was in the wound and he wanted to go in and have a
17 second surgery.

18 Q. Okay. Did you follow advice?

19 A. We did.

20 Q. How did that -- well, let me ask you this. So did
21 you stay with her while she was in the hospital for that --
22 that period of time?

23 A. I did.

24 Q. How was she doing in the hospital?

25 A. I don't recall.

1 Q. How was her emotion level? Scared, happy,
2 confident, sad?

3 A. Well, she was a little concerned that we'd had to
4 do with second surgery.

5 Q. What was your emotional state?

6 A. I was -- I -- I -- I didn't know. I mean, I don't
7 know.

8 Q. As all this was happening, did you feel like you
9 had a -- a good grip on what was happening?

10 MR. KERN: Object to form. Objection, your Honor.

11 THE COURT: Basis?

12 MR. KERN: Leading.

13 THE COURT: Sustained. Leading. Rephrase.

14 BY MR. LUGINBILL:

15 Q. How well were you able to follow what was going
16 on?

17 A. I felt like I knew what was going on, but I'm not
18 sure I knew exactly what they were talking about.

19 Q. What were your observations of how Pat was doing
20 immediately after the washout procedure?

21 A. She seemed to be getting -- getting along good.

22 Q. What was your understanding of what had to happen
23 before you could go home?

24 A. I don't know.

25 Q. What was your understanding of what the infection

1 was?

2 A. I don't -- I don't know.

3 Q. How much do you know about infection?

4 A. Not much.

5 Q. Once Pat was released -- let me ask, were you
6 there in the hospital when Dr. West first saw her?

7 A. I was.

8 Q. How did that visit go?

9 A. Well, this was before COVID and Dr. Frisch, I
10 mean, Dr. West when he came into the room, he had gloves on,
11 masks and everything, and we thought that was kind of awkward
12 for him to be dressed like he was.

13 Q. How was Dr. West's behavior any different than the
14 rest of the doctors?

15 A. He seemed a little standoffish. He wouldn't --
16 you know, he spoke to us from the door, didn't really come in
17 the room, didn't come close to the bed, but just awkward.

18 Q. Were you present when Dr. West gave Pat for --
19 discharge instructions for as far as what she had to do for
20 her antibiotic treatment and that surgery?

21 A. I -- I'm sure I was, but I don't -- I don't really
22 recall.

23 Q. So were there any issues with being able to leave?

24 A. I -- I don't know.

25 Q. Tell us about your understanding of -- of what

1 medications Pat was going to need after she left?

2 A. I think about two week's supply of some type of
3 antibiotic.

4 Q. Was it an oral antibiotic or a -- something she
5 had to go get injected?

6 A. It was oral.

7 Q. What was your understanding after talking with
8 Dr. West of whether Pat was going to be coming back to see
9 him or whether she was done?

10 A. She was done. She didn't have any other
11 appointments.

12 Q. Did anybody from Lowcountry Infectious Diseases
13 contact you all or set up any follow-up appointments?

14 A. Not that I know of.

15 Q. Have you ever been to -- before going back to the
16 hospital in December, had -- in that period of time of
17 September and December, did you ever take Pat to any
18 appointments at Lowcountry Infectious Diseases?

19 A. No, I have -- have not.

20 Q. Where was she supposed to follow-up?

21 A. I don't know if we had any follow-up.

22 Q. Was there any follow-ups set up to go see
23 Southeastern Spine?

24 A. There was.

25 Q. Do you recall how long that was down the road?

1 A. I don't -- a couple of week maybe.

2 Q. Okay. Tell us how she did once she got home in
3 those couple of weeks before that first follow-up.

4 A. After the second surgery, she seemed to be getting
5 better.

6 Q. How long did that improvement last?

7 A. Seemed like maybe six weeks, a month, six weeks
8 somewhere.

9 Q. And then what happened?

10 A. She started having pain again.

11 Q. Was it the same pain? Different pain?

12 A. I think it was the same pain in the lower back.

13 Q. Were you with her in her follow-up visits with
14 Southeastern Spine?

15 A. I was.

16 Q. From your recollection -- to the best you recall,
17 were there any major concerns about another infection?

18 A. This was in December time period?

19 Q. This was after you got out, she's home and you're
20 -- you're following up now with Lowcountry or with
21 Southeastern Spine. Was the discussion about pain levels or
22 was it about infection?

23 A. I don't recall.

24 Q. Do you recall her ever getting blood drawn there?

25 A. I do not. I don't -- I recall that they never did

1 any blood draws that I know anything about.

2 Q. Do you recall whether she was sent out to go get
3 blood somewhere else?

4 A. We weren't sent anywhere to get the blood drawn.

5 Q. Once she started getting -- you said she improved
6 in six weeks. Once she started not improving anymore, how
7 was that pain starting to affect her?

8 A. Well, it affected, you know, the way she moved,
9 how she could get around just everything.

10 Q. After the visits, did it keep getting better? Did
11 it go or did it start getting better?

12 A. After --

13 Q. We'll start where she was seen in October. Did it
14 get better after October? Stayed the same or get worse?

15 A. She got worse after at some point in there,
16 probably after October.

17 Q. And I mean, when you say she got worse, what was
18 getting worse?

19 A. Her pain was getting -- was increasing.

20 Q. How was that affected?

21 A. Well, it made it harder for her to get in and out
22 and get -- get around.

23 Q. Was she able to go to other appointments like
24 physical therapy or primary care doctor, things like that?

25 A. She was.

1 Q. Did you have to help her?

2 A. Not at -- when she was at bed, not right after the
3 second surgery. This was -- she did fine for, you know,
4 several weeks and then it got to some point that she couldn't
5 go back to physical therapy. They said they wasn't -- didn't
6 seem to be doing any good so.

7 Q. At the point where she was doing physical therapy,
8 had you all had discussions about whether she was still
9 trying to get back to work?

10 A. She was always trying to get back to work. I
11 mean, she was, you know, that was one of the biggest things
12 she was disappointed in was that she couldn't go back to
13 work.

14 Q. Were you with Pat in the November visit?

15 A. I was.

16 Q. Do you recall whether Dr. Frisch came in and saw
17 you in November?

18 A. I do not.

19 Q. You don't remember if he was or he wasn't?

20 A. I don't.

21 Q. (Inaudible) this way. During that visit, did
22 Southeastern Spine, to the best of your recollection, tell
23 Pat to stop taking her RA meds or anything like that?

24 MR. KERN: Objection.

25 THE COURT: Basis?

1 MR. KERN: Leading, your Honor.

2 THE COURT: Sustained. Leading and hearsay.

3 Rephrase the question.

4 BY MR. LUGINBILL:

5 Q. Obviously you and Pat talked about her care; is
6 that fair?

7 A. I didn't hear.

8 Q. You and Pat talked about her better preparing what
9 she needs to do?

10 A. We did.

11 Q. Had two of you had any conversations after that
12 November the 28th visit about whether or not she was supposed
13 to stop any other RA medication?

14 A. I don't think she contacted her RA doctor before
15 she stopped her -- before she stopped or started her RA
16 medicine.

17 Q. Was Dr. Frisch involved in those decisions?

18 A. I don't know.

19 Q. Between the November visit and the December 13 --
20 Well, sorry, excuse me, the 16th visit. Tell us kind of how
21 Pat was doing, what she was having to deal with.

22 A. She was in a lot of pain at that point. I was
23 having to help her get in and out of chairs just she did in a
24 lot of pain.

25 Q. Where was this pain primarily focused?

1 A. It was close to where her incision -- in her back.

2 Q. What were you having to do for her?

3 A. I had to help her get in and out of the chair.

4 Had to help her go to the bathroom -- pretty much anything
5 like that.

6 Q. Were the two of you at that time able to take care
7 of what needed to be done around the house?

8 A. Between the two of us, yeah.

9 Q. Was anybody in the community coming and helping or
10 getting any assistance plan?

11 A. Not at that time.

12 Q. Were you there when Ms. Dula came to visit to help
13 set up the Christmas tree?

14 A. I was.

15 Q. How was she doing that day?

16 A. Pat was having, you know, she -- by that period of
17 time, Pat was -- couldn't move. I mean, having trouble you
18 got to have to help her get in the chair, get out of the
19 chair, help her go to the bathroom. Just pretty much
20 anything she did, I had to -- I had to help her with.

21 Q. How was she doing emotionally during the testing?

22 A. Well, she was, you know, disappointed in the way
23 things were going.

24 Q. What was going through your mind watching your
25 wife go through that?

1 A. Well, I was concerned for her. I mean, I actually
2 don't want to see anybody in pain. And so I was, you know, I
3 -- I knew she was having trouble. I -- I just didn't like
4 it.

5 Q. How'd it make you feel?

6 A. Just unhappy about the situation.

7 Q. How well do you think you had an understanding of
8 what was going on or what was at risk with your wife?

9 A. I don't recall.

10 Q. Looking back on it now, did you appreciate how
11 dangerous this situation -- situation was?

12 MR. KERN: Objection.

13 THE COURT: Basis?

14 MR. KERN: Leading.

15 THE COURT: Sustained, leading. Rephrase.

16 BY MR. LUGINBILL:

17 Q. As you sit here now, if you tell the jury about
18 how you feel and how well you understood what was going on at
19 that time.

20 A. Well, I felt like she was getting worse and I, you
21 know, we were disappointed that she was, you know, not making
22 any progress.

23 Q. Who were you looking for to help?

24 A. Southeastern Spine.

25 Q. When you got down there on the 16th, who did you

1 see?

2 A. Dr. Frisch.

3 Q. What did Dr. Frisch tell you at all?

4 A. He recommended that she go back in the hospital.

5 Q. Did he say why?

6 A. I don't recall.

7 Q. What was the conversation about whether you could
8 or couldn't go in that day? Do you recall?

9 A. I do. I -- I asked him if -- if -- because it was
10 the weekend, it was a Friday, asking if we could come back on
11 Monday. Pat had -- we had Pat -- one of Pat's sons was
12 coming home for Christmas because he couldn't be there at
13 Christmas. And Pat wanted to be at home for that.

14 Q. Were the grandchildren involved?

15 A. Yes.

16 Q. Was it your understanding after listening to
17 Dr. Frisch that it was safe --

18 MR. KERN: Objection, Your Honor.

19 THE COURT: Basis?

20 MR. KERN: Leading.

21 THE COURT: Sustained leading.

22 BY MR. LUGINBILL:

23 Q. What was your understanding --

24 A. Okay.

25 Q. -- at your -- let me repeat the whole question.

1 A. Okay.

2 Q. How was your conversation or your impression, your
3 understanding after speaking to Dr. Frisch about whether or
4 not it was safe for her to go home over the weekend?

5 A. I asked Dr. Frisch --

6 MR. KERN: Objection, still leading.

7 THE COURT: I'm going to give him a little latitude,
8 but why should leaving.

9 THE WITNESS: I asked Dr. Frisch directly if it would
10 be, you know, if it -- should we get any worse if we did go
11 home and he said he'd wait for her come in on Monday, would
12 it be fine.

13 BY LUGINBILL:

14 Q. How did she do that next day, between Friday and
15 Saturday?

16 A. They gave us a Number to call if she got worse or
17 whatever. And by Saturday night she had gotten worse to the
18 point that I called the Number they gave us. And had a
19 little bit of trouble getting through. But I -- eventually,
20 somebody called us back and said it would be fine for her to
21 wait till Monday to come in.

22 MR. KERN: Objection, Your Honor.

23 THE COURT: Basis?

24 MR. KERN: Hearsay.

25 THE COURT: If he's repeating what one of the

1 Defendants says, it's not hearsay. It's an admission against
2 in the case.

3 MR. KERN: I don't think he identify --

4 THE COURT: What is he? Well, in the context of the
5 question, it is overruled.

6 You may proceed.

7 BY MR. LUGINBILL:

8 Q. Did you have to make it -- who called you back?

9 A. I'm not sure. Somebody.

10 Q. Somebody from where?

11 A. Somebody from Southeastern Spine.

12 Q. What did the people of Southeastern Spine instruct
13 you to do?

14 A. I think they said we come -- come in on Saturday
15 night or we could wait till Monday.

16 Q. What did you decide to do?

17 A. We decided to wait till Monday.

18 Q. Why?

19 A. She was going -- again, she wanted to have
20 Christmas with her grandchildren, and she wasn't going to get
21 any worse between Saturday and Monday.

22 Q. Why did you have that belief that she wasn't going
23 to get any worse between Saturday and Monday? What were you
24 basing that on?

25 A. I don't know.

1 Q. Did anything change in your phone call with
2 Southeastern Spine from what you thought on Friday?

3 A. She did. She was, you know, in more pain on -- on
4 Saturday night than she had been on Friday.

5 Q. She ever (inaudible). Was there anything in that
6 phone call that made you think she was -- it was dangerous
7 for her to stay and not --

8 MR. KERN: Objection, your Honor.

9 THE COURT: I haven't heard the whole question. Please
10 repeat your question.

11 BY MR. LUGINBILL:

12 Q. Was there anything in the phone call from
13 Southeastern Spine on that Saturday that led you personally
14 to believe she was in any more danger coming in Saturday
15 night versus Monday morning?

16 A. No.

17 THE COURT: Is there any objection?

18 MR. KERN: Leading, your Honor.

19 THE COURT: Sustained, leading. Rephrase.

20 BY MR. LUGINBILL:

21 Q. What were you told by Southeastern Spine on that
22 phone call about the risks staying Saturday versus coming on
23 Monday morning?

24 A. That was no more -- no further risk between
25 Saturday night and -- and Monday.

1 Q. When you all came back on Monday to Southeastern
2 Spine, where did you go?

3 A. Went to the hospital.

4 Q. And what did you learn once you got to the
5 hospital?

6 A. That they needed to admit her.

7 Q. Do you know why?

8 A. I don't recall.

9 Q. How long was Pat in the hospital?

10 A. We stayed from the -- from the -- from the 19th
11 through the 3rd of January.

12 Q. Of the days and nights, in 19th through 3rd, how
13 many of them were you there with her?

14 A. There with her -- I think all, but one night, I
15 think.

16 Q. How did you sleep?

17 A. In the chair part time. They finally brought me a
18 cot and I made sure they didn't get caught back. I watched
19 that cot real close.

20 Q. Do you recall Dr. West coming back in and -- and
21 taking over her there again?

22 A. I saw him yesterday.

23 Q. I want to go back this to the September
24 hospitalization, and you always ready to leave. Do you
25 recall a conversation that you had with Dr. West, it didn't

1 sit quite right?

2 MR. SMYTH: Objection, your Honor, leading.

3 THE COURT: Sustained leading.

4 MR. LUGINBILL: Your Honor, I'll rephrase.

5 BY MR. LUGINBILL:

6 Q. Tell me about the conversation you had with Dr.
7 West before you got ready to be discharged in September of
8 2016.

9 A. As we were getting ready to be discharged we -- I
10 don't recall. I just -- I can't, I'm sorry.

11 Q. Do you remember the conversation that happened --
12 or the incident that happened with the armband?

13 MR. SMYTH: Objection, your Honor. Leading.

14 THE COURT: Sustained.

15 MR. SMYTH: (Inaudible).

16 THE COURT: No speaking. Objection. Sustained.
17 Leading.

18 MR. LUGINBILL: Let me rephrase.

19 BY MR. LUGINBILL:

20 Q. Were you in the room with Pat when Dr. West came
21 to see her the last time?

22 A. I was.

23 Q. Tell the jury what happened during that address?

24 A. We asked him when -- when could we go home? And
25 he said that -- that he wasn't the one that was denying us to

1 go home. And it was -- I can't think of his name the other
2 doctor.

3 Q. Dr. Frisch?

4 A. Dr. Frisch. He said Dr. Frisch was the one that
5 was keeping from going home because Dr. Frisch name was on
6 Pat's armband. Dr. West said that was -- he was not the one
7 stopping from going home. That Dr. Frisch was because he was
8 -- she was his patient.

9 Q. Was there anything about how that conversation
10 went and how Dr. West treated you or spoke to you that didn't
11 sit well?

12 MR. SMYTH: Objection, your Honor. Leading.

13 THE COURT: Leading. Sustained.

14 MR. SMYTH: Relevance.

15 THE COURT: And relevance. I did not ask for speaking
16 objections, I believe. Move on.

17 BY MR. LUGINBILL:

18 Q. Is there anything else about that incident?

19 A. I don't recall. I -- I'm sorry, I'm falling
20 apart. I'm just.

21 Q. Are you nervous today?

22 A. I'm -- yeah, I'm -- I'm pretty nervous. I've been
23 -- I suffer from anxiety and depression and --

24 MR. KERN: Objection, your Honor.

25 THE WITNESS: -- I'm having --

1 THE COURT: Basis? Basis?

2 MR. KERN: Relevance.

3 THE COURT: Give him a little latitude. Overruled.

4 BY MR. LUGINBILL:

5 Q. After Pat was released from the hospital, where
6 did she go to have her IV antibiotics admitted to?

7 A. We did it at home.

8 Q. And where did she go to follow-up with her
9 treatments for the infection?

10 A. Went to the office in -- in Myrtle Beach,
11 (inaudible) Ebama.

12 Q. There you go. And what is the name of that
13 practice?

14 A. Right now I couldn't tell you.

15 Q. Is it Dr. West's group?

16 A. It is.

17 MR. SMYTH: Objection. Leading.

18 THE COURT: Basis? Sustained. Leading.

19 BY MR. LUGINBILL:

20 Q. Tell us how Pat's recovery has gone once she
21 finally got through the IV antibiotics and started back on
22 recovery.

23 A. It's going well. She's gotten a lot stronger.
24 She can do quite a few things. I mean, she's -- she's just
25 getting a lot better. She's just getting well.

1 Q. Has she ever gotten back to being as strong as she
2 was before surgery?

3 A. No. No. She wants -- she can't do everything she
4 could before surgery, but she's doing much better.

5 Q. What are her limitations that you've observed in
6 terms of what she could do physical?

7 A. She didn't do steps. She could do, you know, four
8 or five steps at a time is about all she can do. Walking
9 outside is hard on her. She has trouble on -- not on
10 something beside a hard surface.

11 Q. Has she ever gone back to work?

12 A. She has not.

13 Q. When she first finished her treatments, where were
14 you living?

15 A. We're still at Green Sea.

16 Q. How has her ability -- her inability to go back to
17 work, changed the plan that you all had to recovery?

18 A. Well, when she couldn't go back to work, we had to
19 it -- it -- it changed the plan just completely because she
20 couldn't go back to work. Our plan was -- she was going to
21 work another five or six years and we were going to take that
22 -- take that money and -- and pay some bills.

23 Q. Were you able to do that?

24 A. We weren't when she quit work.

25 Q. As a result of her not being able to at work and

1 not making that income, what did you have to do with your
2 house?

3 A. We sold it.

4 Q. And where did you go?

5 A. We bought a double-wide and moved to the following
6 Tabor.

7 Q. Tell the jury a little bit about the financial
8 stress that -- that change has put you under?

9 A. Well, we just can't do as much as we wanted to do
10 because we don't have any kind to do everything.

11 Q. How has that affected you personally in terms of
12 your emotional health?

13 A. Well, like I said, I'm suffering from anxiety and
14 depression. I don't know.

15 Q. How has Pat's limited physical mobility and
16 limited physical strength affected the two as a person?

17 A. Oh, we managed to get by. We do what we have to
18 do to allow her to do as much as she can.

19 Q. Are there things that could be changed around the
20 farm? You can add finances that will help?

21 A. Yeah. Probably so.

22 Q. Can you think of one?

23 A. I don't have any.

24 Q. If you could change one thing about where Pat's at
25 now physically, what would you do?

1 A. We could maybe put a ramp in stairs.

2 Q. Has the stress of all this affected you and Pat as
3 a couple?

4 A. Not as a couple. I mean, we still love each
5 other. We still there for each other.

6 Q. Has it affected you in any other way?

7 A. Well, I, like, say I -- I fall apart real easy.
8 As -- as you all -- you've all been able to see, you spend
9 the rest 30 minutes.

10 Q. Going forward from you.

11 A. Okay.

12 Q. What is your biggest fear for Pat?

13 A. My biggest concern about Pat is that -- is that
14 because of the where that auto-fusion or whatever they call
15 the bloody spine, that that's not going to last. I'm afraid
16 that's going to deteriorate and get to the point that she
17 won't be able to do anything.

18 Q. Have the two of you discussed that with each other
19 that -- that might happen?

20 A. Well, before we got here in court, you know, as
21 far as I knew she was fine, but from some of the testimony
22 I've seen in the last couple of days, it's obvious that she's
23 not fine that -- that disc is going to continue to
24 deteriorate and a good chance we don't have much -- many more
25 health problems.

1 Q. How has it affected you emotionally to hear the
2 testimony?

3 A. It's --

4 Q. That all of this could have been avoided. She had
5 just had some more antibiotics and some blood work?

6 MR. SMYTH: Objection, your Honor. Leading.

7 THE COURT: Sustained, leading.

8 BY MR. LUGINBILL:

9 Q. Explain to the jury how that testimony affected
10 you.

11 A. Well --

12 MR. SMYTH: Objection, your Honor.

13 MR. KERN: It's the same question. Leading.

14 THE COURT: Sustained, leading. Also speculation full
15 strength and it's tap dancing on the line referenced to.
16 Rephrase.

17 BY MR. LUGINBILL:

18 Q. Edgar, have you heard all the testimony in court?

19 A. I have.

20 Q. What emotional impact have you suffered from
21 watching and hearing that testimony?

22 MR. KERN: Objection, your Honor.

23 THE COURT: Basis?

24 MR. KERN: Bolstering and relevance.

25 THE COURT: Relevance. Sustained.

1 MR. LUGINBILL: What is relevant --

2 THE COURT: (Crosstalk) damages that occurred before
3 not today. On a consortium claim, what is relevant is not
4 today as far as the elements of the cause of action. So I
5 need you to confine your questions for that time frame.

6 MR. LUGINBILL: Your Honor, I hate to -- I have a
7 matter I need to take up outside jury presence.

8 THE COURT: Mr. Foreman, ladies and gentlemen, we have
9 a matter of law to take up. During the break please do not
10 discuss the case. Please leave your notepads in your seat.

11 (Jury exits courtroom.)

12 THE COURT: Yes, sir.

13 MR. LUGINBILL: I understand ruling. I'd like proffer
14 his emotional damage.

15 THE COURT: His -- his emotional damages irrelevant on
16 consortium. How testimony today affects him is not an
17 element of consortium. And that's why I sustained the
18 objection. You can ask him all day long about the emotional
19 effects of this on him, his marriage and everything else, but
20 him sitting in a courtroom today listening to experts and how
21 that affected him, it's not an element of consortium, it's
22 not an element sustained, it's not relevant.

23 Now, if you want to ask a question, that's fine. I'll
24 let you proffer, but in the future, don't debate with the
25 Court. If I want argument I'll ask for that. Okay. You may

1 proceed.

2 Sir, if you would pay attention to the questions and if
3 you all want to cross-examine him on question, I'll allow you
4 that opportunity for the purposes of the cross.

5 You may proceed.

6 BY MR. LUGINBILL:

7 Q. Edgar, until you heard the testimony this week.

8 A. Right.

9 Q. Did the testimony you heard this week change your
10 understanding of whether or not all of this damage would be
11 prevented?

12 A. It did. I mean, I wasn't aware that she -- as she
13 was still as sick as she is and that had we had a -- a more
14 antibiotics earlier, it probably would not -- she probably
15 wouldn't be in the shape she is in now.

16 Q. Have you -- because of that realization suffered
17 any emotional impact here this week?

18 A. Well, I have this morning.

19 Q. Specifically, just from learning that some of the
20 doctors believed it didn't have to happen. How has that
21 affected you?

22 A. I was -- like I said, I thought she was pretty
23 well stabilized. And from testimony I've heard this week I
24 realized now that she's not stabilized and -- and she's will
25 probably get worse and it's -- it's from the treatment she

1 received earlier.

2 MR. LUGINBILL: That'd be it, your Honor.

3 THE COURT: Any questions, Mr. Hood or?

4 MR. HOOD: No questions.

5 MR. KERN: No questions, your Honor.

6 THE COURT: Any questions Mr. Smyth?

7 MR. SMYTH: Stand on prior objections.

8 THE COURT: Any you all want to elaborate on your
9 objection?

10 MR. SMYTH: I think it's pretty clear that any Court's
11 ruling that this testimony is irrelevant based on things that
12 he's learned here in the courtroom. Not whether his own
13 prior knowledge and it doesn't go to (inaudible) complaints.
14 It's also proffer hearsay. And bolstering (inaudible)
15 witnesses as well.

16 THE COURT: Mr. Hood? Oh, I'm sorry. I apologize.

17 MR. KERN: It's all right.

18 THE COURT: I got to get -- I got to get to know your
19 name better and I apologize.

20 MR. KERN: It's all right. We join that.

21 THE COURT: Mr. Kern.

22 MR. KERN: We joined that, your Honor.

23 THE COURT: You may proceed. I'm sorry I didn't hear
24 you.

25 MR. KERN: I'm sorry, (inaudible) we join that.

1 THE COURT: Okay. And any argument Mr. Luginbill?

2 MR. LUGINBILL: Your Honor, it would be our position
3 that the basis for allowing the testimony is that emotional
4 damage related to the harm suffered by his wife are element
5 of consortium claim. He has testified now that he has
6 suffered more from damage, learning additional damages from
7 learning today the extent for damages that he was unaware of.
8 I'm not aware of the case law that says that -- that his
9 emotional damages stopped at the time of court. You will
10 have future emotional damages related to her future
11 condition. This is just part and parcel of that. So that
12 would be our position.

13 THE COURT: The objection is sustained. The premise of
14 your entire cause of action is that these doctors were
15 negligent in their care of your client. That she has now had
16 blood altering injuries as a result. The entire scope of
17 your first expert's testimony was that she should, if she had
18 been treated earlier, that the injuries would've been avoided
19 altogether.

20 So this -- for you to have your client now testify that
21 somehow what he heard in court this week somehow has now
22 exacerbated his emotional injuries is an opposite to your
23 entire theory of your case. And you're correct, he's
24 entitled to recover for mental anguish on consortium, but
25 that would go to the type and it is more the mere

1 disappointment, anger, worry, resentment or embarrassment,
2 although we can't include that. But it would deal with the
3 painful emotions that deal with the scope of his wife's
4 injury.

5 And he should have been cognizant of that way before
6 today. And it should -- and it would've form the basis of
7 when -- of the entire basis of your cause of action. So I
8 sustain the objection relevance.

9 You can ask him all day long you want about his mental
10 anguish that he suffered as a result of what he perceives as
11 this deficient or treatment that fell below the standard of
12 care for his wife. The emotional injuries that he feels he
13 has suffered because of her limitations as it has affected
14 her mobility or otherwise her ability to perform the duties
15 and -- and it sounds so colloquial and outdated, but the law
16 is the way it's written.

17 Her ability to provide services as a wife would within
18 the scope of their marriage, how that has affected their
19 marital relationship. All of that is -- it is fair game, but
20 to come in and frankly, I think it endures quite
21 detrimentally to your client's case to say now that somehow
22 he has a better scope or understanding of his wife's
23 injuries. I -- I think that should have been clear before
24 you put pen to paper.

25 MR. LUGINBILL: Understand, your Honor.

1 THE COURT: All right. Please get the jury for me.
2 Wait, before we do that, does anybody need restroom break?
3 Let's do that right quick. I know it's the morning clocking.
4 Sir, would you like to get up, stand up. You need to
5 go restroom or anything?
6 THE WITNESS: I'm fine.
7 THE COURT: Okay. You can stand up where you are if
8 you want.
9 I'm sorry, I'm talking about food.
10 MR. HOOD: Sounds good.
11 THE COURT: I know, right?
12 MR. HOOD: Yeah.
13 THE COURT: We were talking about this place I
14 discovered in Conway that they make these homemade brick oven
15 pizzas and I --
16 MR. HOOD: What's the name of it?
17 THE COURT: Because I ate the --
18 MR. HOOD: What was the name of it?
19 THE COURT: You know, it's right there on the river
20 where they -- and I was telling them they've redone this
21 whole river walk where you can start and go all the way over
22 to the other side and it's tree-lined. It has benches but
23 it's 100 degrees. I just couldn't do the walk (inaudible).
24 MR. HOOD: Is the one right there by the cypress?
25 THE COURT: It's right. Yeah.

1 MR. HOOD: Yeah.

2 MR. KERN: Where is this?

3 THE COURT: And then all those condos they built over
4 there where it used to be trees.

5 MR. HOOD: Yeah.

6 THE COURT: And I told, I said let's get home every in
7 their boat. I feel that out.

8 MR. HOOD: Do you -- do you really like good like
9 pizza?

10 THE COURT: I like --

11 MR. HOOD: You like pizza? I found a good place on
12 Johns Island (inaudible).

13 THE COURT: Jury ready?

14 THE BAILIFF: Yes, ma'am.

15 THE COURT: All right. And now I want to be clear, I'm
16 not restricting you from asking your client about his
17 emotional damages. I think that's fair game. Matter of
18 fact, you can even ask him, you know, up through today what
19 he's experiencing, but you can't premise it on.

20 MR. LUGINBILL: That's all.

21 THE COURT: All right. We ready? See if jury is ready
22 for me. So you all are you good? You need some more?

23 MR. LUGINBILL: I'm fine. All right.

24 (Jury enters courtroom.)

25 THE BAILIFF: All jurors present, your Honor.

1 THE COURT: Thank you. Ladies and gentlemen, we
2 appreciate your patience. We took advantage of that break to
3 also take a comfort break. So we appreciate it. We'll now
4 resume the witness's testimony.

5 You may proceed, Mr. Luginbill.

6 MR. LUGINBILL: Thank you, your Honor.

7 THE COURT: You're welcome.

8 BY MR. LUGINBILL:

9 Q. Edgar, can you talk about your emotions with us
10 today?

11 A. I didn't hear.

12 Q. Can you talk about your emotions with us today?

13 A. I don't know.

14 Q. You'll try?

15 A. I'll try.

16 Q. How is the stress of all this injury recovery
17 changed your life? Affect your anxiety?

18 A. Well, I mean, it's pretty obvious I fall apart. I
19 mean, I shouldn't be having as much trouble up here, but I
20 can't put two things together. And a lot of it is related to
21 what we've been through the past years.

22 Q. Are you scared for Pat? Are you scared for Pat?

23 A. I am scared for what the outcome might be.

24 Q. Has any of this changed how you feel about Pat?

25 A. Oh no, I'll never.

1 MR. LUGINBILL: You can answer their questions.

2 THE COURT: Any questions for the witness, Mr. Kern?

3 MR. KERN: Yes, your Honor.

4 THE COURT: You may proceed.

5 MR. KERN: Thank you.

6 THE COURT: You're welcome.

7 CROSS-EXAMINATION

8 BY MR. KERN:

9 Q. Good morning, sir.

10 A. Good morning.

11 MR. KERN: Your Honor, may I approach the bench?

12 THE COURT: You may.

13 (Bench conference.)

14 BY MR. KERN:

15 Q. Good morning, sir.

16 A. Good morning.

17 Q. Do you recall testimony earlier -- do you recall
18 that on December 17th, Saturday you all were talking about
19 with Christmas and all that?

20 A. I do.

21 Q. Do you recall that the only option that you were
22 told by the hospital in Southeastern Spine was to come in to
23 the hospital back?

24 A. I don't recall that way. I -- I thought we still
25 had the option to come in on Monday. That's my recollection.

1 MR. KERN: Request the (inaudible).

2 THE COURT: You have to establish he needs recollection
3 in practice. Did you ask anybody he needs his recollection?

4 MR. KERN: (Inaudible).

5 THE COURT: Did you ask specifically what it's he needs
6 to look at?

7 BY MR. KERN:

8 Q. Sir, do you recall giving your testimony to us on
9 December 2019?

10 A. I do.

11 Q. Would it help refresh your recollection looking at
12 your testimony from that day?

13 A. It couldn't hurt.

14 THE COURT: You're going to have to ask him the exact
15 question, see if he needs to refresh his recollection, see if
16 he answers consistently, before you can access this document.

17 MR. KERN: All right.

18 THE COURT: And mark this Court's exhibit, please.

19 BY MR. KERN:

20 Q. All right. So the question sir is: "I'm sure --
21 do you recall what happened after you got admitted on the
22 19th?"

23 A. One -- tell me one more time.

24 Q. The question is: sir, "Do you recall what happened
25 after you got admitted on the 19th?"

1 A. After we got admitted on the 19th. That was a
2 Monday?

3 Q. Yes, sir.

4 A. I don't quite understand what you're asking me.

5 Q. Would it help you with your testimony?

6 A. It would.

7 Q. To the -- refresh your recollection?

8 A. It would.

9 Q. Okay. You have that for you?

10 A. I do.

11 Q. Go to page 40.

12 A. Okay.

13 Q. And read line 41, 10 on the next page.

14 A. Okay.

15 Q. Have you read to line 41, 10, sir?

16 A. And we decided to wait till Monday.

17 Q. Pardon?

18 A. I have.

19 Q. All right. So does that help refresh your
20 recollect -- your recollection that the hospital told you
21 that the only option you have was to come on that Saturday
22 night, the 17th?

23 A. That's -- that was what I said, and I'll -- I'll
24 stand by that.

25 Q. Okay. Thank you. All right. That's the only

1 question I have for you on that, sir.

2 A. All right.

3 Q. All right. You recall that in August of 2019 for
4 your testimony, there was an incident where your wife laid
5 down on the bed and saw some fluid, right?

6 A. That's right.

7 Q. And you -- that prompted you to take a picture of
8 it, correct?

9 A. Sometime in that period. Yes, sir.

10 Q. All right. That was August 19, 2016?

11 A. I don't know the exact date, but it was in that
12 time frame.

13 Q. All right. And then you turned that picture over
14 to your lawyers and they gave it to us, right?

15 A. I did.

16 Q. All right. That's -- that's Exhibit 20. Is that
17 the picture, sir?

18 A. It looks like it is.

19 Q. And that's the picture you took before you all
20 came to see Southeastern Spine on August 23, 2016, right?

21 A. I don't know about the date, but that's the
22 picture I took.

23 MR. KERN: That's all I have for you.

24 THE COURT: Mr. Smyth?

25 MR. SMYTH: Your Honor, may I please the Court?

1 THE COURT: Yes, sir.

2 FURTHER CROSS-EXAMINATION

3 BY MR. SMYTH:

4 Q. Good morning, Mr. McGougan. How you doing?

5 A. Good. I've had better days.

6 Q. Understand. I just have one question for you.

7 That time period between September when your wife got out of
8 the hospital and December when she went back to the hospital.

9 A. Right.

10 Q. You didn't call Dr. West for an appointment, did
11 you?

12 A. Not that I know of.

13 Q. And your wife didn't call Dr. West for an
14 appointment during that time period?

15 A. No, I don't think so.

16 MR. KERN: That's all I have. Thank you.

17 THE COURT: Any re-direct for consistency?

18 MR. LUGINBILL: No, ma'am.

19 THE COURT: Sir, you may step down. You can just leave
20 that there. We'll take care of it.

21 Call your next witness.

22 MS. FLUMIAN: Plaintiff calls Justin Cox.

23 THE COURT: The witness will move forward to be sworn.

24 THE CLERK: Please raise your right hand and place your
25 left hand on the Bible.

1 JUSTIN WILLIAM COX,

2 being duly sworn, testified as follows:

3 THE CLERK: Please be seated. Please state your full
4 name, spelling your last name directly in the microphone.

5 THE WITNESS: My name is Justin William Cox. Last name
6 is C-O-X.

7 THE COURT: You may proceed.

8 MS. FLUMIAN: Thank you.

9 THE COURT: You're welcome.

10 DIRECT EXAMINATION

11 BY MS. FLUMIAN:

12 Q. Justin, can you tell us how you know Patricia and
13 Edgar McGougan?

14 A. Oh, Patricia McGougan is my mother. Edgar is her
15 husband and my stepfather.

16 Q. Okay. Where do you live?

17 A. Myrtle Beach, South Carolina.

18 Q. So how far away do you live from them now?

19 A. It is about a 45-minute-ish drive from my house to
20 theirs depending on traffic. Traffic anywhere now is getting
21 worse so --

22 Q. In 2016, how far away did you live?

23 A. The same distance.

24 Q. Okay. How close are you with your mom and your
25 stepdad?

1 A. Oh, I talk to my mom very -- very frequently, at
2 least a couple times a week. On average, I would say more,
3 at certain times, less others, but on average a couple times
4 a week. Stepfather usually when we're getting together, but
5 we have a great -- great relationship so.

6 Q. How many kids are there in the family you have
7 with your mom?

8 A. My mother obviously is myself, is the oldest. I
9 have a middle brother and a younger brother. So there's
10 three -- three boys. And then I have a stepbrother as well.
11 So there would be a total of four through the -- through the
12 joint marriage.

13 Q. How would you describe in general how family
14 gatherings are, like for holidays?

15 A. Holidays are an important thing. I mean, we -- I
16 mean, what you guys have found holidays are family in my
17 house. That is, we get together. We may not see each other
18 often during the year, but Christmas is always the time to
19 come and get back in touch, get back with each other, spend
20 quality time with the people that you want to be with. So
21 that is -- that is Christmas in a nutshell for us.

22 Q. How would you describe your mom as a mom and a
23 grandmom before any of this happened? How would you describe
24 her?

25 A. Mom, supermom would be the best way to describe

1 her. I think it's the only way I can describe her. She did
2 a lot. Before her and Edgar got married she was a single
3 mother with three kids. So to me, she's a supermom. So a
4 lot of my beliefs, a lot of my -- I don't want to say
5 beliefs, a lot of my character has come from being -- seeing
6 someone that strong is what I -- is -- is -- is what I have a
7 strong foundation from.

8 Q. Did she work while you were growing up?

9 A. 100 percent. And after, you know, I got of age,
10 there was times she had two jobs. So there is not -- not a
11 day that she's gone by that she hasn't worked.

12 Q. What does being a nurse mean to your mom?

13 MR. KERN: Objection, your Honor.

14 THE COURT: Basis?

15 MR. KERN: Stipulation.

16 THE COURT: Overruled. He has a foundation that he can
17 answer that question. He's had ability to observe her on a
18 daily basis. You may proceed.

19 THE WITNESS: Thank you. My observation on what I
20 believe is, you know, her -- her meaning to be a nurse. That
21 was her way of giving back. She has been in the church, she
22 has been in the community. She knew at an early age she
23 wanted to help people, and that was her. She found her way
24 to be there for people.

25 BY MS. FLUMIAN:

1 Q. And have you had the occasion to actually observe
2 your mom as a nurse?

3 A. Oh, how many times can we -- can we talk about how
4 many times? Because there's been quite a few.

5 Q. Well, tell the jury a little bit about what you've
6 observed as your mom as an actual nurse?

7 A. So my mom has been a nurse in many different
8 things. I remember going on visits when she was in home
9 health. So she would go to people's homes and visit them,
10 help them do things that they couldn't do or they needed
11 someone to do for them because she -- and she was the person
12 and was willing to go to people's homes and talk to them. Do
13 you know how it -- how nice it is to have someone who wants
14 to come in and help you and then have a conversation about
15 how you are, what you're doing?

16 I'm going to tell you as a kid, personally, as a kid
17 sitting in a home when you're ready to go and she's still
18 talking, it's unbearable. I wanted to go home. I couldn't.
19 But then it -- what it taught me is that she cared so much
20 for the people she was with. It taught me so much about
21 like, what other people is, I could see myself in other
22 people's shoes from those experiences.

23 Q. So you told us about her working?

24 A. Uh-huh.

25 Q. What were your mom's hobbies before July 16th?

1 A. She had several, but I mean, growing up on a farm,
2 gardening was a huge hobby. She -- I don't know if you guys
3 have ever been on a farm, but this is not a raised bed farm,
4 you know, garden. This is rows, and rows, I mean, several
5 hundred yards of -- of gardening. That does not take -- that
6 is not an easy garden to -- to control. You have to
7 constantly maintain it, weed it, you're in it almost every
8 day.

9 And then, you know, you get the fruits of your labor.
10 That's where that term comes from, is people doing that and
11 growing it at the fruits of their labor. That is an intense
12 thing to do. And she did it without question and wanted --
13 and wanted to -- and when she gave -- she did get it. She
14 gave away half of it, if not more to the people that she
15 wanted to share, so.

16 Q. Through all that.

17 A. Uh-huh.

18 Q. How did your mom's RA affect her? What did you
19 observe about her RA affect her?

20 A. Very minimal. I mean, she had -- she had that
21 under control. She did not let that stop her from doing any
22 of those tasks. She was ready to -- she did not have any
23 just any issues.

24 Q. When did you find out that your mom was going to
25 have to have back surgery?

1 A. Oh, after it was done.

2 Q. Why --

3 A. Because my mother is -- well, I was working in the
4 -- in the -- in the medical field. She -- she had already
5 done the research, the asking of, you know, opinions, done
6 the due diligence of doing it. And then, I mean, obviously I
7 knew that she had was going to do it. I -- I -- I do -- we
8 will take a step back. I have to track myself. I knew she
9 was going to get a surgery. What I needed the result of it
10 was -- it was very minimal because she didn't ask. She
11 already knew her plan. She knew how she wanted to attack it,
12 and I -- she just pretty much told me that it was happening
13 and I trusted her for 100 percent of that.

14 Q. Did you need to help her after the first surgery
15 in August --

16 A. No.

17 Q. -- of 2016?

18 A. No.

19 Q. Did you talk to your mom after that surgery about
20 how she was feeling?

21 A. I do not recall, but if it was, I do not -- to my
22 recollection, I do not remember anything of any -- any issues
23 at this time -- from that time.

24 Q. Did you ever visit your mom in the hospital in
25 2016?

1 A. Yes.

2 Q. When?

3 A. Christmas.

4 Q. Can you tell the jury what you remember about your
5 mom in that hospital visit that you had?

6 A. Not an experience that I care to have, but my
7 experience is -- is I -- I was told she was in the hospital
8 again. We decided that Christmas did, obviously, that she
9 did not -- didn't need to be there alone. I took myself and
10 my two children to go see her with not knowing at that time
11 if she was making it out of the hospital. When I got there
12 she did not look well. It was very concerning and very
13 anxious at that time. It still makes me anxious thinking
14 about it.

15 Q. How old were your kids?

16 A. Six. In 2016, my son was -- let's see, eight.
17 And my -- then I would make my daughter five.

18 Q. How did they react?

19 A. They -- it was hard. I mean, they're younger
20 children, they -- they at this point was saying that they are
21 eight and five. I honestly hope they don't really remember
22 that Christmas, to be completely honest with you. That is
23 not a memory that I would want them to have. Seeing their
24 grandmother in a bed, and at times not able to communicate
25 very well.

1 Q. What do you mean?

2 A. Because she was in pain. She was being treated
3 also for pain. So she was on some -- some -- some medication
4 that was limiting that some of that she was sleepy. It was
5 in and out. It was -- it was -- she was in the hospital.
6 She was trying to get well. So it's not, again, not a -- not
7 a situation I care to.

8 Q. How was your stepdad doing when you went to come
9 and visit the hospital?

10 A. I thought he was handling everything very well.
11 He was really a great point of contact for me because he was
12 right there with her. It felt as if at that time that things
13 -- things obviously had turned, but he was still saying,
14 we're doing this, we're doing this. We had a -- we're, you
15 know, the doctors are doing these things to try and get -- we
16 -- the plan was always to, you know, get healthy, get back.
17 And that was -- we were trying to stay on that path.

18 Q. How would you describe their marriage as you
19 observed it at that time?

20 A. Oh, outstanding. I mean, like, what it's -- I
21 mean, it was something that -- yeah, to be completely honest,
22 Edgar has been an absolute great stepfather. I cannot have
23 wished for someone else to be in that role. And as a kid
24 from a divorced family, that says a lot.

25 Q. After your mom got out of the hospital, were you

1 ever asked to help?

2 A. Yeah. Yes, I did make it there to help. She
3 needed help getting -- just physically moving around. So I
4 was -- I was there to help during that time.

5 Q. Can you tell us about how you helped your mom at
6 her home after she got released from the hospital?

7 A. I had to learn a new skill, and something that I
8 have not forgotten. I had to basically, she -- if she was
9 sitting in front of me, I had to put my feet on the outside
10 of hers. I had to cross my arms. I had to then interlock
11 her hands into mine. And then I had to be almost a pillar,
12 almost leaning the back as she used me as her -- helped her
13 stand up.

14 And then that did -- that also had to be done when she
15 was sitting down. This was not a one time up and move
16 around. And then she could sit down. This was a one time,
17 get up, help her go where she was going, and then do the same
18 exact thing in the opposite motion to have her sit down.

19 Q. So can you give the jury some examples of when you
20 would have to do that with her?

21 A. Obviously sitting in a chair, getting out of a
22 bed. I did help her use the restroom one day -- one time.
23 That was definitely a different experience, but she -- is
24 helping your mother so, I mean, it just -- it is -- is what
25 I'll do, so.

1 Q. How did your mom feel about stopping work?

2 MS. MAPLES: Objection, your Honor.

3 THE COURT: Basis?

4 MS. MAPLES: Calls for hearsay.

5 THE COURT: You need to confine his responses to what
6 he has rationally perceived, not what he would repeat.

7 MS. FLUMIAN: Yes, your Honor.

8 THE COURT: Rephrase the question. This objection is
9 sustained.

10 BY MS. FLUMIAN:

11 Q. Justin, tell us what you observed in your mom when
12 she had to stop working?

13 A. What I observed when my mother had to stop
14 working. Oh, let's see. So many things. Obviously, she's
15 -- after -- let me just say, let me -- let me -- let me jump
16 to the point where she was actually able to do things.

17 Q. Okay.

18 A. Because at that point, until she's well this is
19 kind of not a -- a moot point, but when she is able to start
20 moving again and start being able to be going on her, once
21 she realized she was unable to work, she had to really find
22 her sense of purpose. Even though she has been in the
23 community with the church, but she also works for 50, 60
24 hours a week, then you have to find that 50 or 60 hours a
25 week to then fill in your life again. And I don't care who

1 you are. That's a tough -- that's a tough task.

2 So she spent some time trying to figure that out in --
3 in -- in the limited capacity that she could then now move
4 around and do. I -- I hope that I don't -- I don't know that
5 answer to that question, but that's just that -- that's an
6 observation that I had while she was moving back. It is --
7 it is -- I will redirect her. Do -- do another question,
8 please. I don't know that I've answered that question
9 correctly, so.

10 Q. How did your mom -- what did your mom do during
11 the pandemic, during quarantine?

12 A. I -- not a whole -- like, she was not ready to go
13 out. I mean, listen, we've talked -- talked about how she
14 just had back surgery. She's been in those different things.
15 She didn't want to be -- she wanted to be with people, but
16 didn't also want to be in a position of where she could be
17 infected or have something happen to her. It -- can I give
18 my opinion on something?

19 THE COURT: Yes. There has to be a question.

20 THE WITNESS: Okay. Then I'll -- I'll -- I'll --

21 THE COURT: You can answer the next question.

22 THE WITNESS: Okay. Go ahead.

23 BY MS. FLUMIAN:

24 Q. What does service mean to your mom?

25 A. I think it means a lot. I think, as I've said,

1 she -- that was kind of what one of her foundations she
2 wanted to serve people of -- of -- be of service to people.
3 You didn't become a nurse to do -- to not do that.

4 Q. How was she of service during the pandemic?

5 A. She -- I mean, they -- they did a lot of church
6 things. They did a lot of community things like that. She
7 would try to do different functions in that to try and help
8 out, but she was still very limited during that time. And
9 she had my grandfather to look after as well that he was
10 diminishing in his more -- in more need. He was also in more
11 in needing more personal care at that time. So that was
12 really probably her main service at the time, was my
13 grandfather. And then of, you know, with her church after,
14 you know, during that time in COVID.

15 Q. How do you -- what do you observe about your mom
16 today with regard to pain?

17 A. In regards to what? I'm sorry.

18 Q. Pain.

19 A. My mother is -- is a -- she's sneaky. She's very
20 sneaky. I love her for it, but she's sneaky. She doesn't
21 let on, she's a very, like I said, superwoman, she doesn't
22 like to take off that cap. Sometimes you got to be very
23 mindful of what you're looking at. Now -- now she'll still
24 never tell me she's in pain. I can see it in the ways that
25 she gets up. She gets down facial expressions and she moves

1 a certain way, I -- and then -- but she -- as you guys have
2 heard, she's -- she in the reference of pain. She doesn't
3 say it, but you see it now. You see it almost every time she
4 gets up or down so --

5 MS. FLUMIAN: Thank you, Justin, please you can answer
6 any questions they may have.

7 THE COURT: Any questions?

8 MR. KERN: None from us, your Honor.

9 THE COURT: Any further, Mr. Smyth?

10 MS. MAPLES: Yes, your Honor.

11 THE COURT: You may proceed -- I'm sorry. You may
12 proceed when you're ready.

13 MS. MAPLES: Thank you, your Honor.

14 THE COURT: You're welcome.

15 CROSS-EXAMINATION

16 BY MS. MAPLES:

17 Q. Good morning, Mr. Cox. My name is Allie Maples
18 and I represent Dr. West.

19 A. Good morning.

20 Q. My goal is not to keep you up here too long, but I
21 do want to clarify. You actually have had the opportunity to
22 observe the effects of your mother's rheumatoid arthritis on
23 her condition?

24 A. I've -- explain the question. I'm not sure if I
25 understand.

1 Q. Sure. You've seen how your mother's RA affects
2 her?

3 A. Correct. Yes, I have. I mean, I did, but the --
4 I think my answer was that did it affect her in a way that
5 she let on, I don't think that that happened. I have seen
6 her with RA, yes.

7 Q. You've observed that it causes her to feel
8 hurtful?

9 A. When she is not in her medication it does cause
10 pain. Yes. That is -- that is accurate.

11 Q. You observed that it's affected her ability to
12 pick up or hold things?

13 Q. When -- when on medication -- not on the correct
14 medication. Yes, that is correct.

15 Q. You observed her be in pain in her legs and her
16 hips because of her RA?

17 A. Again, same, yes.

18 Q. And you talk with your mother frequently, correct?

19 A. Yes.

20 Q. You told us it was like two to three times a week?

21 A. Yes, on average, yes.

22 Q. And that was true even in 2016 when she's going
23 through her surgeries?

24 A. I will say that during that time I tried to -- I
25 -- I will say that there was probably a little, it wasn't

1 that average. It was -- I wish it was that or a little bit
2 more to be completely honest. As a bad son, I wish it was
3 more, but I'm also of old school of like, no news is good
4 news. She had a surgery. I feel like she's going through
5 it. I need her to focus on her. So I may -- I may not have
6 called her as -- as on that same average to be -- to be
7 completely fair.

8 Q. But you were able to resume your communications
9 let's say in 2017, the next year?

10 A. Yes.

11 Q. And you continue that to this day?

12 A. Yes.

13 Q. And in all that time, she's never expressed any
14 criticisms of Dr. West to you?

15 A. We have not had that conversation, no.

16 MS. MAPLES: That's all the questions that I have.

17 Thank you very much.

18 THE WITNESS: Thank you.

19 THE COURT: Any re-direct for consistency?

20 MS. FLUMIAN: Briefly.

21 THE COURT: You may proceed.

22 RE-DIRECT EXAMINATION

23 BY MS. FLUMIAN:

24 Q. Justin, how often did your mother ever have
25 anything negative to say about anyone?

1 A. That is zero.

2 MS. FLUMIAN: Thank you so much.

3 THE COURT: Any objection to the witness being excused
4 from Plaintiff?

5 MS. FLUMIAN: No, your Honor.

6 THE COURT: From the Defense?

7 MR. KERN: None, your Honor.

8 THE COURT: From the Defense?

9 MS. MAPLES: No, your Honor.

10 THE COURT: Sir, you're excused.

11 MR. MCGOUGAN: Thank you.

12 THE COURT: You're welcome.

13 Call your next witness.

14 MR. LUGINBILL: Now, we were going to play the
15 videotape deposition Amanda Mills please --

16 THE COURT: May I ask the foreman, ladies and
17 gentlemen, brief matter of law, take up with the -- with the
18 attorneys. We appreciate your patience. Please don't
19 discuss the case and please leave your notepads on your
20 seats.

21 (Jury exits courtroom.)

22 THE COURT: Other than that witness, who else do you
23 plan to call?

24 MR. LUGINBILL: The next witness, your Honor, would be
25 Ms. McGougan, the Plaintiff. And then we have the transcript

1 that we -- very two little short --

2 THE COURT: You need to speak up for me because I can
3 barely hear you I know it's not. And I know you're soft-
4 spoken, so please don't take it untoward when I ask you to
5 speak up. I just want to make sure, because what will end up
6 happening is when this has to be transcribed, it's just going
7 to say, "Inaudible."

8 MR. LUGINBILL: I understand, your Honor. We don't
9 need that.

10 THE COURT: So --

11 MR. LUGINBILL: So Ms. McGougan is definitely going to
12 go. We would we have this videotaped deposition, your Honor,
13 and then we have a group of the discovery deposition of Dr.
14 Rhyne, R-H-Y-N-E, that we would want to -- to read in. Those
15 designations were provided yesterday and have been provided
16 to Counsel.

17 THE COURT: You said, "Dr. Rhyne", because he was not
18 on this list, was he?

19 MR. LUGINBILL: He was a prior expert that has been --
20 that had been removed.

21 THE COURT: But he was not. I did not -- he was not
22 included in voir dire, was he?

23 MR. LUGINBILL: That I don't recall.

24 MR. HOOD: He -- he was not.

25 THE COURT: He's not on my combined list, which means

1 we're never provided with the name. So you're saying that
2 you want to do what now? I apologize. Repeat that for me.

3 MR. LUGINBILL: There are just a couple of short
4 sections of his deposition testimony.

5 THE COURT: What's his name?

6 MR. LUGINBILL: His name is Dr. Alfred Rhyne,
7 R-H-Y-N-E.

8 THE COURT: Have you provided those to your opposing
9 Counsel?

10 MR. LUGINBILL: I have, your Honor.

11 THE COURT: Do you all have any exception to anything?

12 MR. HOOD: I do have a -- a -- a Number of them. Do
13 you want to talk -- have that conversation now we can?

14 THE COURT: We will after I deal with the other
15 deposition.

16 MR. HOOD: So there's --

17 THE COURT: Yeah.

18 MR. HOOD: I can just give you the categories of them.
19 One is a -- a --

20 THE COURT: Well, let me ask this differently. Are you
21 -- what I'm trying to determine is, do you have an objection?
22 I'm not looking for like, specifics within the deposition
23 itself. I'm asking in theory, do you have an objection to
24 him using this witness?

25 MR. HOOD: I do, your Honor. So very briefly, and I

1 can go into more detail later.

2 THE COURT: Uh-huh.

3 MR. HOOD: This witness was identified as an expert.

4 We had a date-certain conference, this date was set.

5 THE COURT: Uh-huh.

6 MR. HOOD: We -- we had a problem because the witness
7 wasn't available and we were given leave an agreement to
8 substitute that expert for another one, which we did. So
9 Dr. Rhyme has not been a witness since he was --

10 THE COURT: Oh, he's one of your witness.

11 MR. HOOD: Yes. He is -- he was an expert witness, not
12 a treater.

13 THE COURT: Okay.

14 MR. HOOD: Who was withdrawn back, you know, in
15 whatever time frame that was before we get here today.

16 THE COURT: Okay.

17 MR. HOOD: And --

18 THE COURT: And you're saying because of scheduling
19 challenges, you all could not depose him. So you decided not
20 to use him.

21 MR. HOOD: Correct. We -- right. And then we
22 identified another expert.

23 THE COURT: Okay.

24 MR. HOOD: Who is not testifying.

25 THE COURT: And that was a result of a scheduling

1 conference with Judge McCoy or was Young?

2 MR. HOOD: It was -- it was Judge McCoy.

3 THE COURT: Okay. And was that reduced to an order of
4 any type or was it just --

5 MR. HOOD: It was not --

6 THE COURT: -- a scheduling conference.

7 MR. HOOD: It was a scheduling conference, your Honor,
8 I don't think there's any dispute about that.

9 THE COURT: Oh, there's not.

10 MR. HOOD: And then procedurally we moved forward in
11 time and we identified the replacement expert for him and --
12 and withdrew Rhyne as we indicated we would do.

13 Subsequently, Counsel for the Plaintiff identified another
14 expert in response to our expert. And we had another --

15 THE COURT: So what type of expert is Dr. Rhyne?

16 MR. HOOD: Dr. Rhyne is an orthopedic surgeon.

17 THE COURT: And so, Mr. Luginbill, I mean, what theory
18 would you be able to call this witness when clearly you all
19 had a scheduling conference? The witness was withdrawn and
20 the chief judge allowed them to substitute the witness. And
21 also what concerns me is this name was not provided during
22 voir dire, which creates a problem.

23 MR. LUGINBILL: The theory would be that he was a named
24 witness earlier in the case. He has been deposed. All the
25 parties were present. All the representative parties were

1 present through Counsel at that deposition.

2 THE COURT: But why then would the judge allow them to
3 withdraw the witness if that was in fact the case? There's a
4 difference between a discovery deposition and the deposition
5 taken for the purposes of trial is different.

6 MR. LUGINBILL: Yes, ma'am. My -- my position that
7 would be the Judge allowed them to -- well back up a little
8 bit to give a context.

9 THE COURT: Uh-huh.

10 MR. LUGINBILL: They were granted leave to name another
11 expert if Dr. Rhyne was not going to be available.

12 THE COURT: Uh-huh. And apparently he's not available.

13 MR. LUGINBILL: A few weeks ago they confirmed he was
14 not available and we would forward with the other expert that
15 was going to be his substitute. In response we also named an
16 expert by agreeing, we -- both of us agreed not to use our
17 newly named experts and go with what had happened up to that
18 point. So he is the orthopedic expert that at the time was
19 called by Dr. Frisch.

20 THE COURT: But you all have had an orthopedic?

21 MR. LUGINBILL: Ours obviously testified. Yes, Your
22 Honor.

23 THE COURT: And they got a different orthopedic.

24 MR. LUGINBILL: And they had -- they do have an
25 orthopedic.

1 THE COURT: So I still need to know under the rules,
2 how are you entitled, especially premised on the scheduling
3 conference where you knew their witness was being replaced.
4 Under what theory would you be able then to utilize this
5 testimony? Especially when one disclosed pretrial and when
6 one disclosed to the Court to use this witness in voir dire.

7 MR. LUGINBILL: I apologize for the last part. First,
8 your Honor. I believe we had said that we -- we were --
9 would call any of the Defense's witnesses.

10 THE COURT: That is not sufficient for voir dire.

11 MR. LUGINBILL: We --

12 THE COURT: It sort of obfuscates the whole reason for
13 having voir dire.

14 MR. LUGINBILL: I -- I understand you.

15 THE COURT: Uh-huh.

16 MR. LUGINBILL: It's a witness who was named, who has
17 been involved in the case, who is more than a hundred miles
18 from the courthouse and who is not available. Under the
19 rules for -- for depositions, we are -- we are then allowed
20 to read the deposition proportions of the deposition.

21 THE COURT: I think the rules are far more complicated
22 than that law firm more conflict than that. And I -- I'm
23 concerned about the fact that you all knew they were
24 substituting an expert and now you want to call and use a
25 discovery deposition instead of having to notify them that

1 you wanted to use them at trial and depose him for that
2 purpose.

3 MR. LUGINBILL: The one thing I can't get around, your
4 Honor, and I don't want to argue the Court, but every other
5 expert has been exposed to this expert has read this expert's
6 deposition and there has been --

7 THE COURT: They can't comment on his deposition.
8 That's opinion -- be inappropriate. They can't comment on
9 somebody else's testimony. Because you're an expert you
10 don't get to comment on somebody else's testimony. You don't
11 get to say whether they're credible or not. Whether you
12 believe what they said. That's -- that's completely an
13 opposite to the rules. They can state an opinion, it can be
14 a different opinion, but they don't get to comment on
15 somebody else's opinion.

16 MR. LUGINBILL: The issue that we -- that I had -- that
17 I found, I'm in a box here, your Honor, that we were -- he
18 was withdrawn 19 days before trial and the witness was at
19 that point unavailable. So we were not able to get a DEE,
20 this is all we had.

21 THE COURT: You could have done that. You could have
22 asked the judge for a continuance. She could have made them
23 -- he could have made provision to depose him. And it did
24 not come as a surprise to you because you had a status
25 conference where they put you on notice that he was not

1 available and they were going to substitute.

2 MR. LUGINBILL: No, ma'am. We were put on notice that
3 he might not be available.

4 THE COURT: I think when I -- then you got a notice
5 that they substituted, right?

6 MR. LUGINBILL: Nineteen days before trial.

7 THE COURT: And there's nothing that stopped you from
8 asking the Judge for a continuance and saying, we need to
9 depose this other witness, right?

10 MR. LUGINBILL: I can't say whether a date certain that
11 had been set months in advance would've been continued --

12 THE COURT: I need --

13 MR. LUGINBILL: -- but I did not ask for one.

14 THE COURT: -- chief administrative judge, probably
15 more times than I can count on both civil and criminal. And
16 I've never denied somebody the ability to continue a case and
17 continue discovery. I think you only get to try a case once.
18 And I don't want any judge in this building that's going to
19 deny you that.

20 Now, whether you had to balance, whether you wanted to
21 go forward now or whether you wanted to take that person's
22 deposition, that was your decision, but there's nothing that
23 precluded you from asking for a continuance and deposing this
24 witness.

25 MR. LUGINBILL: I understand, your Honor.

1 THE COURT: And that concerns me. And so what exactly
2 is it that you would be trying to elicit from this
3 deposition? And did you provide those excerpts to Mr. Hood
4 and Mr. Smyth.

5 MR. LUGINBILL: In reverse order of those questions,
6 yes, we have. We provided last night. Oh, the exact page in
7 line.

8 THE COURT: Why'd you wait till last night?

9 MR. LUGINBILL: Based on the testimony of Dr. Davne
10 earlier, there's two points that he was cross-examined on
11 that this witness specifically spoke to.

12 THE COURT: Why can't you elicit that through their
13 experts?

14 MR. LUGINBILL: Perhaps I will. I don't know what the
15 testimony is going to be or how they'll ask the question.

16 THE COURT: I think you should try and then I can make
17 a decision about whether I'm going to let you do that or not.
18 Because if you can elicit what you're trying to attempt to
19 another witness, it's just the whole scenario concerns me.

20 MR. LUGINBILL: I was trying not to call them as a
21 rebuttal, but, your Honor, that certainly would be going
22 option.

23 THE COURT: You wouldn't have to do it in rebuttal
24 because if you could elicit on cross -- what latitude is
25 given in cross-examination, if they have another orthopedist

1 it -- I would be strained to believe that that orthopedist is
2 not going to say the same thing that the first person they
3 selected is not going to say, or that their opinions would
4 vary with any material difference.

5 MR. LUGINBILL: Yeah. I'm -- I'm happy to wait until
6 after the cross-examination and then --

7 THE COURT: I think that's probably the good way to
8 handle it. Especially when the witness's name was not
9 provided in voir dire. And when you just provided the
10 excerpts to them last night, they have -- clearly, you all
11 had a status conference, and you were put on notice that they
12 were going to substitute -- or have the capacity to
13 substitute an expert because they believed their expert was
14 going to be unavailable.

15 And while a date certain is something that is --
16 something you can request there's nothing that precluded you.
17 And I know, you know, Judge McCoy very well. She's very
18 flexible as -- and I'm not trying to say that the rest of the
19 judges in the building aren't, because we all are.

20 Nobody is going to tell you, you can't have a
21 continuance to depose somebody if it's critical and the
22 person is unavailable. Because we recognize that you only
23 have one chance to try a case. You don't get a do over. And
24 you should be able to try it as fully and completely as you
25 -- as you find necessary and to complete as much discovery as

1 you need to. I think you should make an attempt to elicit
2 whatever line of questioning you feel this is through the
3 other experts, specifically the one that was substituted for
4 Dr. Rhyne. Now, who was substituted for Dr. Rhyne?

5 MR. LUGINBILL: Your Honor, that's part of my problem
6 is that that witness has also been withdrawn.

7 THE COURT: They're not calling an orthopedist?

8 MR. LUGINBILL: They have a different orthopedist.

9 THE COURT: Yeah, but he's -- they -- they wouldn't
10 even if they substituted someone and don't want to speak for
11 you. But in the interest of time, I sort of need to cut to
12 the chase. They pick a witness because they expect them to
13 follow a certain line of questioning logic and reasoning. If
14 they substituted somebody else, they anticipate that witness
15 name the same thing that the other two was going to say or
16 they wouldn't be using it, I assume. So give me the history
17 you had Dr. Rhyne--

18 MR. HOOD: Sure, Your Honor.

19 THE COURT: -- (inaudible) Dr. Rhyne for --

20 MR. LUGINBILL: Yeah. So 2018 case, right?

21 THE COURT: Uh-huh.

22 MR. HOOD: So we did discovery and had a scheduling
23 order to finish up discovery back in '21 I think it was. And
24 so we did expert disclosures, expert depositions on both
25 sides. All of that was done. And this case was sort of

1 finished at that point. Got 40J. And then Mr. Luginbill
2 took over the case. He restored it back in September of
3 2023. We then started seeking dates -- date certains and
4 like everybody else are waiting in line. So --

5 THE COURT: Well, yeah, nobody could -- anticipated
6 COVID, I mean.

7 MR. HOOD: Oh, yeah.

8 THE COURT: COVID was -- it just shut down everything.
9 And even when we tried to have cases you -- even now we have
10 Judge Mullen tried to do a case recently and five of the
11 jurors after three days had COVID. I mean, so and the
12 lawyers. So, you know, it is what it is.

13 MR. HOOD: So when we came before Judge McCoy for the
14 status conference we had Dr. Ryan as an expert.

15 THE COURT: Uh-huh.

16 MR. HOOD: We had --

17 THE COURT: Who is an orthopedist, correct?

18 MR. HOOD: He's an orthopedist, correct.

19 THE COURT: Uh-huh.

20 MR. HOOD: And we also had Dr. Glaser as an expert,
21 he's an orthopedist. And we had --

22 THE COURT: And what is his specialty?

23 MR. HOOD: He's an orthopedist as well.

24 THE COURT: Okay.

25 MR. HOOD: And the third expert we have was Dr. Dailey,

1 who's infectious disease.

2 THE COURT: Uh-huh.

3 MR. HOOD: So what --

4 THE COURT: So tell me why do you need two
5 orthopedists? Or are you about to tell me you eliminated
6 one?

7 MR. HOOD: We're only going to call one expert witness.
8 I -- I didn't know that you were going to be our trial judge,
9 but I have had enough trials with you to know that I'm not
10 going to be able to call two orthopedists.

11 THE COURT: Now, they going to say the same thing?

12 MR. HOOD: So -- so we went forward --

13 THE COURT: Well, now I take that back. If they didn't
14 object, you know, you know me well enough know I'm going to
15 object myself, you know.

16 MR. HOOD: But --

17 THE COURT: I think if people don't object, there's a
18 reason.

19 MR. HOOD: But the other part is, you know, sort of
20 prudence dictates that -- that sometimes if you have two, you
21 might get one who could be there and you don't have to deal
22 with some of the problems that we're talking about --

23 THE COURT: With scheduling. Uh-huh.

24 MR. HOOD: So we were concerned that we were going to
25 lose Dr. Ryan as an expert because of potential

1 unavailability, raise that in the court and said okay.

2 THE COURT: Uh-huh.

3 MR. HOOD: Well if you all are going to substitute,
4 that's fine. So we did and we did just in August do that. I
5 don't -- I'm not disputing the timeline.

6 THE COURT: Uh-huh.

7 MR. HOOD: And so at that point we had another expert
8 whose name is Dr. Yakel, Y-A-K-E-L. And so he was
9 identified, he was made available for a deposition.
10 Mr. Luginbill took his deposition. The following day, we had
11 a hearing before Judge McCoy on Webex on my motion to exclude
12 his late identified expert. So we went through this whole
13 motion and part of the response from the Plaintiff was goose
14 gander Jamie is getting an idea, another expert even if it's
15 at leave the court, we should be able to do the same.

16 THE COURT: Uh-huh.

17 MR. HOOD: She says, "I'm not going to exclude anybody.
18 If anyone's going to exclude anything, it's going to be the
19 trial judge, but you all come back to me if there's something
20 else."

21 THE COURT: And I think you all know, Supreme Court
22 precedent is just so heavy weighted against excluding, I mean
23 that there are probably two cases we're both excluded
24 witnesses and God affirm. I mean it's -- you just always
25 going to give people the ability to call witnesses and to --

1 well, to have additional time.

2 MR. HOOD: That's right.

3 THE COURT: To explore it and discuss it.

4 MR. HOOD: And so in that motion hearing, I explained
5 our -- our position was he should be excluded because he is
6 outside schedule or sort of the jumper theory. The second
7 option would be to have a dog fall where he doesn't use his
8 expert and we don't use ours.

9 THE COURT: Uh-huh.

10 MR. HOOD: And then the third would be to continue the
11 case.

12 THE COURT: Uh-huh.

13 MR. HOOD: And the judge says, "Well, there's something
14 you all need on a continuance to come back and see me."

15 THE COURT: Uh-huh.

16 MR. HOOD: And so Counsel for the Plaintiff and I had
17 some conversations thereafter. We did not want to continue
18 the case because we've been trying to get it tried.

19 THE COURT: Well, since 2016. Uh-huh.

20 MR. HOOD: And so we each agreed not to use,
21 Dr. Yakel.

22 THE COURT: Okay.

23 MR. HOOD: And Plaintiff not to use their other expert
24 who also apparently had some availability issues. So now
25 here we are at trial and yesterday, last night at whatever at

1 9:00, I get an email with designations for some segments of
2 Dr. Rhyne's testimony who would be called as an expert
3 witness in the Plaintiff's case.

4 THE COURT: We have something problematic.

5 MR. HOOD: And so we have all these logistical issues
6 about there's no foundation for him being recognized as an
7 expert. So Counsel about infectious disease.

8 THE COURT: And that's why I asked and made the
9 distinct, there's a difference between the discovery
10 deposition and deposition claim use of trial. It's a whole
11 different category of -- of deposition. It's a little
12 different when you have a fact witness. But I'm -- how are
13 you going -- how would you even be able to declare him an
14 expert? You are not going to be able to, they have the --
15 they should have the ability to cross-examine the witnesses
16 and there's no way for this Court to judge pursuant to Rule
17 702 whether he should be an expert. I interrupted you.

18 MR. HOOD: No.

19 THE COURT: Go ahead I'm listening.

20 MR. HOOD: That's what I was going to say is, like, you
21 know, for a discovery deposition of an expert witness where
22 that is not laid out and not designated, there's no basis on
23 this record for this Court and this jury to hear that this
24 person is or isn't qualified. That would raise concerns if I
25 were in Mr. Smyth's shoes because the expert's opinions may

1 lay into an impact infectious disease. And Mr. Smyth would
2 probably say, would you agree you're not an infectious
3 disease expert? And the witness may say yes and may not be
4 able to offer those opinions.

5 All of that theoretical opportunity is missed by
6 designating portions of his deposition as if he were a
7 treating physician and simply unavailable. So they don't
8 have the -- the basis to tender. Without a basis to tender
9 and to tender to the Court, the Court doesn't have anything
10 to rule on. And -- and at that point, the witness would not
11 be permitted to offer opinion testimony because they haven't
12 been recognized as an expert witness.

13 And then an expert witness who doesn't have any
14 independent knowledge, wouldn't have any relevant information
15 to the facts at issue in this case if he's not offering his
16 opinions. So we -- we get into this very complicated web of
17 things that, because Plaintiff's Counsel wants to use a
18 couple of snippets out of a discovery deposition.

19 THE COURT: And there is some case law that supports
20 the Plaintiff calling or in -- actually, I've had this come
21 up in state in criminal cases more often than in civil cases
22 where the opposing side has called the other parties expert
23 that they decided not to call.

24 MR. HOOD: Yeah.

25 THE COURT: But it's live.

1 MR. HOOD: Right.

2 THE COURT: And you have the ability to cross-examine
3 that person live. And there is a difference between a
4 discovery deposition and a deposition even tend to use at
5 trial. And you have more than adequate opportunity to do
6 that, but objections are different. The record is different.
7 The purpose for doing it -- the reason the rules are
8 different is because, you know, you're, you know, you're
9 using it for trial and you -- and the -- but for the person
10 not being available it's just like they were here by
11 testifying. It's just problematic.

12 MR. LUGINBILL: I understand, your Honor.

13 THE COURT: And you had adequate time to depose him if
14 that was your desire, you could ask for a continuance.
15 There's nothing related that you can do that.

16 MR. LUGINBILL: I can't argue that certainly that we
17 could not have asked for a continuance that was before the
18 chief administrative judge. And -- and --

19 THE COURT: She'd have given you continuance.

20 MR. LUGINBILL: We -- Judge --

21 THE COURT: If I was chief judge, I'd have given your
22 continuance. I don't know anybody in this building that
23 wouldn't have.

24 MR. HOOD: You -- you might have wished you did.

25 THE COURT: You know, I tell you what I feel very

1 fortunate to do what I do for a living. It's always
2 (inaudible). It's always interesting. It keeps me on my
3 toes, keeps my brain active. I just, you know, again, I
4 emphasize that we are all a -- I know when I say we all, I
5 feel comfortable speaking from my colleagues that we are all
6 cognizant.

7 And I say this all the time, that's why I think the
8 rules are so rigid, for lack of a -- a better word in terms
9 of excluding things. Because everybody in this building
10 recognize that if I'm speaking to my colleagues. We
11 recognize you only get one time to try a case. There's no do
12 over. And so to the extent that you need to fully explore
13 issues, take depositions they'll do whatever you need to do
14 to prepare for trial, nobody's going to exclude your ability
15 to do that. Because we recognize you don't get to do it
16 again.

17 And lawyers, you know, I -- I practiced a long -- long
18 time ago, but, you know, I still remember beating myself
19 feeling like, did I get that out? Did I forget that? You
20 know, I mean, you do enough of that already when you're fully
21 prepared for something. So you never want to cut off a
22 person's ability because we're lawyers (inaudible)
23 personality thing with perfection.

24 So I was trying to figure out how we could have done it
25 better. Did I miss this? I missed that. I mean, you

1 already have enough of that without have -- with -- without
2 being precluded your ability to do what you need to do to
3 prepare for trial. And so, I'm just concerned about it. I
4 am at this point, inclined not to allow you to do it.
5 Because there is a distinct difference between a deposition
6 that is used for discovery and a deposition that is used for
7 the purposes of trial.

8 And while there is great latitude given in using
9 depositions usually more in the nature of impeachment or as
10 we did today, allow the witness to use it to refresh their
11 memory of their previous testimony. It's just problematic.

12 The witness was not disclosed in voir dire. Which is
13 another concern that I have, which I probably might be able
14 to cure by giving additional voir dire to the jury. But I
15 have a greater concern which is you were very clear that this
16 witness probably was going to be replaced due to his
17 unavailability. You had the ability to depose him or to
18 request that if you decided or felt to needed to do that,
19 which I think is a more proper use if you were going to call
20 him as a witness.

21 And in addition to that, I think it's premature because
22 I'm not certain you're not going to be able to elicit that
23 testimony from the expert that they do.

24 And so you're calling Dr. Glaser as your orthopedic
25 expert?

1 MR. HOOD: That's correct, your Honor.

2 THE COURT: And I don't have any indication that you
3 will not be able to elicit that same testimony from Dr.
4 Glaser. And so I think that is the preferable and why
5 latitudes given in cross-examination. And I think that you
6 should be able to ask him the -- or post to him the very same
7 questions and -- and -- and then we'll go from there. But I
8 think at this, and especially having just sent those
9 designations to them, not last night, it's just this
10 problematic.

11 MR. LUGINBILL: Judge, if I had to clarify ruling one,
12 I think I can address the qualification because --

13 THE COURT: I don't think I -- I'm not going to find
14 somebody an expert based on -- on a discovery deposition. I
15 need to be able to observe that I need.

16 MR. LUGINBILL: That -- that -- that answers my second
17 question.

18 THE COURT: It's problematic. And I don't think -- and
19 that's why there's again, the distinction between the
20 discovery deposition and a deposition that's taken for trial.
21 Because then you go through all of those questions that are
22 foundational in determining if somebody's an expert witness
23 so that you can elicit their opinions for that purpose and
24 this (inaudible). And you've already had an orthopedic
25 expert, so you haven't been prejudiced in any way.

1 MR. LUGINBILL: I understand.

2 THE COURT: But I would -- I would make every attempt
3 on your part to elicit whatever testimony it is you felt you
4 were going to get from Dr. Rhyne's testimony from their
5 expert that they're calling, which is Dr. Glaser. Now, back
6 to the matter at hand, which is -- oh, that's what we're
7 talking about. You said you wanted to call Ms. Mills as your
8 next witness?

9 MR. LUGINBILL: Yes, ma'am.

10 THE COURT: Who did you want to call after that?

11 MR. LUGINBILL: Ms. McGougan.

12 THE COURT: And then who after that?

13 MR. LUGINBILL: I believe we'd be done.

14 THE COURT: Okay. Now, somebody is cooking something
15 that smells wonderful, Ms. Jones. And I don't know what,
16 probably one of my favorites, but it smells wonderful and
17 then it is distracting, I guess because it's 11:38. Ms. --
18 it distracted me because I meant to ask Mr. Smyth if he had
19 anything he wanted to add about Dr. Rhyne. So it smells like
20 (inaudible).

21 MR. SMYTH: Well, I think the Court has a firm grasp on
22 all the issues and -- and understands the problems with that.
23 I think we would concur with Mr. Hood's position, but I -- I
24 think the Court understands our concerns.

25 THE COURT: Okay. Now, as in regards to Ms. Mills'

1 deposition, I read it and thankfully it was only 18 pages, so
2 I was able to make -- I was actually able to read it twice
3 prior to ruling on the objection.

4 And, Mr. Kern, do you have another -- another one of
5 these objections that you gave to me? I apologize because I
6 wrote on mine.

7 MR. KERN: I do.

8 THE COURT: I wanted to be able to make it an exhibit
9 and I apologize.

10 MR. KERN: I actually have no updated one. Agreed to
11 withdrawal the objection on page --

12 THE COURT: Oh, you withdrew some?

13 MR. KERN: On page 18.

14 THE COURT: Okay. So you withdrew that one?

15 MR. KERN: Yes, your Honor.

16 THE COURT: Okay.

17 MR. KERN: Can I approach?

18 THE COURT: You could. Yes, sir. Absolutely.

19 MR. KERN: And then the other problematic part of that,
20 I think we agreed to clip the testimony on page eight, but
21 there was some audio issues that we weren't aware of at the
22 time we gave you that.

23 THE COURT: So you all have agreed. So you withdrawing
24 that as well. Is that --

25 MR. KERN: He's going to -- he's going to take that

1 out.

2 THE COURT: So is that correct, Mr. Luginbill? You all
3 agreed to page eight, line seven. Well -- well, tell me what
4 -- which you all agreed to.

5 MR. KERN: I believe --

6 MR. LUGINBILL: Mr. (Inaudible) provided me -- make
7 sure I understand it. Since we (inaudible) you and I have
8 had a chance to talk page eight, line 17 through page nine,
9 line three. Is that right?

10 MR. KERN: Right.

11 MR. LUGINBILL: That's the only part that you care
12 about?

13 MR. KERN: Yes.

14 MR. LUGINBILL: I (inaudible).

15 THE COURT: So you've agreed to that?

16 MR. KERN: I do.

17 THE COURT: All right. So then do I need to do
18 anything else?

19 MR. KERN: Nope. I think you already clipped it.

20 THE COURT: No, what I'm saying is, do I need to rule
21 on these other objections?

22 MR. KERN: No, your Honor.

23 THE COURT: Okay. So you all resolved it then?

24 MR. KERN: Yes.

25 THE COURT: Have you already edited it?

1 MR. LUGINBILL: I have not. I -- again, I just -- I
2 got this while on --

3 THE COURT: So maybe you want to call your other
4 witness and so you can edit it?

5 MR. LUGINBILL: Until we edit it over -- over lunch
6 break.

7 THE COURT: That's what I'm -- because I don't want
8 them sitting, you know, that editing is an unpredictable
9 process. I mean, it could take. So I mean, do you have
10 somebody employed to do that for you or are you planning just
11 to stop it and start it?

12 MR. LUGINBILL: It -- it -- it -- I'll do one edit. It
13 won't -- it shouldn't take me that long. I can probably do
14 it in 10, 15 minutes. I -- I also don't want further there.
15 My bigger concern where I would -- I want to do, Your Honor,
16 is have to break down Ms. McGougan --

17 THE COURT: We might have to, time is a premium.

18 MR. LUGINBILL: If we can play I play the tape would be
19 right at 12 and she start in poll after -- after lunch.

20 THE COURT: But you haven't edited it yet. You said
21 you need 15 minutes to do that. That puts us at noon bet.

22 MR. LUGINBILL: We close.

23 THE COURT: Yeah, you can't just stop and start it at
24 that point. It's only 18 page deposition.

25 MR. LUGINBILL: I -- I -- I can try. I probably, I can

1 just fast forward through it.

2 THE COURT: Why don't we try that? Is that acceptable?

3 MR. LUGINBILL: I can mute it. I can probably do this,
4 your Honor. I can probably mute it.

5 THE COURT: That works. That might be easier.

6 MR. LUGINBILL: Just let it go through and then hit
7 play again.

8 THE COURT: That might be easier.

9 MR. LUGINBILL: That I can do.

10 THE COURT: Okay. Does that work for everybody?

11 MR. KERN: Yes, your Honor.

12 MS. MAPLES: Yes, your Honor.

13 THE COURT: That works. All right. And then I'm going
14 to have your designations marked as a -- as a -- I would
15 assume you want this marked as -- marked as an -- a court's
16 exhibit, it -- or can I just mark it resolved and I don't
17 need to.

18 MR. KERN: I think we can mark it resolved basically
19 upon the --

20 THE COURT: Okay. That works for me.

21 MR. KERN: Yes.

22 THE COURT: Because I originally -- so the only -- so
23 basically you're telling me you're withdrawing all of your
24 other objections, you have agreed to page eight, line 17
25 through page nine, line three. And you're going to mute

1 that, correct (inaudible). And then you all have withdrawn
2 your objection to page 18 lines one through 11.

3 MR. KERN: Yes, Your Honor.

4 THE COURT: And so the other ones you all have resolved
5 as well?

6 MR. KERN: Yes, your Honor.

7 THE COURT: Okay. Works for me. All right. You all
8 ready?

9 MR. LUGINBILL: Ready.

10 THE COURT: You -- do you need to test your technology
11 at all before we get started?

12 MR. LUGINBILL: We will test it. Hopefully it
13 shouldn't take --

14 THE COURT: Are you on utilize the wireless? What are
15 you all doing?

16 MR. LUGINBILL: No, I have it on the -- on the
17 computer. Just need to hook it up.

18 THE COURT: Okay. Why don't we do the test run before
19 we -- yeah.

20 MR. KERN: And just to be clear, Your Honor, otherwise
21 -- other -- Mr. Luginbill's playing the rest of deposition
22 including the cross-examination, I believe; is that right?

23 THE COURT: Yes. It's my understanding that he's going
24 to play it from the beginning and then, and I'm going to give
25 them a brief instruction about what a deposition is so. And

1 then he's going to mute it at page eight, line 17 through
2 page nine, line three. And then they'll play the rest. Is
3 that everybody's understanding?

4 MR. KERN: Yes, your Honor.

5 MS. MAPLES: Yes, your Honor.

6 THE COURT: Okay. Mr. Luginbill, is that your
7 understanding?

8 MR. LUGINBILL: Yes, ma'am. That is my understanding.

9 THE COURT: Okay. And what I will do, I -- I will
10 assume that this is -- this you all's only copy of Ms. Mills,
11 the transcript of her that you all gave me? Because I have
12 the -- the -- the -- the digital version. But if -- if this
13 is -- if I'm going to attach what you all gave me to that.
14 So it's one complete package. Is there any exception to
15 that? There's no need for me to hold onto eliminate you all.
16 Give me another copy.

17 (Video played - inaudible.)

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

20 MR. LUGINBILL: Yes, ma'am. I -- I'm able to mute it
21 on the fly.

22 THE COURT: Perfect. Now, are we good with why we test
23 the sounds and everything let's make sure we're okay.

24 (Video starts.)

25 THE REPORTER: 2024. We are on the record at 11:34.

1 (Video ends.)

2 THE COURT: (Crosstalk) just increase it just a little
3 bit for --

4 MR. LUGINBILL: Playing through this not that.

5 THE COURT: Well, the -- placing all the speakers. So
6 there speakers open the juror's head. I just need to make
7 sure.

8 (Video starts.)

9 THE VIDEOGRAPHER: My name is Pam (inaudible).

10 (Video ends.)

11 THE COURT: Maybe not. Do you have --

12 MR. LUGINBILL: I think it's playing a little bit. Let
13 me see if I can switch the output to the --

14 THE COURT: I think that's probably what you need to
15 do.

16 MR. LUGINBILL: That work.

17 THE COURT: All right. We good? So do you need to
18 just bring it back to the -- to the beginning?

19 MR. LUGINBILL: Yes, ma'am. Turn that down a little
20 bit more. Actually, I think you all will have to turn that
21 down once I give it --

22 THE COURT: Yeah, once you -- yeah, she'll adjust it.

23 MR. LUGINBILL: (Inaudible).

24 THE COURT: So why don't we -- why don't you play it a
25 little bit so I can have her adjust before the jury comes in.

1 (Video starts.)

2 THE VIDEOGRAPHER: This is the beginning of media one.
3 Today is September 5, 2024. We are on the record at 11:34
4 a.m. My name is Pamela (inaudible) and legal videographer
5 with Virtual Media Columbia, South Carolina. Amy Freeman as
6 notary and court reporter with Queen City Court reporting
7 Charlotte, North Carolina. We are engaged by Counsel for the
8 Plaintiff to take this video deposition of Amanda Mills with
9 the deposition being held by way of Zoom video conferencing
10 in the court of common pleas, selection Number
11 2018-310-56-75, state of South Carolina, County of
12 Charleston. Please introduce yourself with the record after
13 which the court reporter will swear the witness.

14 MR. LUGINBILL: Daniel Luginbill and Julia Flumian for
15 the Plaintiff.

16 MR. KERN: Brian Kern with the Defendant Richard Frisch
17 and the Southeastern Spine.

18 MS. MAPLES: Allie Maples for Defendants, Dr. Timothy
19 West and Lowcountry Infectious Diseases.

20 THE REPORTER: Hi, and just to clarify, I am Amy
21 Freeman with Creek Queen City Court Reporting, but I'm
22 located in Charleston, South Carolina.

23 So can -- Ms. Mills, can you raise your right hand?

24 AMANDA MILLS,

25 being duly sworn, testifies as follows:

1 (Video ends.)

2 THE COURT: I think that's good. That's (inaudible).

3 (Video starts.)

4 DIRECT EXAMINATION

5 BY MR. LUGINBILL:

6 Q. Good morning, Ms. Mills. My name is Daniel
7 Luginbill I represent the Plaintiff (inaudible) deposition
8 (Inaudible). If everybody could make sure they're muted
9 (inaudible) feedback. So first thing first, tell us a little
10 bit about yourself. Where are you from?

11 A. My name is Amanda Mills. I am from Dolores, South
12 Carolina.

13 (Video ends.)

14 THE COURT: We can start. I think that's the far --
15 you all good?

16 MR. LUGINBILL: Okay.

17 MR. HOOD: Judge, before you bring that I just --
18 logistical question for the afternoon, I want to make sure
19 I've got however many witnesses we need to get moving.

20 THE COURT: Uh-huh.

21 MR. HOOD: What -- what time do you intend to go till
22 today?

23 THE COURT: I'll try to stop at 5:00.

24 MR. HOOD: 5:00? Okay.

25 THE COURT: Yeah, I mean, if we're in the middle of a

1 witness like yesterday, I mean, I'm going to try to finish
2 them, but I -- it just depends on how long the last witness
3 is.

4 MR. HOOD: Sure.

5 THE COURT: And I'm going to break -- I'm -- that's why
6 I brought the jury in earlier because I wanted to break as
7 close to noon as possible because then it gives us more use
8 of the afternoon when you got to come back at 2:00.

9 MR. HOOD: Understood.

10 THE COURT: Yeah.

11 MR. HOOD: So plan on -- we're going to be back at 2:00
12 and we'll get three hours in.

13 THE COURT: Well -- well, probably if we finish this
14 deposition like 12:00, then I'm probably going to break then.
15 And then take an hour for lunch and then resume.

16 MR. HOOD: Got it.

17 MR. LUGINBILL: Your Honor, do you want me to do the
18 whole reading? And obviously you have to have it sworn, but
19 do you want me to do the video reading and --

20 THE COURT: You don't necessarily have to do all that.
21 I think you can start where she says her name.

22 MR. LUGINBILL: Yeah.

23 THE COURT: Because I'm going to tell the jury what
24 deposition is.

25 Do you -- get the jury for me?

1 THE BAILIFF: Yes, ma'am.

2 THE COURT: Thank you.

3 (Jury enters courtroom.)

4 THE BAILIFF: All jurors present, your Honor.

5 THE COURT: Thank you. Ladies and gentlemen, we
6 appreciate your patience. Please know we do not take your
7 time for granted. The Plaintiff may proceed. Call your next
8 witness.

9 MR. LUGINBILL: Your Honor, Plaintiff calls Ms. Amanda
10 Mills via video tape.

11 THE COURT: Ladies and gentlemen, you're about to watch
12 a testimony that has been done by deposition. A deposition
13 is either written document or a video where a witness
14 testifies under oath. It is the same as if the witness were
15 here present and testifying. Counsel for each party is
16 present and they will each have the opportunity to question
17 the witness.

18 Again, I emphasize that it is the same as if the
19 witness were here present and testify. And it is then for
20 you as the finder of fact to give the testimony the weight,
21 value, and effect you decide it should receive. We've tried
22 to dim the lights as best we can to take the glare off the
23 screens. We got new equipment so we're playing with it to
24 figure out which controls control which. So I may turn all
25 the lights off because the glare is better on this side than

1 on this side. So just bear with us. We appreciate your
2 patience.

3 You may proceed, Mr. Luginbill.

4 MR. LUGINBILL: Thank you.

5 THE COURT: You're welcome.

6 (Video starts.)

7 THE REPORTER: Charleston, South Carolina. Ms. Mills,
8 can you raise your right hand?

9 AMANDA MILLS,

10 being duly sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MR. LUGINBILL:

13 Q. Good morning, Ms. Mills. My name is Daniel
14 Luginbill I represent the plaintiff. If everybody could make
15 sure they're muted (inaudible) feedback. So first thing
16 first, tell us a little bit about yourself. Where are you
17 from?

18 A. My name is Amanda Mills. I am from Dolores, South
19 Carolina. I have worked in health care for 35 years as a
20 nurse in different roles and I'm now not working.

21 Q. Can you tell me when you first came to work with
22 Ms. Patricia McGougan?

23 A. I believe it was around 2000 maybe I'm not exactly
24 sure the date.

25 Q. Fair enough. Sometime around what time?

1 A. It was about -- it was probably about 2011 maybe.

2 Q. Okay. And what was your role at the time?

3 A. I was -- 2011, I was the CNO at McLeod Loris
4 (inaudible).

5 Q. And that would be chief nursing officer?

6 A. Yes, sir.

7 Q. All right. At what position did Ms. McGougan
8 have?

9 A. She was working as a nurse supervisor.

10 Q. All right. If you would just tell the jury what a
11 nurse supervisor would do at the (inaudible)?

12 A. A nurse supervisor is a clinical resource to the
13 nursing staff and to -- a resource to the patient and the
14 family. They do a mission, a placement. They do respond to
15 emergencies. They coordinate the care from the admission to
16 discharge with the physicians and the nursing staff. They
17 ensure that everyone is doing the quality of care and the
18 quality of nursing work that is expected.

19 They are kind of like a person that handles if there's
20 any issues that arise, whether it be staffing or emergencies
21 or physician that needs to transport a patient or if a
22 patient needs transferring within the facility, they are your
23 clinical expert in staffing, making sure that they are in
24 compliance with the Labor Licensing Board, that the nurses
25 and the staff are qualified and that's a little bit about the

1 job.

2 Q. While they're actually physically there doing the
3 job. Are they -- is it a normal eight-hour day Monday to
4 Friday? How does that work?

5 A. At the time it is basically a 12 hour shift. They
6 did -- it is covered 7:00 a.m., to 7:00 p.m., and then 7:00
7 p.m., to 7:00 a.m., is night shift and it's a 12 hour period.
8 One week you're not doing three days the next week, four
9 days. And during that time we were trying to do some
10 transitioning of having a nurse manager handle from the
11 seventh degree, but ultimately get back to the -- the nurse
12 supervisor. Such a -- a -- a demanded probably we have to
13 have him.

14 Q. Okay. Now, it is my understanding that the nurse
15 supervisor, although they have sort of these coordinating
16 type roles, they also need to be physically able and
17 qualified to do actual hands-on patient care; is that
18 correct? They have to do.

19 A. They have to -- they're an RN, so they're licensed
20 by the board and usually they have had a lot of experience in
21 various roles in the hospital and they do have to be able to
22 physically, mentally be able to juggle many things. And
23 again, I emphasize the word a great resource to the staff and
24 to -- to ensure that the patients are cared for with the best
25 care.

1 Q. If there was a code on the floor, would the
2 nursing supervisor be expected to physically participate in
3 that code?

4 A. Absolutely.

5 Q. If a nurse or a nurse's aid be to help physically
6 move a patient out of a bed, is that something that a nurse
7 supervisor would have to do?

8 A. Yes, a nurse supervisor has to be able to respond
9 where the needs are. It's like in an emergency you have to
10 be on speed trying to get the -- the patient real quickly to
11 the area. And so people -- you just jump in and do what is
12 required of the patient -- of the -- for patient needs.

13 Q. Is there a supervisor at McLeod Loris? A job that
14 can be done sitting in a chair to desk for 12 hours?

15 A. No.

16 Q. So tell us a little bit about Ms. McGougan herself
17 and how she did roll for you?

18 (Video ends.)

19 MR. LUGINBILL: Your Honor, since we shifted the
20 control of it. I cannot mute.

21 THE COURT: Oh, come on the bench.

22 (Bench conference.)

23 MR. LUGINBILL: All right. Whenever you're ready,
24 (inaudible). You ready?

25 THE COURT: I'm ready.

1 (Video starts.)

2 BY MR. LUGINBILL:

3 Q. So (inaudible).

4 A. I would say that is excellent. She was respected
5 by the staff and stated by.

6 Q. When injured her back in 2016, if everything had
7 gone right and she was able to physically come back and do
8 the job, would that job have been there waiting on her?

9 A. (Inaudible).

10 Q. Okay. I'll try to address his -- his objection to
11 (inaudible). You were still the supervisor, you were still
12 the CON at that time in 2016; is that right?

13 A. Yes.

14 Q. Okay. In the role as nursing or as the CON, would
15 you have had a role to play in whether or not Ms. McGougan
16 was able to return to work?

17 A. Yes. If she met still the requirement as the
18 nurse supervisor, she certainly would have been back in her
19 position. Just have to be able to do the job in all areas.

20 Q. And so assuming Dr. Frisch gave her a clean bill
21 of health and said she was released back to work with no
22 physical restrictions, would you as a CON have allowed her to
23 continue working?

24 A. Yes.

25 Q. And as far as you know, did she have any end day

1 decide when she was no longer going to work?

2 A. No, I -- I didn't. I -- I didn't know of any
3 plans.

4 Q. And is there any mandatory retiring age at McLeod
5 Loris?

6 A. No.

7 MR. LUGINBILL: Ms. Mills, thank you. That's all I
8 have for you. Thank you.

9 THE WITNESS: Thank you.

10 CROSS-EXAMINATION

11 BY MR. HOOD:

12 Q. Hi, Ms. Mills.

13 A. Hi.

14 Q. My opportunity to just cross-examine you one
15 couple of these issues that we've been talking about. Okay?

16 A. Okay.

17 Q. All right. You agree that you do not work in
18 human resources directly for the hospital, correct?

19 A. Yes.

20 Q. All right. And you agree that you don't have any
21 knowledge of whether Ms. McGougan applied for any special
22 accommodations that will be required by law to work in the
23 hospital, correct?

24 A. I'm not aware of any of that.

25 Q. Okay. And you agree that Ms. McGougan was valued

1 members of the team and at the hospital, correct?

2 A. Yes.

3 Q. And she, in your estimation possessed
4 institutional knowledge hopeful to the entire hospital; is
5 that correct?

6 A. Yes.

7 Q. And that you would expect that she could be
8 valuable with any Number of roles at that hospital if she was
9 needed or has looked -- been to that, correct?

10 A. If she was qualified to do the job.

11 Q. Yeah. As far as you know, she had all the
12 qualifications she needed for a variety of jobs in the
13 hospital, right?

14 A. In the nursing and the field of nursing?

15 Q. And including as a supervisor, correct?

16 A. Yes. She was a great supervisor.

17 Q. Okay. And you're not here to testify that you
18 have any specific knowledge of her other medical conditions
19 or physical complications that did or did not for stay out,
20 correct?

21 A. Correct.

22 Q. And you're not expert in physical therapy,
23 occupational therapy, orthopedics, correct?

24 A. Correct.

25 Q. Okay. You in fact were contacted by Ms. McGougan

1 a couple weeks ago and asked if you could come get testimony
2 today, right?

3 A. Yes.

4 Q. And your understanding was that you were here to
5 give some testimony about her complaints and her ability or
6 inability to work, right?

7 A. I was aware that it was regarding that I was her
8 supervisor at the time of her employment as at McLeod as CON.

9 Q. Okay. And -- and -- and at the time you all were
10 -- I mean you all were friendly as work coworkers, correct?

11 A. Profession, yes.

12 Q. And when she got sick you took flowers and maybe a
13 cake or a gift to her house?

14 A. I did one time go and carry a cake and I believe
15 flowers to her on behalf of nursing.

16 Q. Okay. And -- and you're not here to testify about
17 any information you received directly from any of her doctors
18 about her ability or inability to work, right?

19 A. No.

20 Q. All right. And you've never spoken with anybody
21 about that time of that?

22 A. No. Unless it was with the job at the time at HR,
23 I -- I don't recall.

24 Q. Okay. And you're not here to testify about
25 knowledge of any, all those potential jobs that Ms. McGougan

1 might have been able to do at that hospital, correct?

2 A. Correct.

3 Q. Agreed that accommodation was needed then the
4 hospital was legally required to evaluate and do the best to
5 accommodate (inaudible)?

6 A. Yes, we can call it at gate.

7 Q. Now, in terms of the -- the work structure on your
8 team, you are not aware of a specific part-time program that
9 guarantees some a nurse hours at the hospital, right?

10 A. Right.

11 Q. Their experience is if there is -- if the hospital
12 be part-time work, they go through the PRN program where they
13 reach out to individual directly as needed, correct?

14 A. Correct.

15 Q. And you don't have any knowledge of Ms. McGougan
16 of any requests she made to come back to work in the hospital
17 after surgical complications, correct?

18 A. Not that I recall.

19 Q. And you've never had the opportunity to review any
20 of her evaluations by doctors or talk to her doctors about
21 what -- their ability?

22 A. No, I haven't.

23 MR. HOOD: Okay. Thank you for your time. That's all
24 I have.

25 THE WITNESS: Thank you.

1 FURTHER CROSS-EXAMINATION

2 BY MS. MAPLES:

3 Q. Ms. Mills, my name is Allie Maples and we met
4 earlier. Again, I represent Dr. West and Lowcountry
5 Infectious Diseases. And as Ms. McGougan's supervisor, you
6 were familiar with her hours as an employee, correct?

7 A. Yes.

8 Q. You understood she was an hourly employee, not
9 salaried?

10 A. Yes.

11 Q. And that she wasn't guaranteed any specific Number
12 of hours as a nursing supervisor?

13 A. As a full-time supervisor, she was guaranteed
14 hours.

15 Q. But she wasn't guaranteed a specific Number of
16 hours pursuant to any contract?

17 A. No contract.

18 Q. And she wasn't guaranteed any shift differentials
19 per contract?

20 A. Not by contract, but it was with her job that she
21 applied for, I mean that she was working in.

22 Q. So they were an option?

23 A. Well, full-time requirements were guaranteed
24 full-time hours which was 36 to 40 a week. And the
25 supervisors, the position she was in was a full-time position

1 and she worked I think three one week and four 12 hours
2 together.

3 Q. I understand that, but speaking about shift
4 differentials she wasn't guaranteed a specific shift
5 differentials at any specific time pursuant to a contract or
6 other agreement.

7 A. There is policy that have shift differentials on
8 the evening and night shift and when she was working those
9 shifts, she would receive those differential and the
10 supervisors worked on those hours.

11 Q. But the supervisors also worked during the day
12 when there weren't shift differentials?

13 A. Seven to three was not a shift differential, but
14 the hours were 12-hours shift. So from three to seven
15 would've been a differential. And from the 7P to 7A within a
16 differential.

17 Q. Now, I understand that you're not able to speak to
18 McLeod Loris accommodation process today, but you can tell us
19 that while you were working at McLeod Loris and working as
20 Ms. McGougan's supervisor, they did make accommodations for
21 nurses like Ms. McGougan who had restrictions, correct?

22 A. Yes.

23 Q. And they were happy to do so?

24 A. Absolutely. We were desperately needing nurses.

25 Q. Not only required to do so by law, but you needed

1 the staff, right?

2 A. Absolutely. Provide the care to the patients.

3 MS. MAPLES: Okay. I don't have any other questions.

4 Thank you.

5 THE WITNESS: Thank you.

6 THE COURT: Anybody else?

7 MR. KERN: No, ma'am.

8 MR. LUGINBILL: Sorry, this is Dan. I had myself
9 muted.

10 RE-DIRECT EXAMINATION

11 BY MR. LUGINBILL:

12 Q. In speaking to the question, you were just asked
13 about accommodations. The hospital would make
14 accommodations, but he -- but the person being accommodated
15 still has to be a performing charge, correct?

16 MR. HOOD: Objection. Leading

17 THE WITNESS: Yeah.

18 BY MR. LUGINBILL:

19 Q. Okay. And so when you say accommodations, what
20 accommodations would you be able to provide to Ms. McGougan,
21 if she had, you know, a 10-pound weight restriction or
22 couldn't be on her feet for more than an hour at a time. Can
23 you -- are those restrictions that -- that you did
24 accommodate in that nursing supervisor?

25 A. Not in the nursing supervisor role.

1 Q. To your knowledge, did Ms. McGougan apply to the
2 hospital for other roles?

3 A. Not to my knowledge.

4 Q. Okay. Would that have come directly through you
5 or would that have come through HR?

6 A. HR really is where they would've talked to the
7 physician and she -- they may have copied me by information
8 wise to say that there's a job in radiology, answer the phone
9 or something, but I'm not aware of that.

10 Q. Okay. And the best of your recollection, HR never
11 contacted you to say, here's a job she can do, reach out to
12 her or anything like that?

13 MR. HOOD: Objection. Leading.

14 THE WITNESS: I do not -- I do not recall them.

15 BY MR. LUGINBILL:

16 Q. We were asked whether she was qualified to do the
17 main job at the hospital to communicate that she was. Are
18 you -- do all those jobs that she's qualified to do assume
19 she's physically capable of doing them?

20 A. Yes. She would have to be qualified to do those
21 jobs on training and make sure she does this appropriate
22 certification.

23 Q. And so she -- so when you say qualified, she has
24 to have both the -- I'll call the academic training
25 background and also physical needs to be qualified?

1 MR. HOOD: Objection. Leading.

2 THE WITNESS: Yes.

3 BY MR. LUGINBILL:

4 Q. Okay. And to address that last objection, what do
5 you mean when you say qualified for a position?

6 A. Trained as an RN, trained in skills that are
7 required for nursing, certifications, quite like emergency
8 responses. What as the appropriate protocol. Compliance
9 with the policies and features of the hospital. Pulling from
10 experience, you know, to look for when a person's going down
11 the wrong path and they're going to need emergency
12 intervention or a rapid response knowing it is from
13 experience a lot evidence.

14 Q. And what role does physical division play in that
15 qualification definition?

16 MR. HOOD: Objection.

17 THE WITNESS: This --

18 MR. LUGINBILL: Go ahead.

19 MR. HOOD: (Inaudible).

20 THE WITNESS: Physical -- physically able to perform
21 roles like starting IVs, holding patients, moving patients in
22 needed emergencies. A nurse supervisor has to be on their
23 feet and their legs. They not -- you got to be there for
24 staff and for the patients and for the physicians. So your
25 presence physically is you got to be there.

1 MR. LUGINBILL: That's all I have. Thank you.

2 Anyone else?

3 MR. HOOD: No re-cross.

4 (Video ends.)

5 MR. LUGINBILL: That's the end, Your Honor.

6 THE COURT: Mr. Foreman, ladies and gentlemen, we're
7 going to take advantage of this break and testimony to take
8 our lunch recess. During the break, please do not discuss
9 the case among yourselves with anyone else. Please don't
10 have any contact with anyone in or about the courthouse.
11 Please leave your notepads in your seats. It's 12:14. We're
12 going to break until 1:15 -- 1:30 give you an hour and 15
13 minutes because you got to get out of the building.

14 Return directly to your jury room at 1:30, at which
15 time will resume testimony. Have a good lunch. And again,
16 thank you for your patience.

17 (Jury exits courtroom.)

18 THE COURT: All right. Is there anything before we
19 break for lunch from the Plaintiff?

20 MR. LUGINBILL: No, ma'am.

21 THE COURT: From the Defense, Mr. Hood?

22 MR. HOOD: I'm just going to hand up our jury charges.

23 MS. FLUMIAN: Oh, we can do that as well, your Honor.

24 THE COURT: Thank you. Appreciate it.

25 Thank you, sir.

1 And thank you, ma'am.

2 MS. FLUMIAN: Thank you.

3 THE COURT: All right. Guys, you all have a good
4 lunch. I'll see you at 1:30.

5 (Off the record.)

6 THE COURT: Plaintiff ready to proceed?

7 MR. LUGINBILL: We are, your Honor.

8 THE COURT: Defense ready to proceed?

9 MR. HOOD: Yes, your Honor.

10 MR. SMYTH: Yes, your Honor. Oh, I'm sorry.

11 THE COURT: Jury should be right behind me. Who's your
12 next witness?

13 MR. LUGINBILL: We call the Plaintiff, Ms. McGougan.

14 (Jury enters courtroom.)

15 THE BAILIFF: All jurors present, Your Honor.

16 THE COURT: Thank you. I hope you all enjoyed your
17 lunch. We'll now resume testimony. You may call your next
18 witness.

19 MR. LUGINBILL: Thank you, your Honor. The Plaintiffs
20 call Patricia McGougan.

21 THE COURT: Ma'am, if you would come to the stand to be
22 sworn.

23 THE CLERK: Please raise your right hand and place your
24 left hand on the Bible.

25 PATRICIA MCGOUGAN,

1 being duly sworn, testified as follows:

2 THE CLERK: Please be seated. Please state your full
3 name, spelling your last name directly in the microphone.

4 THE WITNESS: My name is Patricia McGougan.

5 THE COURT: You would spell your last name for the
6 court reporter, please.

7 THE WITNESS: M-C capital G-O-U-G-A-N.

8 THE COURT: You may proceed.

9 MR. LUGINBILL: Thank you, your Honor.

10 THE COURT: You're welcome.

11 DIRECT EXAMINATION

12 BY MR. LUGINBILL:

13 Q. Good afternoon, Pat. You're soft-spoken you're
14 going to need to take your mouth in front of that microphone.

15 A. Yes, sir. Okay.

16 Q. Tell the jury a little bit about where you grew
17 up.

18 A. I grew up at Sandy Plains in Tabor City, North
19 Carolina. It's a farm that I lived beside my grandparents.
20 My mom and dad who were married 60-some years. Next door to
21 my grandma and granddaddy. My mom was the oldest of 11
22 children, so I was the oldest granddaughter of that crowd.
23 My brother was the oldest grandson. I was the oldest
24 granddaughter. So a lot of cousins were looking up to us.
25 There's about 100 of us now, big family.

1 Q. How big is the farm?

2 A. Growing up the farm was around 125 acres.

3 Q. And how is it now?

4 A. It's 400.

5 Q. Okay. And what did your dad do other than
6 farming?

7 A. My dad was -- is a retired -- was a retired
8 minister. I lost him last year. And he did various other
9 jobs other than farming.

10 Q. Now, where did you go to school growing up?

11 A. I went to Tabor City.

12 Q. Now where'd you go after that?

13 A. I went to Western Carolina for a couple of years
14 studying speech pathology and felt the need to get -- go home
15 and get married. I went back to Tabor City and went to
16 Southeastern Community College that was nearby and got my
17 nursing degree.

18 Q. And where did you start your nursing career?

19 A. In Loris at the -- at the Loris Community
20 Hospital, which is now McLeod Health.

21 Q. What was your job?

22 A. My job there was, I worked in various -- I had
23 opportunities to work in medical surgical unit back in '78.
24 You guys were not thought of being probably, but I was a med
25 surg nurse first, and then I was employed in ICU and I also

1 had a -- a year and a half to work with OB helping deliver
2 babies in our community.

3 Q. As your career went off, what did you end up doing
4 and where were you doing it?

5 A. In 2011, I moved back to Loris after I had worked
6 in other positions in a nursing administration being a
7 nursing supervisor for several years, 20-plus years. I went
8 back to Loris and I had married Edgar and I wanted to be
9 closer home, so I worked at Loris as a nursing supervisor.

10 Q. What does a nursing supervisor at Loris Hospital
11 do?

12 A. Well, like you've heard we are the extra set of
13 hands for whatever is going on in the hospital. No matter if
14 it's cleaning a floor, if someone's had an accident, you make
15 sure that that is a safe environment for your nurse, your
16 patient and always any -- any visitors that are coming in and
17 out.

18 Q. Is it a physical job?

19 A. Very physical. I was on my feet and loved it. I
20 was on the move. I liked running -- running quad. All the
21 entities that -- that you juggle in a day on that -- for that
22 particular job.

23 Q. About eight-hour shifts?

24 A. No, they're 12-hour shifts.

25 Q. How many of those 12-hour shifts would you do in a

1 week?

2 A. I did for every two weeks, we did 36 the first
3 week and then we'd do 48 the second week for the hours I
4 worked in the two-week period and that's when we were paid
5 every two weeks.

6 Q. Following the same shifts or did that rotate?

7 A. Oh, it rotated constantly. Day, night, evening.
8 It was -- it was a variety.

9 Q. All right. Now, Edgar tried to tell us a little
10 bit about how you met. How did you guys meet?

11 A. Well, Abeline was in the choir with me, and that
12 was his aunt, and it was her husband he was getting the
13 lifetime deacon award in our church. So all of the Huggins
14 family, which was Edgar's mama's family, came to church. And
15 so she decided to hook us up that day and we didn't know it.
16 We had no idea that was her plan, but she called -- told me
17 that he was wanting my Number and she told him that I was
18 wanting him to call me and Abeline hooked us up and it was --
19 it's history.

20 Q. Oh, and they could figure out that was going to
21 work?

22 A. We met in July of '05 and we were married in March
23 of '06.

24 Q. How old was your son?

25 A. Robert -- Robert was 11.

1 Q. And how old was your youngest?

2 A. My youngest was a senior in college. I had
3 finished raising my three boys. My friends thought I was a
4 little crazy, but I thought it was a blessing. We -- we got
5 along immediately. It was good.

6 Q. Once you all got married, where did you decide to
7 live?

8 A. We lived in -- in Green Sea at the home place, the
9 McGougan home place. We sold the house that I'd raised my
10 boys in and it was a little -- little house in Tabor City and
11 -- and it was, you know, a block from everything where I
12 raised my boys. It was literally a block to the grocery
13 store, a block to the funeral home and a block to the
14 doctor's office. That's how small the town is. So, but we
15 decided to move to grow up to Green Sea, Edgar's home.

16 Q. How important is that home to Edgar?

17 A. Well, the home place it was built when he was four
18 years old. His -- his parents were able to build the house
19 and it was like maybe a half mile from where he and his
20 sister were as little children on the home place. So that
21 home was quite important. His -- his mother was a teacher.
22 His daddy was post office worker and both of them vets from
23 World War II.

24 Q. How far was it from where you lived there in Green
25 Sea to where you were working?

1 A. I mean, it was 25 miles. I was working in
2 Whiteville, North Carolina.

3 Q. And then during that time, were you also helping
4 with your dad and your mom?

5 A. My mother had Alzheimer's and she was diagnosed
6 early in the 60s. And my dad, who was my hero, took care of
7 my mother for 11 years with Alzheimer's. And my job was to
8 make sure the food was in the house, that the caregivers were
9 lined up to help relieve dad on certain days. And then
10 weekends I took care of mother.

11 Q. And in terms of years, from when to when was this
12 your life?

13 A. Mother died in -- from the time I was married to
14 Edgar in 2006, mother was diagnosed at that point. She died
15 in '11 and -- no, she died in '12, I'm sorry, but those years
16 were, my math mind is not working right now.

17 Q. How was your dad health as of '12 when he had to
18 start living by himself?

19 A. Dad was very independent and just a strong-willed
20 man farmer and knew what he wanted in life. At -- at the end
21 of mother's life, he wanted to be with her, but he -- he made
22 sure that he was busy, but it was my responsibility to make
23 sure his house was cleaned, get people there, make sure that
24 if he needed help with groceries, but he would -- he even
25 learned how to navigate the grocery store. I was real proud

1 of him for quite a while.

2 Q. So were you able to physically and just know the
3 hours of the day and get all that done?

4 A. Oh, yeah. Oh, yeah.

5 Q. How?

6 A. You do what you want to do, do what you need to
7 do.

8 Q. When were you diagnosed of rheumatoid arthritis?

9 A. 2007, a year after I married Edgar.

10 Q. And so you were able to do all this despite your
11 diagnosis?

12 A. Always.

13 Q. When you would have a flare up, how would it
14 affect you?

15 A. I would usually have a frozen joint, like the --
16 when I was diagnosed, my shoulder had frozen. I couldn't --
17 I said my wing was broke. I went to the doctor and said my
18 wing is broke. I can't move my elbow from my body. And he
19 did some blood tests and it come back that I had RA and he
20 referred me to a rheumatologist for treatment then.

21 Q. And who is your rheumatologist?

22 A. Dr. Joseph Shanahan.

23 Q. Still today?

24 A. Yes.

25 Q. Let's say from -- excuse me, 2014, 2015, going

1 into '16, had you had any problems with your rheumatoid?

2 A. None. I was -- I was taking Enbrel and Arava are
3 the two medicines that the doctor had me on and I was
4 controlled with my -- I did not -- was not having flares. I
5 was able to keep moving all the time.

6 Q. And how was Enbrel against you?

7 A. It's on SubQ. It is a -- a shot in your belly or
8 your -- your leg.

9 Q. And how about the Arava?

10 A. It's by mouth. Arava is by mouth.

11 Q. Okay. And did you all -- you did the injections
12 yourself?

13 A. Yeah. Yeah.

14 Q. How often would you have to go see Dr. Shanahan
15 for a follow-up at that point?

16 A. It was according it was six months to a year that
17 he would have me come back in and -- and look at, make sure
18 my meds were right and we hadn't changed meds for years.

19 Q. And so in 2016.

20 A. Yeah.

21 Q. You know sounds like a full life.

22 A. Yeah.

23 Q. What did you and Edgar like do for yourself?

24 A. We would -- in 2011, we were at the point of being
25 able -- Robert was a junior in high school getting ready to

1 go to college and we were making trips to campuses to see,
2 but really there was only -- he applied several places, but
3 he went to Clemson and we got a Clemson graduate from there.
4 So we then started participating in Clemson activities,
5 trying to, you know, go to games and tailgate with my niece
6 and sister-in-law because they were there also.

7 Q. Did your RA hold you back from being able to do
8 any of that?

9 A. No.

10 Q. Did you have any other health problems that were
11 holding you back from doing any of that?

12 A. No.

13 Q. Tell me what happened on July 5, 2016?

14 A. As Edgar said, we were shopping, I'd worked all
15 night and we'd had a really busy night. We'd had like six
16 admissions that night. I -- there's some things you don't
17 forget. And we decided to go get breakfast and do some
18 shopping. Get groceries, though we had -- we were in Walmart
19 and when I reached for -- I didn't want my bread to be
20 smashed because the lady acted like she wasn't going to. So
21 I reached for it from the end. I did do a long reach and --
22 and something popped and I didn't realize I had made noise,
23 but Edgar's like, what is wrong with you? And I was like, I
24 don't know, something is just happened in my back and my leg.
25 And from that point on I -- I started -- I couldn't -- I

1 couldn't bend my leg at -- at lunch after we got it was, you
2 know, just really -- really uncomfortable.

3 Q. Where did you first go to have somebody take a
4 look at that?

5 A. I think as I recall, we -- we started in the
6 emergency room and Dr. Michael Morgan was an ER doctor I
7 worked with a lot. And he was there and they did some test
8 and he thought maybe I had something called a SI joint
9 inflammation maybe that something had pulled. And he -- you
10 know, he said you might go to the chiropractor and see if
11 they can't pull it out.

12 So I went to the chiropractor, but he wouldn't do any
13 treatments on me. He did some X-rays and did some
14 electrical, some -- some kind of unit on my lower back. And
15 I got worse after two treatments. And he said go to
16 Dr. Harkins, who was my medical doctor and see that you can
17 get some help there. We need to see some -- what else is
18 going on. So at that point I went to Dr. Harkins and then he
19 ordered MRI.

20 Q. And after he got that MRI back, what was his
21 recommendation?

22 A. Well, he told me I needed to see a neurosurgeon
23 that -- that it was indicated that I had a problem.

24 Q. After your visit with Dr. Harkins, did he -- did
25 you change up any of your RA medications after that visit?

1 A. No.

2 Q. After that visit then you recommended you go to
3 doctor or go to a neurosurgery?

4 A. No, I was -- I was on my RA medication at that
5 time.

6 Q. Do you remember about what date that would've been
7 in July?

8 A. It was the end of July 25, 26 something.

9 Q. When did you take your last injection of Enbrel
10 before seeing Dr. Frisch?

11 A. I had -- I feel sure I had -- well, I have been
12 looking back, I had taken my Enbrel that week and my Arava, I
13 had not stopped my medication at that time.

14 Q. Why did you pick Dr. Frisch?

15 A. Well, there's, you know, lots of advertisements on
16 TV. That was one thing, but the most important part for me
17 was that I talked to Amanda Mills who was my boss, and I
18 said, Dr. Harkins thinks I need a neurosurgeon. And who
19 would you recommend, you know? I'm in Loris working in South
20 Carolina, who would you recommend? And she said that she
21 knew that Southeastern Spine had -- had been successful and
22 that Dr. Craig, one of our surgeons had had surgery there.
23 And she said, you know, Dr. Craig's got along great so, you
24 know, she would recommend them. So I called Dr. Harkins back
25 and -- and gave that name of -- of that group.

1 Q. Once you got down to Southeastern Spine, just tell
2 me what you thought about coming up into their complex there
3 (inaudible).

4 A. This beautiful -- beautiful facility, very clean
5 just nice full parking lot was full. We had trouble finding
6 a parking place, but we -- that was it. Yes. Just had a lot
7 of.

8 Q. Once you got to see Dr. Frisch. What was your
9 impression?

10 A. Everything was fine. I was -- I was -- I was glad
11 I was there. He felt like he could help me. I was glad to
12 be seen as quickly as I was.

13 Q. What was his recommendation?

14 A. He felt that I needed to have the disc -- a
15 discectomy of L -- the L -- between the L4 and L5 that.

16 Q. Did you -- did you understand what was wrong and
17 what he was going to do to fix it?

18 A. Well, I never had that, but I -- I understood his
19 explanation.

20 Q. What was your understanding of how long you'd be
21 out to work?

22 A. Six to eight weeks. I should be able to return to
23 work.

24 Q. Was that your goal?

25 A. Oh, absolutely.

1 Q. How did you plan to keep income coming in while
2 you were out six, eight weeks?

3 A. Well, I had accrued paid days off called "PDOs" is
4 what we referred to them as. I had accumulated quite a few
5 hours and I would have enough to pay me full time while I was
6 out.

7 Q. You had to pay days off for eight weeks?

8 A. Yes.

9 Q. How long does it take you to build up that much?

10 A. I don't know. It's you -- you accumulate about
11 seven hours every two weeks, so.

12 Q. How did -- how was the surgery? Did the
13 discectomy itself, all that -- so what was that experience
14 like?

15 A. It was fine. We -- we went in the hospital, had
16 the procedure done and was ready to come home the following
17 day.

18 Q. Tell us how you felt that first week once you got
19 home.

20 A. I was okay. I -- I was doing everything I'd been
21 told to do. They'd given me a list of things to do. After
22 my surgery I went home and did all those things and
23 everything was going good I thought.

24 Q. All right. When did that change?

25 A. Well, it was after my return visit, I -- we'd been

1 to the return visit and everything was okay and we'd gotten
2 back home about four days after my return visit, after my
3 surgery. And I took a shower and I was very tired after I
4 had taken my shower. So I went and laid down and on my bed
5 and when all of a sudden I felt this hot liquid pouring under
6 my lower back and I called Edgar to come to me and -- and
7 look, I said, something is wrong. I -- I'm not supposed to
8 have warm fluid there. And he says, guy, your wound is open.
9 So that -- at that point I called Dr. Frisch office and let
10 them know what had happened.

11 Q. As a result of that phone call, what did you do?

12 A. I went back to his office, they scheduled me an
13 appointment and we returned to Charleston.

14 Q. What did that fluid look like when it first dashed
15 out?

16 A. Well, it was a yellow fluid. It was -- I -- I
17 would have documented it, not knowing all that the experts
18 have said this week, but I would've said it was serious. It
19 didn't have blood in it.

20 Q. What were your concerns when you saw it?

21 A. Well, my wound had opened. I -- I was afraid. I
22 was afraid.

23 Q. What did that mean to you that you now had an open
24 wound?

25 A. Well, that's an entry for potential infection.

1 Q. In the days leading up to where the wound opened.

2 Had there been any changes in your pain levels?

3 A. Prior to that?

4 Q. Yes, ma'am.

5 A. No.

6 Q. Do you recall seeing Ms. Buck on that return visit
7 to the VA?

8 A. Oh, yes.

9 Q. So show this and -- and if you would read that top
10 part and see if that refreshes your memory.

11 A. Okay. Okay. I rated that a six out of 10.

12 Q. I'm ready -- show that.

13 A. Okay.

14 Q. Do you recall telling Ms. Buck that?

15 A. I would've thought that was my postoperative pain
16 because I've had surgery.

17 Q. I want to back up one minute and we're going to
18 reference it in this. After your first visit at the
19 Southeastern Spine, your first post-op visit, why were you
20 given a Medrol Dosepak?

21 A. I don't know unless I was having a flare thinking
22 that I had a RA flare. I recall that my arm hurt where the
23 IV was that a joint had swollen.

24 Q. Were you having any problems with your legs at
25 that point?

1 A. Well, my back, yeah, it was my lower back and left
2 -- left leg, but that was.

3 Q. When you -- when she described you the -- the
4 Medrol Dosepak, was there any discussions that you recall
5 about what the steroids might do to your immune system?

6 A. No.

7 Q. What did she tell you about the antibiotics that
8 she chose?

9 A. That it was a -- a skin infection. That it was
10 just the antibiotic for skin. That your top layer is what I
11 understand.

12 Q. Any discussion about anything other than a
13 surface-level infection?

14 A. No.

15 Q. From the time you moved over to -- saw Mr. Buck,
16 how much you can put an idea, how much drainage are we
17 talking about?

18 A. Well, it would saturate the four by fours. We
19 were doubling and tripling them. And Edgar was putting them
20 on my back for me and it was every four hours easily that
21 we'd have to replace them. I had to put padding in my -- in
22 my chairs so that I wouldn't drain on my chairs.

23 Q. And would -- was Ms. Buck aware of that?

24 A. Yes.

25 Q. Do you recall any blood work being done?

1 A. No, sir.

2 Q. Were you told to follow-up with any other doctors
3 getting blood work done or have anything checked?

4 A. No.

5 Q. Do you recall what your discharge instruction for
6 that day or when you were going to return?

7 A. I think it was another four weeks.

8 Q. And you should turn, what is the date of that
9 Plaintiff's Exhibit 5?

10 A. Encounter is 8/30.

11 Q. And so if you saw Ms. Buck on the 23rd, what was
12 your return date?

13 A. Seven -- seven days. Thank you.

14 Q. All right. So the time that you saw Ms. Buck and
15 she put you on the -- the -- the initial antibiotic, well let
16 me ask this. Tell us about what happened once you took the
17 Bactrim?

18 A. The Bactrim, I started itching and had I call it
19 hives, I couldn't stand it. It was like being in hot ashes.
20 There was -- I was itching all over and a thick rash.

21 Q. Who did you call and tell?

22 A. I called -- I called the doctor's office.

23 Q. And what did the Southeastern Spine tell you?

24 A. Stop taking the Bactrim.

25 Q. They gave you a different medication after that.

1 A different antibiotic to replace it, correct? Do you
2 remember?

3 A. I don't.

4 Q. Do you remember being given a different
5 antibiotic?

6 A. Yes, it was. I had been taking --

7 Q. (Inaudible).

8 A. Yeah. Okay. Thank you. I'm sorry. Bactrim and
9 doxycycline. Yes, sir. Yes, sir.

10 Q. Did you have any problems with that medication?

11 A. No, I finished that course of antibiotics.

12 Q. Did the drainage immediately stop?

13 A. Oh, no. No, no.

14 Q. Did it continue to drain -- let me ask you this,
15 had it stopped all the way by the time you got to the
16 appointment where you were actually seen by Dr. Frisch?

17 A. Well, I changed the dressing out in the parking
18 lot because I didn't want it to go through on their chairs in
19 the office. It had slowed drainage. What date are you
20 talking about? Do you talk about the after that?

21 Q. Well, let's start in general.

22 A. Yeah.

23 Q. Without going to quantify it. Had it -- had the
24 drainage stopped by the time you saw Dr. Frisch in the
25 office?

1 A. No.

2 Q. Okay. Had the wound itself healed all the way
3 back over?

4 A. No.

5 Q. When you saw Dr. Frisch, what did he want to do?

6 A. He suggested that week that I go back in the
7 hospital to have it cleaned out to -- he suspected that I had
8 an infection.

9 Q. Based on you and Edgar looking at it through that
10 whole time, how much different did the wound itself look when
11 you -- when Dr. Frisch saw it versus when Ms. Buck saw it?

12 A. As I recall, the -- the wound had gotten smaller,
13 but I was still draining. It was -- it was like very -- a
14 small area that had not healed.

15 Q. Okay.

16 A. I was still draining out of that little spot.

17 Q. When did you first start having some fevers?

18 A. I don't know -- I don't know, sir. That's the
19 truth.

20 Q. And when -- how bad was the fevers?

21 A. I think it was like a 100.9 or a 100.7, maybe just
22 low grade.

23 Q. Once you got back into Dr. Frisch's office, when
24 you had left that day to get to Southeastern Spine, was it
25 your plan to go into the hospital that day?

1 A. No. No.

2 Q. And when -- once you got into the hospital, what
3 did they do to you?

4 A. There was -- they did MRI, they did some more and
5 did some testing.

6 Q. Do you remember what kind of testing?

7 A. I don't know.

8 Q. Whatever the records.

9 A. Yeah, whatever he ordered it -- it was done.

10 Q. After the MRI, what was your understanding of what
11 was going on in your back?

12 A. That I had a -- a -- he saw that there was fluid
13 at the surgical site down in the surgical area, he said, and
14 that he was going to go in and wash it out and close it back
15 up.

16 Q. With your point of view, did that make sense?

17 A. Yeah. Yeah.

18 Q. When did you first meet Dr. West in this process?

19 A. Oh, they did the nasal swabs for the Staph
20 infection. And after that come back positive he referred --
21 I was told that I had been referred to an infectious disease
22 doctor.

23 Q. Walk us through that first time Dr. West came to
24 see you in your room.

25 A. Well, we were put on isolation and so everybody

1 that come in was covered in their protective gear. Dr. West
2 come to the door and he did his exam from the door.

3 Q. Okay. Did Dr. West (inaudible) on you every day
4 that you were in the hospital?

5 A. I think so. I believe so.

6 Q. What was it going to take? In other words, what
7 did they have to see in your lab work or whatever before you
8 knew it?

9 A. The -- the nurse -- Dr. Frisch had discharged us
10 that morning very early and the nurse that had come on for
11 day shift said, you know, "We've got" --

12 MS. MAPLES: Objection, your Honor. Hearsay.

13 THE COURT: Basis of your objection?

14 MS. MAPLES: Hearsay.

15 THE COURT: Sustained. Hearsay.

16 Ma'am, you can't say what someone said to you. You can
17 say what you did as a result of the conversation. Do you
18 want to repeat the question?

19 MR. LUGINBILL: Yes, ma'am.

20 THE COURT: You may proceed.

21 THE WITNESS: Okay.

22 BY MR. LUGINBILL:

23 Q. What was your understanding of what had to happen
24 before you agreed?

25 A. I had to have orders for antibiotics to take after

1 my discharge.

2 Q. Do you recall whether or not there were any
3 specific lab values that had to be reached for clean culture
4 or anything like that that had to --

5 MS. MAPLES: Objection, your Honor.

6 THE COURT: Basis?

7 MS. MAPLES: Leading.

8 THE COURT: Sustained leading. Rephrase.

9 BY MR. LUGINBILL:

10 Q. Dr. West came in to see you the last time?

11 A. Yes.

12 Q. Do you recall that conversation?

13 A. Yes, sir.

14 Q. Tell us about that conversation.

15 A. We had been waiting for the discharge orders and
16 -- and I don't know how it started, but -- but my husband
17 spoke to Dr. West and said --

18 MS. MAPLES: Objection.

19 THE COURT: Basis?

20 MS. MAPLES: Hearsay. She's quoting her husband.

21 THE COURT: No, she was about to say the doctor said,
22 did I misunderstand just?

23 THE WITNESS: Yes. Yep.

24 THE COURT: She's about to say that the doctor said
25 that hopefully. You may answer the question, ma'am.

1 THE WITNESS: Dr. West --

2 BY MR. LUGINBILL:

3 Q. I -- I'll do -- we rephrase it up and we
4 (inaudible).

5 A. Okay. All right.

6 Q. Why had you been waiting on Dr. West?

7 A. For the orders. For the antibiotics for me to
8 take home and to be discharged.

9 Q. What was Dr. West's reply when you told him you
10 been waiting on him?

11 A. He asked my husband if he looked at my armband and
12 Edgar said, "Well actually no I haven't." And he said,
13 "Well, you won't see my name on her armband. So the doctor
14 that is on her armband is the doctor that will discharge her.
15 You're not waiting on me."

16 Q. How did you take that?

17 A. Well, it was a little cut.

18 MS. MAPLES: Objection.

19 THE COURT: Basis?

20 MS. MAPLES: Relevance.

21 THE COURT: I need you to approach. Turn the noise on
22 approach.

23 (Bench conference.)

24 THE COURT: Please rephrase the question.

25 BY MR. LUGINBILL:

1 Q. Was there anything about Dr. West demeanor that
2 gave you pause for having him continue or being your
3 infectious disease doctor?

4 MS. MAPLES: Objection.

5 THE COURT: Basis?

6 MS. MAPLES: Relevance.

7 THE COURT: You're going to have to make it relevant.
8 Rephrase the question. Needs to make a fact of consequence
9 more or less relevant, more or less probable. And right now
10 it's not. It's passion, prejudice feelings of biases.

11 BY MR. LUGINBILL:

12 Q. What was your understanding of your post
13 discharge?

14 A. I asked Dr. West if I would be seen by him. When
15 would I see him again? And he said, you'll never see me
16 again. There will be no need for you to see me again. He
17 said, if anyone asks you if you've had a Staph infection, you
18 have been treated for it and you are well. That's what I was
19 told not to call him back because I was expecting to see him
20 after discharge, but he said that would not be needed.

21 Q. Based on what he told you, how he said it to you,
22 did you have any question in your mind whether or not you
23 were supposed to follow-up with Dr. West?

24 MS. MAPLES: Objection.

25 THE COURT: Basis?

1 MS. MAPLES: Leading.

2 THE COURT: Sustained leading. Rephrase.

3 BY MR. LUGINBILL:

4 Q. Based on his tone and based on his statements,
5 what was your plan for going back to see Dr. West?

6 MS. MAPLES: Objection.

7 THE COURT: Basis?

8 MS. MAPLES: Leading.

9 THE COURT: Sustained leading.

10 BY MR. LUGINBILL:

11 Q. Do you recall being given an appointment to see
12 anybody at Lowcountry Infectious Diseases?

13 A. No, sir.

14 Q. Were you given an opportunity to do so?

15 A. No, sir.

16 Q. Who were you supposed to follow-up with after you
17 were released from East Cooper Medical Center?

18 A. Dr. Frisch only.

19 Q. Who was going to be monitoring the effectiveness
20 of your antibiotics?

21 A. I don't know.

22 Q. So when is the next time you saw somebody at
23 Southeastern Spine?

24 A. After my discharge from East Cooper in January,
25 2017.

1 Q. And how did that deployment done?

2 A. It went very well. Dr. Ebama was the physician
3 and she was --

4 Q. Okay. I (inaudible) the statement.

5 A. Okay.

6 Q. You went back to Southeastern Spine.

7 A. Oh, excuse me. Okay. I am sorry.

8 Q. How did that work go?

9 A. Post-op, I was doing, yeah, I was doing good
10 post-op second time I was hopeful. Had big sutures in my
11 back. Looking forward to getting well, getting over this
12 thing.

13 Q. And what were you going to have to do to get well
14 so you could be released to go back to work?

15 A. I had to follow the instructions of no driving, no
16 picking up, all of the instructions I was given post-op with
17 the first surgery I was to recover.

18 Q. What was your home exercise program?

19 A. I was to walk 10 minutes every hour. Waking hour,
20 not 24 hours a day.

21 Q. And so how did you do that?

22 A. I had a path in my house that I walked for 10
23 minutes every walking hour because that would was to help
24 heal and help my blood flow and all of those good things.

25 Q. Were you able -- how much did your personal care

1 were you able to do at that point?

2 A. Everything. I was caring for myself.

3 Q. When did you first start to have return of
4 symptoms?

5 A. I -- my surgical site healed and I had asked about
6 physical therapy and physical therapy was ordered. So the
7 1st of November, it was like six weeks after my surgery, I
8 was able to start physical therapy and the physical
9 therapist, I continuously got weaker on every visit for
10 physical therapy. I couldn't do what she was trying to work
11 with me. And the end of November, she -- before I went back
12 to Dr. Frisch, she said that she couldn't see me until I got
13 clearance from the doctor that she felt like something was
14 wrong, that I needed to call the doctor.

15 Q. And did you follow those instructions?

16 A. Yes, sir, I did.

17 Q. Now, have you seen any of your other doctors in
18 between them?

19 A. Saw Dr. Harkins.

20 Q. Can you tell us what you were seeing him for?

21 A. Low back pain left. I don't -- I don't know the
22 exact, I don't -- do you have that -- that I could look at?

23 Q. Were you having any problems with -- with your
24 rheumatoid arthritis flaring up?

25 A. We -- we didn't know what was wrong. They were --

1 there were -- but didn't know what was going on. Just knew
2 that my pain had increased and mobility was decreasing.

3 Q. Do you recall whether or not you restarted your RA
4 meds after your visit with Dr. Harkins?

5 A. I called Dr. Shanahan to tell him my symptoms and
6 he gave me permission to restart my meds.

7 Q. Okay. How long after you restarted your meds were
8 you seen by Ms. Buck again at Southeastern Spine?

9 A. I'm not sure about the length of time.

10 Q. Days or weeks?

11 A. Days.

12 Q. Okay. Do you recall what date you went back to
13 Southeastern Spine?

14 A. December. No, we're talking about November 28th.

15 Q. And you recall the November 28th visit?

16 A. Let me think about this. My pain was increasing
17 and I -- I -- I was not running fever. I had no fever at
18 that time and I was told to go home and I --

19 Q. Okay. Other than the pain, what other symptoms
20 were you having trouble with?

21 A. I was having trouble walking, getting up and down.
22 I could not -- I could not stand or sit without help.

23 Q. That is the Plaintiff's Exhibit 10?

24 A. Yeah.

25 Q. And this is the 11/28 office note?

1 A. Yeah. My pain was eight out of 10.

2 Q. What do you recall telling Ms. Buck at
3 Southeastern Spine that day about your medications?

4 MS. MAPLES: Objection.

5 THE COURT: Basis?

6 MS. MAPLES: Calls for hearsay.

7 THE COURT: Mr. Foreman, ladies and gentlemen, I have a
8 brief matter of law to take up with Counsel. During the
9 break please do not discuss the case and please leave your
10 notepads on the seats. You don't have to take them all the
11 way down the hall. You can just have them stand in the
12 hallway.

13 (Jury exits courtroom.)

14 THE COURT: Okay. I'm trying to figure out, are you
15 trying to elicit admissions? She's their employee. So she's
16 their agent, correct? Isn't Ms. Buck?

17 MS. MAPLES: Yes. But the question was what or she --
18 you asked her what she relayed to Ms. Buck as if --

19 THE COURT: Statement for diagnosis. I'm confused.
20 Say that one more time.

21 MS. MAPLES: Sure. My objection was to his question
22 asking Ms. McGougan what she said.

23 THE COURT: She can say what she said. She's a
24 proponent, you have the chance to cross-examine her. That's
25 not hearsay. What Ms. Buck says to her she's an agent of the

1 entity.

2 MS. MAPLES: Yes, your Honor.

3 THE COURT: So, yeah, that's not hearsay either, but it
4 still has to be within one of those exceptions, submissions
5 against interest.

6 MR. LUGINBILL: So, your Honor --

7 THE COURT: Just get to say what she said. Yeah.

8 MR. LUGINBILL: -- it would be a statement for medical
9 diagnosis and treatment.

10 THE COURT: Statements for medical and diagnosis and
11 treatment may not be subjective in nature. And normally
12 they're what the patient says to the doctor in terms of
13 relating their symptoms and their symptomology based on case
14 law. So it would -- it would fall within the nature of the
15 -- of an admission that it's not a statement for diagnosis
16 and treatment. Because courses of treatment are subjective.
17 They're subject to different analysis.

18 The reason you allow the patient to make a statement to
19 a doctor and it comes within the ambit of the rules, is
20 because there's a presumption that they're being honest about
21 what their condition is. Those are what the rules
22 contemplate in the case law interpret statements made for
23 diagnosis and treatment, not the other way around.

24 So normally it's not because what a doctor says can be
25 subjected, it could be many different causes of treatment.

1 It's not that cut and dry. So what I'm trying to figure out
2 is what exactly is, so I sent the jury out for a second.
3 What exactly is it that you're trying to elicit from her
4 about what Ms. Buck told -- I'm sorry, Dr. Buck. No.

5 MR. LUGINBILL: Yes.

6 THE COURT: Yeah.

7 MR. LUGINBILL: Ms. Buck.

8 THE COURT: Uh-huh.

9 MR. LUGINBILL: What she told the doctor in relation to
10 what medications she was taking and then what Ms. Buck
11 relayed back to her about what to do with those medications.

12 THE COURT: Is there any exception to that line of
13 questioning?

14 MS. MAPLES: No, your Honor.

15 THE COURT: Okay. And, Mr. Kern, I assume you don't
16 feel a cat and dog in the fight.

17 MR. KERN: No dog in the fight.

18 MR. LUGINBILL: That's correct, your Honor.

19 THE COURT: Please get the jury for me.

20 (Jury enters courtroom.)

21 THE BAILIFF: All jurors present.

22 THE COURT: Thank you ladies and gentlemen, we
23 appreciate your patience.

24 You may proceed.

25 BY MR. LUGINBILL:

1 Q. Pat, what do you recall telling Ms. Buck about
2 your resuming your medications?

3 A. That I had permission from Dr. Shanahan to -- to
4 continue my Arava.

5 Q. Do you recall whether you told her just the Arava
6 or both the Arava and the -- the IV antibiotics?

7 A. I had been taking both, the -- I believe.

8 Q. All right. And why did you take the prednisone
9 that mentioned?

10 A. I don't know. I -- I don't recall.

11 Q. After relaying that information to Ms. Buck, what
12 did she tell you to do about those medications?

13 A. To continue.

14 Q. Were you able to see Dr. Frisch that day?

15 A. No, sir.

16 Q. Was any blood work done that day?

17 A. No, sir.

18 Q. Were you sent anywhere to have any further testing
19 at any time?

20 A. No, sir.

21 Q. When were you supposed to return?

22 A. I -- I don't recall what the date was that I was
23 to return. Let me look at it again. I'm sorry.

24 Q. Does four to six weeks sound right?

25 A. Yes, sir. Yes, sir.

1 Q. How did your symptoms change from leaving that
2 office over the next few days?

3 A. It continued to increase in being able to stand
4 and sit and lie down. I couldn't without assistance to stand
5 and sit, the pain increased.

6 Q. How was that limiting your abilities to get out of
7 the house and do what you needed to do?

8 A. I could not. I could not cook. I could not clean
9 the house. I could not take care of life.

10 Q. What caused you to finally call back to
11 Southeastern Spine?

12 A. My fever started again. I started having some
13 temp.

14 Q. And what did they advise you to do?

15 A. To come to the office.

16 Q. What date do you recall that being?

17 A. The 16th of December.

18 Q. Okay. Were you instructed anything other than
19 that, like time you prepared to stay or to show up?

20 A. No, we were coming to the office to see the
21 doctor, see -- see someone of with my increased problems.

22 Q. Was there any testing done that day?

23 A. No, sir.

24 Q. When did you have the MRI done?

25 A. The following week Monday.

1 Q. You didn't have an MRI on the 16th?

2 A. Wait, yes I did. I apologize. Yes, I did.

3 Q. Where was that at?

4 A. At the office.

5 Q. Okay.

6 A. And --

7 Q. After that MRI, were you able to see Dr. Frisch?

8 A. Yes. Yes.

9 Q. What was your understanding following his meeting
10 with you? What was going on in your head?

11 A. There was concern that I may have had more
12 infection and that I needed to be put in the hospital.

13 Q. What went through your mind when he told you that?

14 A. Well, as you've heard many of you that Kyle and
15 Hayden were coming and Hayden was five years old. Kyle was
16 my middle son who is a single parent and I would not be able
17 to see them anytime during Christmas except that Saturday.
18 That was my time to spend Christmas with them. And I was
19 hoping to see them.

20 Q. Did you and Dr. Frisch have a discussion about the
21 risks in fact of going in versus waiting?

22 A. He told us he did not see any reason that we
23 couldn't wait till Monday. That little would be done over
24 the weekend and that Monday would be okay.

25 Q. What were you supposed to be on the lookout for?

1 A. Increased fever.

2 Q. If the increased fever did happen, what were you
3 supposed to do?

4 A. Call back. Call back.

5 Q. What Number were you supposed to call the date?
6 Specific Number or just call the officer?

7 A. No call the -- call the on call. There was a
8 group that -- that covered. They have someone on call all
9 the time.

10 Q. After -- in your discussions with Dr. Frisch, did
11 he ever tell you there's any risk to you of permanent
12 life-threatening damage if you didn't go to the hospital
13 right then?

14 A. No, sir. No.

15 Q. If he had told you that, what would you have done?

16 A. We would've gone -- I would've been admitted.

17 Q. How was that ride back?

18 A. Tough.

19 Q. What was going through your mind?

20 A. Well, that you -- there's so much unknown. You
21 don't know what you're -- I'm trying to get home and see my
22 -- my grandson, Santa Claus was needed to come to him and I
23 needed to give Kyle that stuff to hide so that Santa could
24 come and that was what I was thinking about and that I needed
25 to go back in the hospital, but I'm hoping that I would get

1 better on the way home.

2 Q. From a physical standpoint, what was the ride home
3 like?

4 A. Well, it was very painful.

5 Q. Once you got home on Friday, did your pain get any
6 better?

7 A. No, sir.

8 Q. How about going into Sunday or Saturday morning?

9 A. It was Saturday. That Saturday evening. It was
10 Saturday evening when it started getting worse.

11 Q. Did you get to have Christmas?

12 A. We (crosstalk) yeah, we did that Saturday morning.

13 Q. How much were you able to do with him?

14 A. I couldn't -- I could watch him open the gifts,
15 which made me happy.

16 Q. When -- what was it that motivated you to call
17 back Southeastern Spine that day?

18 A. I'm not sure if I've had fever or if I was just
19 feeling it was -- I -- I can't remember the exact reason
20 because at that point Edgar was like, I'm calling and seeing
21 what they want us to do. I -- I was so sick, I don't really
22 know. And he made the call.

23 Q. Based on that call, what did you do?

24 A. We were -- I thought that we were told, it was my
25 -- under my impression -- my impression was that we were to

1 be admitted on Monday.

2 Q. Do you recall on Monday whether you went straight
3 to the hospital or did you go to the -- their offices?

4 A. I think I called and they told us to come in and I
5 think we went to the hospital. I -- I just don't.

6 Q. Do you recall seeing Dr. Frisch that day?

7 A. I'm sure I was admitted. I don't know what time I
8 saw him.

9 Q. So the time that you were admitted, the first two,
10 three days, how much did you drain?

11 A. Not much, was heavily medicated.

12 Q. How long were you in the hospital?

13 A. The 19th through January 3rd.

14 Q. So little over to -- what was that experience like
15 for you?

16 A. It was very frightening. It was being told that,
17 you know, that your -- your lab studies aren't -- your --
18 your cultures are not clearing your -- we didn't -- they
19 couldn't give me an antibiotic. They put a PICC line in had
20 to take it out. The one doctor put it in, another doctor
21 said it was wrong to put it in and we didn't have our -- my
22 cultures clear. And then every day by Christmas Eve, I was
23 praying for a Christmas miracle, praying earnestly for a
24 miracle that I could just walk again. That I could stand on
25 my own again.

1 Q. Was your family able to come down, try to give you
2 support?

3 A. They did. They did. All of them did at different
4 times.

5 Q. What was your biggest concern?

6 A. My -- I thought I was going to die. I truly
7 didn't think I was going to live to get out of the hospital
8 during that time.

9 Q. Tell us why?

10 A. Because every day things got worse. I ended up in
11 a unit, I was in isolation. I ended up in a cardiac unit.
12 They had to do testing on my heart, worried about my kidney
13 functions. I was, you know, I was like, great day. What
14 else am I going to hear?

15 Q. When you finally got discharged, what did you have
16 to go through as far as your antibiotics?

17 A. Well, the PICC line stayed in and we had to go to
18 --

19 Q. Let me ask this.

20 A. What?

21 Q. Did you have any problems with that PICC line from
22 the time you were discharged until you were done with it?

23 A. When I finished the antibiotics?

24 Q. Yes.

25 A. IV antibiotics? Well, I had a reaction to the

1 vancomycin.

2 Q. About PICC line itself, did you have any issues
3 with not being able to get a PICC line?

4 A. A PICC line was put in, but my veins had worked,
5 had collapsed. I had multiple issues with my -- with my
6 veins.

7 Q. When did that start?

8 A. Well, I don't know.

9 Q. Was that during the December admission or had you
10 had any of those problems prior?

11 A. No, never. Never had that. Since during that
12 hospital stay.

13 Q. In your September hospital stay, had you had any
14 problems with your regular IVs there?

15 A. They gave me my IVs, IV fluids and IV meds.

16 Q. Did you have any problems with that?

17 A. No, sir.

18 Q. Where were you doing your follow-up with
19 Lowcountry Infectious Diseases?

20 A. At Myrtle Beach.

21 Q. Was there at Myrtle Beach option available? In
22 other words, was that practice that office open in September?

23 A. I don't know. I was never given a Number or
24 anything to call in September.

25 Q. When did you first find out that they had one up

1 there?

2 A. When I looked it up.

3 Q. And were you able to -- did you ask to be
4 transferred up there or did they transfer you?

5 A. No, I asked to be transferred. I called the
6 Charleston office and asked them did they have another site
7 and they said they had a Myrtle Beach site.

8 Q. Who did you see there?

9 A. Dr. Ebama.

10 Q. How was she?

11 A. She was lovely. Very -- very pleasant.

12 Q. When did you find out what was going on with your
13 L4-L5 disc and the vertebrae on each side?

14 A. After I completed with Dr. Frisch, I was told that
15 I was -- I had an appointment one week with Frisch and then
16 the same week I had it with Dr. Grossy at Duke.

17 Q. I want to back you up the time --

18 A. Okay.

19 Q. -- (inaudible).

20 A. Sorry.

21 Q. Yeah, that's the actual hospitalization. When did
22 you find the results of the December 20th and then -- then
23 the December 24th MRIs? Do you recall having a discussion
24 with anybody about this?

25 A. No, sir.

1 Q. Okay. Fair enough. As best as you can recall,
2 now, when did you find out that the disc had been infected
3 and that the vertebrae cells had been infected?

4 A. Dr. Grossy told me that when I got there in March
5 or April of 2017.

6 Q. Prior to seeing Dr. Grossy at the Duke, had you
7 had any similar discussions with anybody from Southeastern
8 Spine about the extent of the damage from the infection in
9 your back?

10 A. No, sir.

11 Q. Did Dr. Frisch ever tell you the disc is gone, the
12 bones collapsed or hoping they'd fused together?

13 A. No, sir.

14 Q. Were you ever offered any other treatment from
15 Southeastern Spine to try to help that?

16 A. No, sir.

17 Q. At the time you finish your -- your treatment with
18 Lowcountry Infectious Diseases, have you ever been able to go
19 back to work?

20 A. No, sir.

21 Q. Did you try to keep that job?

22 A. Yes, I did.

23 Q. How?

24 A. But there was -- there was no way I could work. I
25 couldn't sit for two hours at the time. I couldn't walk for

1 two hours at the time. There was no way I could do a 12-hour
2 shift. And -- and the doctor told me that I would not be
3 able to -- that he wouldn't release me to go back.

4 Q. And which doctor was that?

5 A. Dr. Grossy said that I was not able to do that.

6 Q. How did you find out that the hospital had
7 formally terminated your employment?

8 A. I got a letter in the mail.

9 Q. How did that feel?

10 A. I cried a lot.

11 Q. Did you accept it?

12 A. Not initially. It's very painful when you're
13 hoping and praying to go back to work and you need to work.
14 You've got bills to pay. I've always paid my bills and I
15 needed to work.

16 Q. Did you fill out the paperwork to apply for any
17 other positions that might be billed?

18 A. They -- no, sir. They -- they sent me a form from
19 McLeod that said would I work if -- if they offered me
20 something, but they -- I was never offered a job.

21 Q. You've been in the hospital setting for a long
22 time?

23 A. Yes.

24 Q. What job do you think you could have done?

25 A. I could not have done, I could not. An eight-hour

1 shift would've been too much. A 12-hour shift was
2 impossible. I couldn't have done that.

3 Q. What kind of stress did that put on you when it
4 happened?

5 A. Well, it caused us to sell our house. We -- we'd
6 never -- that wasn't in our plan. We were going to stay at
7 the home place in Green Sea and sail into the sunset. Okay.

8 Q. How did moving out there and giving up the home
9 place affect Edgar?

10 A. It's caused leaving -- leaving where he was so
11 accustomed to being has been very hard on him, losing the
12 home place his parents have built.

13 Q. Did that stress on him, financial stress on you,
14 physical stress on you? How did that affect your
15 relationships with each other?

16 A. We're very strong and we have a lot of faith. It
17 made us hold together, but financially we've had to struggle
18 at times. And intimacy has been hard. It's been very hard
19 not to be what I thought he needed me to be.

20 Q. Once you got out the -- the car.

21 A. Yeah.

22 Q. (Inaudible) that soon?

23 A. Yes. Yes.

24 Q. Were you able to help him?

25 A. I was able, the way I helped him was managing

1 folks that helped him, having people to come in. He was --
2 he had services from social services to come in and fill with
3 his care and it was -- I tried to make sure food was there
4 and grocery shopping was done. I could not lift him, I could
5 not move him. And I'd always been able to do that.

6 Q. Would Pat McGougan on July 1st of 2016, been able
7 to do that?

8 A. Yes, sir.

9 Q. Was that hard for you?

10 A. It was.

11 Q. How is your back now?

12 A. Thank God I've got one. Okay. It hurts, but it
13 -- I've got one. I can stand, I can walk, I can be careful.
14 I just am slow and steady. Slow and steady. No lifting.

15 Q. Give the jury an example of how your back now
16 changes how you live your life.

17 A. Well, currently my folks come to me, my children
18 and grandchildren come to my house. I don't get to go to
19 theirs as much. I have to be very careful and plan ahead of
20 time and plan to rest afterwards if I go. Lots of changes.
21 Just lots. Everything's changed.

22 Q. What is Wednesday supper?

23 A. Wednesday night supper at the church is a
24 community where the community comes in and I get to help cook
25 if I'm able. And if I'm not able, I usually cook something

1 at home. We load it up, we go to be with the church, but I
2 -- the next day I can't move after being on the concrete
3 floors. But Wednesday night supper once a month is very
4 important for me to be a part of.

5 Q. How often do you have to make that calculus
6 between what you want to do and what's going to cost you if
7 you do it?

8 A. Every day.

9 Q. How often do you have to make the calculation
10 about what you want to do is what you could afford to do?

11 A. Every day.

12 Q. How has this experience affected your personal
13 savings?

14 A. I took all the money I had in my -- on 403(b) and
15 paid my doctor bills with it. And I can't -- I couldn't go
16 back to work to fill it back up.

17 Q. If you had to find it -- if you had been able to
18 work, how could you modify your current home to make it
19 easier for you with it?

20 A. The -- the stairs would have a ramp. There would
21 be some bars in my bathroom to help pull up with. My bathtub
22 I can't get in, I cannot get out of it if I get in it I'd
23 have to do some modifying on that.

24 Q. Do you have the means to do that?

25 A. No, sir.

1 Q. If you had worked the plan, what -- you haven't
2 really talked about the plan. What was the -- what was the
3 plan for you and -- and full time work?

4 A. I would work till -- I had planned to work till
5 age 70. There was no reason I'd been trying to take care of
6 myself, be healthy, work every day, work my shift, take my --
7 take my turn.

8 Q. So in 2016, going forward, how many were full time
9 years did you plan doing?

10 A. At least five to seven full time.

11 Q. And then after full time, what were your plans?

12 A. Well, many of my friends who are nurses have
13 worked till 70 and after. And you just work part time. You
14 work a shift a week to keep your license up and -- and keep
15 going.

16 Q. If you had worked the plan, would that have been
17 allowed to happen?

18 A. Yeah.

19 Q. Would you be in any debt right now?

20 A. No, sir.

21 Q. Are you in debt?

22 A. Yes, sir.

23 Q. Given how long you've been in health care, is it
24 hard for you to walk into a lawyer's office about a medical
25 malpractice?

1 A. Very --

2 MR. HOOD: Objection, your Honor.

3 THE COURT: Basis?

4 MR. HOOD: Relevance.

5 THE COURT: Sustained. It -- it --

6 MR. LUGINBILL: I move on, your Honor.

7 THE COURT: Thank you.

8 BY MR. LUGINBILL:

9 Q. Do you believe knowing what you know now that this
10 could be avoided?

11 A. Yes.

12 MS. MAPLES: Objection.

13 THE COURT: Basis?

14 MS. MAPLES: Calls for an improper opinion. Relevance.
15 Lacking foundation.

16 THE COURT: I need you to rephrase the question.

17 BY MR. LUGINBILL:

18 Q. (Inaudible). What coordination between your
19 doctors occurred and the time you left East Cooper Hospital
20 in September, and the time you got readmitted to East Cooper
21 Hospital till discharge?

22 A. I'm sorry, I didn't understand the question.

23 Q. You understand the time period?

24 A. Well, before.

25 Q. Discharged in September until you were readmitted

1 --

2 A. Yes.

3 Q. -- in December?

4 A. Yes.

5 Q. Okay. In all in the visits that you've had in
6 Southeastern Spine, were you ever asked, look, your other
7 doctors were advising you or --

8 A. No.

9 Q. You ever told --

10 A. No.

11 Q. -- to go talk to those doctors to have anything
12 checked?

13 A. No.

14 Q. Was there any way for you personally to know that
15 you needed monitoring of your antibiotic preference?

16 A. No, sir.

17 Q. You've heard questions asked about whether or not
18 you called Dr. West's office at any point after September
19 26th, did you?

20 A. No, sir.

21 Q. What reason would you have had based on your
22 conversation with Dr. West to have called his office?

23 A. I have no idea. I -- I don't know.

24 Q. Was there really reason for you to call him
25 instead of Dr. Frisch?

1 A. No, sir.

2 Q. Who assumed the role of monitoring your recovery
3 from the incision drainage procedure?

4 A. Dr. Frisch.

5 Q. What? Okay. And where is he? Southeastern
6 Spine?

7 A. Yes, sir.

8 Q. At Southeastern Spine, did anybody at any time
9 tell you that you needed to be monitored for the
10 effectiveness of your antibiotics after you were discharged
11 on September 26?

12 A. No, sir.

13 Q. When you were discharged in January, were they
14 working with Dr. West in Lowcountry Infectious Disease to
15 monitor how your antibiotic were doing then?

16 A. Yes, sir.

17 Q. Did you get the same amount of care attention in
18 December or in January that you got in September?

19 A. No, sir.

20 Q. Bear with me one minute. Then I'm going to show
21 you what was marked Plaintiff's Exhibit 137. So we're not
22 making it up. From the time you got out of East Cooper in
23 September -- September the 26th for. Did these appear to be
24 -- I'm going to go through more than that. That appeared to
25 be an accurate amount of total medical bills you received

1 from East Cooper Hospital to the best your knowledge?

2 A. Yes.

3 Q. Now I looked under (inaudible) to point out of the
4 state that we have --

5 MS. MAPLES: Objection.

6 THE COURT: Basis?

7 MS. MAPLES: We can have matter of law we'd like to
8 seek up from the jury.

9 THE COURT: Mr. Foreman, ladies and gentlemen, we have
10 a brief matter of law. During break please do not discuss
11 the case and please leave your note pads in the seat. So at
12 the time you just have them step out to the hallway for me
13 please.

14 (Jury exits courtroom.)

15 THE COURT: Yes, ma'am.

16 MS. MAPLES: It's our understanding that Plaintiff's
17 are going to reduce this exhibit by 600 and some amount of
18 dollars because it included dates.

19 THE COURT: Six hundred and twenty. (Crosstalk) do you
20 have any indication they didn't?

21 MS. MAPLES: Yes. It's the same exhibit we were shown
22 before.

23 THE COURT: Mr. Luginbill, is that correct?

24 MS. MAPLES: Yes, ma'am. And when I was getting ready
25 to ask the question more to object.

1 THE COURT: Uh-huh.

2 MR. LUGINBILL: That Number is correct. We made an
3 error. And reflect that error in my question and I've had
4 exactly no steps to (crosstalk) --

5 THE COURT: Are you seeking to it -- are you seeking to
6 admit this or are you only using it as a manuscript?

7 MR. LUGINBILL: This -- this story is already admitted
8 and we just realized that there's that one mistake.

9 THE COURT: Is there -- is it a mathematical error?

10 MR. LUGINBILL: Yes.

11 THE COURT: So where is it at?

12 MR. LUGINBILL: It was supposed to pick up from 12 on
13 the Lowcountry Infectious Disease -- supposed to pick up from
14 9/26. So it included \$642.

15 MS. MAPLES: Twenty.

16 MR. LUGINBILL: Supposed to be on that line.

17 THE COURT: I'm sorry, I didn't hear you. You said --
18 said what, ma'am?

19 MR. LUGINBILL: She said (inaudible).

20 THE COURT: Oh, I'm sorry.

21 MS. MAPLES: Six hundred and twenty.

22 MR. LUGINBILL: Six hundred and twenty dollars.

23 THE COURT: So how's that -- where -- where should 620
24 be deducted from?

25 MR. LUGINBILL: From line Number two.

1 THE COURT: Can't you all just write it on there?

2 MS. MAPLES: Yes.

3 MR. SMYTH: That's what we thought was going to happen.
4 So we -- my understanding is it is not going to show to the
5 jury with the error on it.

6 THE COURT: Why don't you just -- strike that.

7 Yeah. So from line two, you need to subtract \$620. It
8 means you need to subtract from the bottom line as well,
9 correct?

10 MR. LUGINBILL: Correct.

11 THE COURT: Do you need a calculator?

12 MR. LUGINBILL: I think I can do it.

13 THE COURT: Okay. Better than instruction because I
14 have one you can use. You want to let them see it. Make
15 sure the Number is correct.

16 MR. HOOD: Judge, it sounds like he's getting ready to
17 wrap up with this witness. Would you be willing to let us go
18 to the bathroom before I start my cross-examination?

19 THE COURT: Oh, yes.

20 MR. HOOD: Okay. That'd be great.

21 THE COURT: I'm bad about -- I -- I'm bad about
22 restroom break. So you get to pee just waive the white flag
23 on me because once I sit I can -- I'm it's not a good habit
24 for this (inaudible). Just let me know and I'm, you know,
25 I'm flexible about that, but I've sent (inaudible) I'm sorry.

1 MR. HOOD: No problem.

2 THE COURT: Are those Number s now accurate?

3 MS. MAPLES: Yes.

4 THE COURT: Everybody is good?

5 MS. MAPLES: Yes. Thank you, Your Honor.

6 THE COURT: You are welcome.

7 (Jury enters courtroom.)

8 THE BAILIFF: All jurors present.

9 THE COURT: Thank you, sir.

10 You may proceed, Mr. Luginbill.

11 MR. LUGINBILL: Thank you, Judge.

12 THE COURT: You're welcome.

13 MR. LUGINBILL: I apologize there was an error --

14 mathematical error they pointed it out. You now fixed that.

15 BY MR. LUGINBILL:

16 Q. So Number two, the total of Lowcountry Infectious
17 Diseases. Does that seem about right for the professional
18 opinions related to the care that you got there?

19 A. Yes, sir. Yes.

20 Q. And in the interest of speed, I'm assuming no
21 objections, I'll just go through these and you tell me if any
22 of them are wrong.

23 A. Okay.

24 Q. McLeod Hospital of \$40,000 it a change. Liberty
25 Home Care. What was Liberty Home Care doing for you?

1 A. That was -- they got my IV supplies and sent a
2 nurse out to do my lab draws.

3 Q. And what was McLeod doing from October through
4 December of 17th?

5 A. I -- I couldn't tell you. I went there for
6 physical therapy. That may be it.

7 Q. You found physician associates, you had follow-up
8 for?

9 A. Dr. Harkins.

10 Q. Okay. Physical therapy was a different place.
11 You went for therapy?

12 A. Yes.

13 Q. Correct?

14 A. Yes.

15 Q. What are you getting done now at Duke Health?

16 A. They're doing ablations about every six months to
17 control -- control my pain.

18 Q. When's the last one you've had?

19 A. It's been two months, maybe six weeks.

20 Q. How long does that relief last?

21 A. About six months.

22 Q. Is it six months, and then it falls off table or
23 is it just sort of start to lax off after a while?

24 A. You -- you -- it -- it starts -- it you know it's
25 time to go back.

1 Q. So are you still in the good part right now or?

2 A. I'm in the good part.

3 Q. Is it the amount that we have there through and
4 this only December of 19 about \$12,000? Does that sound
5 about right?

6 A. Yes, sir.

7 Q. Assuming you still have one hand and you can
8 afford it, do you intend continue getting those?

9 A. Oh, yes. I will need -- I need, yes, sir.

10 Q. And then we have one MRI from the imaging. Do you
11 recall that? That brings this to a grand total of
12 \$188,225.36. You see about --

13 A. Yes, sir.

14 Q. -- what you remember?

15 A. Yes, sir.

16 Q. How do you keep your head -- what do you do to
17 keep yourself from letting it overwhelm you?

18 A. Pray. Stay busy. Stay busy in my little house.
19 Walk from one end to the other. A lot of faith believing
20 that things are going to get better.

21 MR. LUGINBILL: Would you answer any questions Jaime
22 may have. (Inaudible) the Defense.

23 THE COURT: Mr. Foreman, ladies and gentlemen, we're
24 going to take advantage of this break in testimony to take a
25 brief comfort break. During the break, please do not discuss

1 the case and please leave your note pads in your seat. I
2 anticipate we'll be out about 10 minutes.

3 (Jury exits courtroom.)

4 THE COURT: Okay. We'll be at ease for about 10
5 minutes.

6 (Off the record.)

7 THE BAILIFF: All rise, please.

8 THE COURT: Okay. Plaintiff ready to proceed?

9 MR. LUGINBILL: Oh, we are, your Honor.

10 THE COURT: Defense ready to proceed, Mr. Hood and Mr.
11 Smyth?

12 MR. SMYTH: We're ready, your Honor.

13 THE COURT: Mr. Kern. And you all bear with me.
14 And, Ms. Maples?

15 MS. MAPLES: Yes, your Honor.

16 THE COURT: All right. Please bring in the jury.

17 (Jury enters courtroom.)

18 THE BAILIFF: All jurors present and seated.

19 THE COURT: Thank you. Ladies and gentlemen, we'll now
20 resume testimony.

21 You may proceed, Mr. Hood.

22 MR. HOOD: May I please the Court?

23 THE COURT: Yes, sir.

24 CROSS-EXAMINATION

25 BY MR. HOOD:

1 Q. Good afternoon, ma'am.

2 A. Good afternoon.

3 Q. In a few questions I want to cover with you. If
4 you can't hear me or don't understand the question, let me
5 know.

6 A. Okay.

7 Q. And I don't think it's going to be a memory test,
8 but if you need something, we've got all kinds of paper, we
9 can help you with that.

10 A. Thank you.

11 Q. So I start with sort of backwards and talk about a
12 little bit about your background. So you worked as a nurse,
13 right?

14 A. Yes.

15 Q. And you described for us the different positions
16 that you enjoyed as a nurse, right?

17 A. Yes.

18 Q. By the time you get to July of 2016, you were
19 still working at Loris Hospital, right?

20 A. Yes.

21 Q. And I mean, it literally was -- starts with a loaf
22 of bread this story?

23 A. Literally.

24 Q. I mean, it -- it sounds like you're very active
25 and I'm sure that had to catch you by surprise?

1 A. It did.

2 Q. All right. Can you -- can you tell us a little
3 bit about what your symptoms were before you got to
4 Southeastern Spine. What were you experiencing?

5 A. On the day that I started hurting. It didn't get
6 any better. I went to the ER and then I went to the
7 chiropractor and I ended up at Dr. Harkins' office and I was
8 having lower back pain, left leg pain.

9 Q. Okay. So let's -- that's what I'm just trying to
10 figure out what kind of pain was it. Was -- were you able to
11 move your left leg? Were you having difficulty walking?
12 Tell us a little bit --

13 A. It was hurting every step I took hurt.

14 Q. Okay. And did it get worse from the time the loaf
15 of bread until you eventually had surgery?

16 A. It stayed about the same. It just hurt.

17 Q. Okay. All right. So I think if the records are
18 -- are correct that your first visit at Southeastern Spine
19 was actually July the 28th and you saw a Dr. John Johnson.
20 Do you remember that?

21 A. I do.

22 Q. Okay. And Dr. Johnson does -- he doesn't perform
23 surgery there, right?

24 A. That's correct.

25 Q. And so the idea was to see if there was some kind

1 of minimally invasive or conservative treatment that could be
2 available for you?

3 A. That's right.

4 Q. And so Dr. Johnson and a PA --

5 A. Yes.

6 Q. -- Ms. Grant had an assessment and evaluation,
7 right?

8 A. Yes.

9 Q. He was immediately concerned that you were a
10 surgical candidate; is that right?

11 A. That's -- yes, that was what I was told.

12 Q. All right. And so they penciled you in to come
13 see Dr. Frisch the following day for emergency working?

14 A. Yes.

15 Q. All right. So you all went home and then came
16 back the next day?

17 A. We did.

18 Q. And that would've been the first time that you
19 were seen by Dr. Frisch and had a conversation about the
20 surgery?

21 A. I believe that's right.

22 Q. All right. Before we get to that surgery, I -- I
23 want to pause on that timeline and I want to go back. You
24 were talking about rheumatoid arthritis.

25 A. Yes.

1 Q. And then you had been treating that for a Number
2 of years?

3 A. Yes.

4 Q. And you had it managed?

5 A. Yes.

6 Q. And the management included a couple of medicines
7 that you said earlier, Arava and Enbrel?

8 A. That's correct.

9 Q. And as I understand it's Dr. Shanahan, and your
10 (inaudible)?

11 A. Yes.

12 Q. And any time your medical condition changed, you
13 would always call Dr. Shanahan to inform him of the change
14 and to find out what, if anything, you should do about your
15 medicines?

16 A. Yes.

17 Q. And so when you knew that you were potentially
18 going to a neurosurgeon, you reached out to Dr. Shanahan?

19 A. I reached out when I thought I was having surgery,
20 it would've been after my visit.

21 Q. All right. And Dr. Shanahan told you this because
22 you were having surgery to stop taking your --

23 A. Yes.

24 Q. -- your medications?

25 A. Yes.

1 Q. And I -- I know that the -- there's been some
2 confusion over the life of this case about what medicines you
3 were taking and when?

4 A. Yes.

5 Q. So let -- I just want to try to get all the way to
6 the ground on that here today.

7 A. Okay.

8 Q. All we have. So we met or we gave a deposition
9 and -- and we talked to you about your medications?

10 A. Yes, you did.

11 Q. And I think at that point you were under the
12 impression that you had stopped the medicines and didn't take
13 them again until 2019?

14 A. I was wrong.

15 Q. Right?

16 A. Yeah.

17 Q. And -- and listen, that's -- I'm not accusing you.

18 A. Yeah.

19 Q. I'm trying to get to the bottom of it.

20 A. Okay.

21 Q. It's been a long time ago. And so as I understand
22 now, when you went in to do the surgery, not you do the
23 surgery, but when you went in for surgery with Dr. Frisch in
24 August, you had stopped your -- your rheumatoid arthritis
25 medications?

1 A. Yes, sir.

2 Q. And your -- as I understand it, you resumed your
3 Arava, that's the -- the pill, right? Arava is the pill?

4 A. Arava is the pill. Yes, it is.

5 Q. And Enbrel is an injection?

6 A. That's correct.

7 Q. All right. And so as I understand it, you didn't
8 take any of your rheumatoid arthritis medicines in August or
9 September?

10 A. That's correct.

11 Q. And then you contacted Dr. Shanahan, I think you
12 testified, and he said, "You could resume your rheumatoid
13 arthritis medication."

14 A. Yes.

15 Q. And I've got a cheat sheet of your notes.

16 A. Yes. Yes.

17 Q. You want me to show to you, I -- I -- I'm happy
18 to. But I believe that -- that you didn't take any RA
19 medicines in October either, according to your notice?

20 A. That's correct.

21 Q. And it says November 20th you started back, but no
22 Enbrel. Can we -- I'm showing this to you.

23 A. If -- if I agree.

24 Q. Well --

25 A. I'm -- I remember writing those, but I couldn't

1 tell you right now if that's on there, yes or no.

2 Q. I understand.

3 A. Okay.

4 Q. So I'm just at that last section.

5 A. Oh, yeah, Enbrel started on the 28th of November.

6 Q. Okay. Just above that. It says November 20th,
7 started back -- started Arava back?

8 A. Right. I started Arava on the 20th and then
9 Enbrel was on the 28th.

10 Q. Okay. So then we had an Enbrel shot on the 28th,
11 the 5th, and the 12th?

12 A. Yes, sir.

13 Q. The 12th was your last dose?

14 A. Yes.

15 Q. All right. Thank you. All right. So to your
16 best recollection that the notes that you were taking at the
17 time showed you off of these RA medicines before surgery all
18 the way through August, all the way through September, all
19 the way through October, and then started November, '20?

20 A. Yes, sir.

21 Q. And then you did the shot, first shot November
22 28th? The first --

23 A. Yes. Yes.

24 Q. So for Enbrel, it would've been sometime in July.
25 And July 25th was the last Enbrel shot before --

1 A. Right.

2 Q. -- November 28th. So that's August, September,
3 October, November. So that's four months.

4 A. That's correct.

5 Q. Okay. And as I understand your testimony earlier,
6 when you had a change of circumstances, your condition
7 changed after -- in -- in the, I guess, holiday season of
8 2016 and you reached back out to Dr. Shanahan and the
9 Southeastern Spine?

10 A. Yes.

11 Q. And based on what you're describing, having not
12 been taking the rheumatoid arthritis medicines, it made sense
13 to try to restart those to see if that would calm down what
14 was going on, right?

15 A. Yes. Yes.

16 Q. Because at this point in November, you had been
17 out of surgery, this to clean out for over two months. You
18 didn't think you had an infection and you were expecting this
19 to be RA, get it out control with your medicines, and move on
20 the plan?

21 A. Yes.

22 Q. And that's what your medical team thought was
23 happening?

24 A. I hope so. I was trusting them.

25 Q. And that's Dr. Shanahan and Dr. Haskins. Is it

1 Haskins?

2 A. Harkins.

3 Q. Harkins, I'm sorry. Dr. Harkins.

4 A. Harkins.

5 Q. All right. I have it mentioned now.

6 So Dr. Harkins is your internal medicine doctor?

7 A. He's my primary care physician. He's no longer
8 around us now. I miss him.

9 Q. Understood on that. And so back at this time
10 frame, he was your primary care doctor and you would go see
11 him for management of your blood work, managing how your body
12 was responding to all your medicines.

13 A. Yeah.

14 Q. Things like that.

15 A. Yes, sir.

16 Q. And he was involved in these conversations in the
17 October and November time frame as well?

18 A. I don't know when I went to him, to tell you the
19 truth, I don't recall.

20 Q. Fair enough. All right. So I got sidetracked.
21 We were talking about coming into surgery on the meeting on
22 July 3rd or 29th, and then surgery on August 2nd. And I got
23 sidetracked talking about your medicine. So let's go back to
24 surgery. You obviously understood that there was a host of
25 risks associated with this surgery, true?

1 A. Yes, sir.

2 Q. And death, bleeding, spinal injury, all of those
3 sort of risks?

4 A. Yes.

5 Q. Infection?

6 A. Yes.

7 Q. But you also knew that if you didn't do the
8 surgery, the problems that you were having may be permanent
9 and irreversible?

10 A. Yes.

11 Q. And so at that point, you had the ability to
12 balance the benefit of surgery versus those risks, and -- and
13 you and Dr. Frisch agreed that the benefits outweighs risks?

14 A. Yes.

15 Q. So the risks were still there, but -- but everyone
16 was cautiously optimistic that you'd have a full recovery?

17 A. Yes.

18 Q. So you had surgery, how did you feel after
19 surgery?

20 A. I -- I felt like I'd had surgery. You hurt, but
21 you're -- you're hopeful that everything is going to get
22 better.

23 Q. Unfortunately I understand. So with respect to
24 the leg pain, was it the same or did it feel better?

25 A. It felt better at first.

1 Q. Okay. And it sounded like your incision, your
2 back pain from where they did the surgery that improved?

3 A. It did.

4 Q. And once that had improved, you felt pretty good?

5 A. It's feeling better.

6 Q. All right. So by the time you came back to
7 Southeastern Spine of your first visit there, you've got the
8 records, I think it was August the 16th. You were by all
9 accounts, had a pretty good outcome at this point?

10 A. That's correct.

11 Q. All right. And then you mentioned the Medrol
12 Dosepak, you were given that for five days, right?

13 A. Yes.

14 Q. Okay. And then you came back?

15 A. Excuse me.

16 Q. Yes, ma'am. We have waters back here if you need
17 some?

18 A. I'm good.

19 Q. And then you came back a week later and saw the
20 folks of Southeastern Spine on August 23rd; is that right?

21 A. Dates are?

22 Q. Fair enough. At this --

23 A. I -- I would agree.

24 Q. Okay.

25 A. You've got the records. I'm --

1 Q. Fair enough, ma'am. So between your first and
2 second visit though, things changed your -- your wound began
3 to drain?

4 A. Yes.

5 Q. And that was in part why Edgar took the photograph
6 of your back?

7 A. That was not, that was after it was healing.

8 Q. So the information provided to us is this
9 photograph was taken on August the 19th?

10 A. I don't know, sir. I do not recall the date. I
11 know that he took a picture and I had small drainage. I -- I
12 don't know, sir.

13 Q. All right. So then you come back to Southeastern
14 Spine and you were prescribed a medication Bactrim, you took
15 the Bactrim, you had a reaction so you stopped?

16 A. Yes.

17 Q. You came back to your scheduled visit, told them
18 that you had stopped the Bactrim, they put you on a new
19 medicine?

20 A. Yes.

21 Q. And you completed that?

22 A. Yes.

23 Q. Right. During this time frame, after the new
24 medicine was given and you're running the full course, the
25 pain got better?

1 A. It started getting better again, we thought.

2 Q. And your -- your back started, I mean, things
3 started looking better. You thought things were trending in
4 the right direction?

5 A. Yeah, but I was still draining.

6 Q. Understood. But in terms of looking at the
7 trends, you thought things were moving in the right
8 direction?

9 A. I was hoping so. I was ready to get over it.

10 Q. I bet. All right. So now we're in early
11 September timeframe and you come back, I think there was two
12 visits early September and then you have a visit with
13 Dr. Frisch on September 20th?

14 A. Okay.

15 Q. Do you remember that?

16 A. Yes.

17 Q. Okay. And at this point things had changed pretty
18 significant?

19 A. Yes, sir.

20 Q. You were now in pretty serious pain?

21 A. Yes.

22 Q. And you all of a sudden had fevers?

23 A. Yes.

24 Q. Now, if I remember correctly, you're one of those
25 folks who really doesn't get fevers very often?

1 A. That's correct.

2 Q. And if you get one, it's usually not going to be
3 that high?

4 A. That's true.

5 Q. So when I think about a low-grade fever, low grade
6 for me and low grade for you might be different?

7 A. That's true.

8 Q. So when you had a fever and you were taking your
9 temperature regularly at home?

10 A. Yeah.

11 Q. And so when it started, you knew something was
12 changing?

13 A. Yeah.

14 Q. And you wanted to get in and that's when you saw
15 Dr. Frisch?

16 A. Yes.

17 Q. And at that point, Dr. Frisch knew that while
18 things had previously been trending, they're not going in a
19 different direction, right?

20 A. Correct.

21 Q. And so now we've got this wound that -- that won't
22 close up. You've got severe pain and you've got fever. And
23 he says, "Ma'am, we got to get you into the hospital", right?

24 A. Yes.

25 Q. So you had to go unexpectedly to the hospital for

1 the surgery where they opened the wound up, clean it up?

2 A. Yeah.

3 Q. So you were in the hospital for five or six days
4 and then you went home, I think the date was September 26th
5 or so. At that point in time you had had your wound cleaned
6 out, right?

7 A. Yes.

8 Q. They had given you IV medicines?

9 A. Yes.

10 Q. And they had sutured up or sowed up the -- the
11 wound?

12 A. Yes.

13 Q. Okay. So the first one that when it looked like
14 this, they didn't have stitches on the outside?

15 A. No, they didn't. No.

16 Q. For the second time they had stitches?

17 A. Yes.

18 Q. And so from that point until, I guess it was
19 around the holidays when everything started to become really
20 painful again. During that whole period of time, you thought
21 things were basically over?

22 A. I was recovering from second surgery end of
23 September, October, not driving, not lifting, doing my walks,
24 doing everything I've been told to do for October. Not
25 allowed to do physical therapy until November, I believe.

1 And after starting physical therapy, my pain started
2 increasing and I became weaker on every visit to physical
3 therapy.

4 Q. Yeah, I think you described that earlier in the --
5 the physical therapist said you need to go deal with your
6 pain and then come back.

7 A. Yes.

8 Q. Okay.

9 A. Yeah.

10 Q. And that was the time that you had reached out to
11 Dr. Shanahan, right?

12 A. All -- every -- all of them, yes, sir.

13 Q. Okay. And that's that. And looking back when we
14 figure out when it all got started, looking at the medicine
15 timeline sort of helps because we know November 20th or so is
16 when you started your Arava again.

17 A. And the pain had already been going on for two --
18 over two weeks.

19 Q. Okay.

20 A. While I was in therapy.

21 Q. And then you came back in to see the folks at
22 Southeastern Spine, I think you mentioned that was on
23 November 28th?

24 A. Yes, sir.

25 Q. (Inaudible). All right. Now, at that visit you

1 had resumed your medicines?

2 A. Yes.

3 Q. And you started taking Enbrel just first dose was
4 that day the 28th?

5 A. Okay. I --

6 Q. Had a sheet if you need it.

7 A. No.

8 Q. I just need (inaudible) copy.

9 A. Yep. Okay. All right.

10 Q. All right. So your first Enbrel dose was November
11 28th, which was the same day that you were going back to
12 Southeastern Spine, right?

13 A. Okay.

14 Q. At this point, you're still hopeful that this is
15 all rheumatoid arthritis and get your Enbrel back on as you
16 get your inflammation under control?

17 A. Yes.

18 Q. You get Ms. McGougan back to Ms. McGougan?

19 A. That's right.

20 Q. All right. And so when, at that point in time --
21 let's see, that was November 28th. So you were seen at
22 Southeastern Spine and then I think the next visit you had
23 was with Dr. Harkins on early December. I recall December
24 12th if I'm wrong, I'm pretty confident your lawyer will tell
25 me or ask you to clarify it. But do you remember going to

1 see Dr. Harkins in December?

2 A. I do remember going to see Dr. Harkins. Edgar was
3 with me. Edgar carried me.

4 Q. Okay. Is our understanding at that point you
5 thought you were having a rheumatoid arthritis flare up and
6 he injected a steroid shot into your left sacral joint?

7 A. It was my understanding he was putting it in that
8 SI joint. Is that -- is that the same place? I -- I'm sorry
9 I -- that was what I understood him to tell me.

10 Q. Okay. And so you had that injection, right?

11 A. Yes, sir.

12 Q. Did you have those steroid injections before?

13 A. No.

14 Q. Is this the first time you'd ever had one?

15 A. Yes.

16 Q. And did you get immediate relief?

17 A. No.

18 Q. Did you get any relief?

19 A. No.

20 Q. So what was your expectation after talking to
21 Dr. Harkins about what -- how long did you need to wait
22 before you need to do something else? If that steroid didn't
23 help.

24 A. I don't recall talking to him about that.

25 Q. So he does the injection, you go home, you --

1 you're still waiting for it to kick in and it just never
2 does?

3 A. That's correct.

4 Q. So then three days later or four days later,
5 you're back in Southeastern Spine?

6 A. Yes.

7 Q. And at this point an MRI had been performed; is
8 that right?

9 A. I don't know what date it was done to tell. Yes,
10 it was. That's correct. Because we went to that other
11 building that day and then we come back and saw Dr. Frisch.

12 Q. All right.

13 A. That's correct.

14 Q. And then you had the conversation with Dr. Frisch
15 that, you know, he's looking at your MRI, you're going to
16 have to come back into the hospital, you're going to have to
17 figure out what's going on?

18 A. Yes.

19 Q. And that was the whole conversation about this
20 Christmas and we wait, that sort of thing?

21 A. Yes.

22 Q. And so to be clear on that visit, Dr. Frisch's
23 recommendation was for you all to go into the hospital that
24 Friday, right?

25 A. No, he said that he thought it was reasonable. I

1 could wait till Monday.

2 Q. Well, will get there. But the first thing he said
3 is that he --

4 A. Let's go into the --

5 Q. -- to the hospital?

6 A. Yes.

7 Q. Okay. And then you said what? I mean do we
8 really need to go in on Friday? Can we go in on Monday? And
9 he explained why, right?

10 A. Yes, sir.

11 Q. And he said, "Well, if you promise to call me if
12 it gets worse or something changes."

13 A. Yes.

14 Q. Then I think it'd be okay for you to wait and go
15 on Monday.

16 A. Yes.

17 Q. Is that -- that basically --

18 A. That's my understanding.

19 Q. -- your recollection?

20 A. Yes.

21 Q. All right. And then Saturday comes and we heard
22 from your husband earlier and we heard the testimony that he
23 called and they told him the only option was to come in that
24 night?

25 A. I don't remember that.

1 Q. Okay. And that was obviously it's never
2 convenient to go to the hospital. Nobody was to go to the
3 hospital on the weekend. And so you all's thought process
4 was to sit tight, get there on Monday morning, and see what's
5 going on?

6 A. Yes.

7 Q. But each step of the way, you knew that if your
8 condition changed and worsened, that you needed to reach back
9 out, and you knew that anyway from your nursing background?

10 A. That's correct.

11 Q. And that's why on Saturday when things were
12 uncomfortable, you all reached out?

13 A. Yes.

14 Q. You also know that doctors aren't going to treat
15 you over the phone?

16 A. That's right.

17 Q. You know they're always going to tell you is come
18 on in or go to the hospital, right?

19 A. Not always.

20 Q. Well, okay, fair enough. Because you could call
21 Dr. Shanahan whose managing medications and he might tell you
22 what to do?

23 A. Yes, sir.

24 Q. But you understand in -- in the world of surgery
25 and surgical complications that they need to see you in order

1 to make their own assessment of what's going on and they
2 can't do that over the telephone?

3 A. That's correct.

4 Q. And that's why the question is come on in or if
5 you can't just go to the hospital and get a ride?

6 A. We were not told that. It was not my
7 understanding that we were told that.

8 Q. Okay. So then you come back on Monday and I think
9 you got a phone call with Dr. Frisch; is that right?

10 A. Monday. Yes.

11 Q. You said --

12 A. Come on in.

13 Q. -- it's not -- not better or you need to get in.

14 A. Yes.

15 Q. Immediately.

16 A. Yes. Yes.

17 Q. Came in, they got you admitted, did the workup and
18 it wasn't like the last time we had to open it up again?

19 A. That's right.

20 Q. This hospitalization you were medically managed,
21 right?

22 A. That's correct.

23 Q. And the difference being there wasn't a surgery,
24 it was the administration of medicine, fluids, those sorts of
25 thing, to -- to try to treat the infection?

1 A. Yes, sir.

2 Q. And they told you that you had something called
3 osteomyelitis?

4 A. They did.

5 Q. And you know that's an infection in the bone?

6 A. I do.

7 Q. And they had the only way to treat that was to
8 give you IV antibiotics?

9 A. Yes.

10 Q. All right. So at this point, this is the first
11 time you've been diagnosed with a bone infection, right?

12 A. That's correct.

13 Q. This isn't anything like what happened in
14 September. This is -- this is not a surgical site infection,
15 this is a bone infection?

16 A. Right.

17 Q. All right. So now, I mean it's the same location,
18 but the infection is different. It involves a bone now,
19 right?

20 A. Yes.

21 Q. So that's why you're getting the medication and
22 they gave you the PICC line, right?

23 A. Yes.

24 Q. And then they sent you home with the PICC line in
25 place so you could follow-up and get those medicines?

1 A. Yes.

2 Q. And as I understand it from -- in January until
3 you finish your round of IV medications, you were seeing one
4 of Dr. West partners up in Myrtle Beach, Dr. Ebama?

5 A. Dr. West. Yes.

6 Q. Okay. Let -- let's just make sure we're speaking
7 on the same level.

8 A. Yeah.

9 Q. So in Myrtle Beach, the doctor was Dr. Ebama,
10 right?

11 A. Yes.

12 Q. Okay. And that was Dr. West partner?

13 A. Yes.

14 Q. And from there, the course of antibiotics ended
15 and there was no further indication of infection in your
16 bone, true?

17 A. We hope not. I was told that it could come back
18 at any time.

19 Q. Understood. Today -- by today it hasn't, right?

20 A. Today it hasn't. We -- we hope not.

21 Q. Understood. So your -- your treatment with Dr.
22 West ended and you followed up with a few more times in
23 Southeastern Spine, and then you also received up at Duke?

24 A. Yes.

25 Q. So in terms of sort of the -- the treatment for

1 that bone infection, the infection was resolved through those
2 IV antibiotics in the bone, but let me restate that. That's
3 not funny. The bone infection was resolved by the IV
4 antibiotics, correct?

5 A. The bone infection was I -- I presume it was.

6 Q. Okay. And then we heard about how the doctors at
7 Duke explained to you that over time after the bone infection
8 that it ended, that the bones had sort of collapsed onto to
9 each other and grew into one another, re-fused.

10 A. No, he didn't tell me that.

11 Q. Did the doctor at Duke explain that to you?

12 A. He explained that I had an unstable spine. He
13 said he would not touch it with my medical history, having
14 had osteomyelitis that I could pray for auto-fusion, I could
15 pray for that to happen, but he would not recommend surgery.

16 Q. Okay. Understood. So I think we're -- I was too
17 far ahead.

18 A. Okay.

19 Q. That was your first visit to do, right?

20 A. Yes.

21 Q. He said hope for auto-fusion?

22 A. Yes.

23 Q. And then I guess 2019, when you went back and they
24 looked at it, at that point it had impact (inaudible)?

25 A. They were hoping that it's still -- they're

1 telling me it's not stable.

2 Q. Okay. So your business with Southeastern Spine,
3 for example, they ended I think about 2017, that by what
4 year?

5 A. Yes.

6 Q. And do you know in terms of this auto-fusion, did
7 -- do you know when that occurred?

8 A. No, sir.

9 Q. Bear with me for just a second. I think I might
10 be finished.

11 A. Okay.

12 MR. HOOD: All right. Thank you.

13 THE WITNESS: Thank you.

14 THE COURT: Any questions for those?

15 MS. MAPLES: Yes, Your Honor.

16 THE COURT: You may proceed.

17 CROSS-EXAMINATION

18 BY MS. MAPLES:

19 Q. Good afternoon, Ms. McGougan.

20 A. Good afternoon.

21 Q. This is our first time meeting. My name is Allie
22 Maples and I represent Dr. West.

23 A. It's nice to meet you.

24 Q. As a nurse, you understand that patients can have
25 undesirable outcomes even when they receive the appropriate

1 care, right?

2 A. Yes.

3 Q. You understand that things can happen that are
4 outside of other health care provider and yourselves control?

5 A. Yes.

6 Q. Patients can have unsightly scarring?

7 A. Yes.

8 Q. They can have unexpected bleeding?

9 A. Yes.

10 Q. And they can develop infections?

11 A. Yes.

12 Q. You not only knew that professionally, but you
13 knew it personally before your surgery with Dr. Frisch,
14 right?

15 A. I didn't know it. I just had studied that, but I
16 didn't know it like I know it now.

17 Q. But you were generally aware that an infection
18 could occur?

19 A. It had in other people, yes.

20 Q. And you knew surgery wasn't without risks?

21 A. That's correct.

22 Q. Just so everyone was on the same page Dr. West, he
23 wasn't involved in your spinal surgery, correct?

24 A. Not to my knowledge. I don't think he was in the
25 room. I don't -- I don't know who was in there.

1 Q. But Dr. West, he did come in after your surgery
2 and provide you infectious disease care, correct?

3 A. I was given antibiotics under his direction, I was
4 told.

5 Q. But you actually met Dr. West after --

6 A. I did.

7 Q. -- your surgery?

8 A. I did meet him.

9 Q. He came to your room?

10 A. He came to the door of my room.

11 Q. Okay. And it was during this visit, you were
12 actually in contact isolation because of your infection,
13 correct?

14 A. That's correct.

15 Q. Your providers they would wear masks and gowns
16 because of your infection?

17 A. Yes.

18 Q. And it was under Dr. West's direction that you
19 received five days of IV antibiotics during your September
20 hospitalization?

21 A. No.

22 Q. You did receive IV antibiotics, correct?

23 A. Yes.

24 Q. And those were at the direction of Dr. West?

25 A. Yes.

1 Q. You received antibiotics on the 22nd?

2 A. Okay.

3 Q. Is yes?

4 A. Yes.

5 Q. On the 23rd?

6 A. Yes.

7 Q. On the 24th?

8 A. Yes.

9 Q. On the 25th?

10 A. Yes.

11 Q. And on the 26th the day of your discharge?

12 A. No, I didn't get an IV antibiotic that day.

13 Q. But you were discharged with antibiotics, correct?

14 A. That's correct.

15 Q. And that was also at the direction of Dr. West?

16 A. Yes, ma'am.

17 Q. And you took those antibiotics, which were a 14
18 day course as prescribed, correct?

19 A. Yes, ma'am.

20 Q. And initially you did well in that postoperative
21 period, correct?

22 A. Initially I did. I -- I was feeling -- I was
23 hopeful that things were getting better.

24 Q. You were living at home?

25 A. Absolutely, yes.

1 Q. You told us you were able to take walks?

2 A. In my house.

3 Q. You also began physical therapy?

4 A. That was in November. I didn't start physical
5 therapy in September.

6 Q. Understood. But it was after you had finished
7 that antibiotic and some time had passed, you were able to
8 begin physical therapy?

9 A. Yes, ma'am.

10 Q. And in that time you never called Dr. West,
11 correct?

12 A. No, ma'am.

13 Q. You never looked up his Number ?

14 A. No, ma'am. I was never given his Number .

15 Q. But you never looked it up either?

16 A. I -- I didn't know his first name. I didn't -- I
17 didn't have any idea. I -- it was a Dr. West was all I was
18 told.

19 Q. Okay. Fair enough. You didn't look up for
20 Dr. West?

21 A. No, ma'am.

22 Q. You didn't do that in my understanding, September,
23 October, November, or December, correct?

24 A. That's correct.

25 Q. But in December when you were hospitalized again,

1 Dr. West, he treated you again, correct?

2 A. That's correct.

3 Q. Now, it was, I think you told Mr. Hood it was in
4 this December hospitalization you had developed that bone
5 infection, correct?

6 A. Yes.

7 Q. And then you received more antibiotics by
8 Dr. West?

9 A. Under his direction. Yes, ma'am.

10 Q. Through a PICC line?

11 A. Yes.

12 Q. And those -- those more or additional antibiotics,
13 they weren't without side effects, correct?

14 A. That's correct.

15 Q. You actually had a reaction to the first course,
16 the Vancomycin IV antibiotics?

17 A. And they started me on the daptomycin that was IV
18 infusion through my PICC line.

19 Q. Yes, ma'am. Part of your reaction to the more or
20 additional antibiotics was you started to have kidney
21 problems?

22 A. That was what I was told.

23 Q. Well, you also developed ringing in your ear?

24 A. Yes.

25 Q. But it was once you started to experience these

1 side effects, Dr. West he transitioned you to a different
2 type of IV antibiotic, correct?

3 A. Yes.

4 Q. And you were on those for about three months?

5 A. Yes.

6 Q. Eventually you were able to have that PICC line
7 removed?

8 A. But Dr. Ebama was managing that and the lab
9 values. That's who I was seeing. I wasn't seeing Dr. West
10 after my discharge from the hospital. I never saw him after
11 my discharge from the hospital, I saw Dr. Ebama.

12 Q. Right. And that was Dr. West's partner?

13 A. That was what I was told.

14 Q. Okay.

15 A. I didn't know. Yeah. I just knew that I -- that
16 was their infectious disease doctor that I could see.

17 Q. And you could see Dr. Ebama closer to home?

18 A. Yes.

19 Q. And I'm correct that since 2017 you have not had a
20 reoccurrence of your infection?

21 A. I hope not. Not that I know of.

22 MS. MAPLES: I don't have any other questions. Thank
23 you for your time.

24 THE WITNESS: Thank you.

25 THE COURT: Any redirect for this -- oh, I think Ms.

1 John is objecting.

2 MS. MAPLES: Actually I do have an additional question.

3 THE COURT: Go ahead.

4 BY MS. MAPLES:

5 Q. I'd like to clarify a point real quick. You told
6 me a moment ago that you did not receive another IV
7 administration of antibiotics on your day of discharge in
8 September of 2016, correct?

9 A. That's correct.

10 Q. And I know some time has passed. So I'm going to
11 show you what has already been entered as Defendant's Exhibit
12 116. Are you able to see that in front of you?

13 A. I do.

14 Q. Can you see what's highlighted? It is September
15 26, 2016, correct?

16 A. The -- the admission date and time was 9/26 at
17 4:00 in the morning; is that right?

18 Q. Yes, ma'am.

19 A. Is that what you're saying? Okay. Yes, ma'am.
20 That's correct.

21 Q. And it indicates that on -- and this is the day of
22 your discharge?

23 A. Yes, ma'am. I'm sorry, that was before day, so I
24 didn't realize it was that day honestly.

25 Q. So it's true that you received five days of IV