

STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Maite Murphy
Circuit Court Judge

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

Rebecca Turisk,

Appellant,

v.

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

Respondents.

RECORD ON APPEAL – VOLUME I

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SC Court of Appeals

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S.C. SUPREME COURT

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C.A. No.: 2018-CP-10-02109
	)	
Rebecca Turisk,	)	
	)	
Plaintiff,	)	[Proposed] ORDER DENYING
	)	PLAINTIFF’S MOTION FOR A NEW
vs.	)	TRIAL AS TO PROXIMATE CAUSE
	)	AND DAMAGES ONLY, OR, IN THE
	)	ALTERNATIVE, FOR JUDGMENT
Dennis K. Schimpf, M.D. and Sweetgrass	)	NOTWITHSTANDING THE VERDICT,
Plastic Surgery, LLC,	)	OR, ALTERNATIVELY, FOR A NEW
	)	TRIAL ABSOLUTE
Defendants.	)	
	)	

This matter came before the Court on November 28, 2022 for a hearing regarding Plaintiff Rebecca Turisk’s (“Plaintiff”) Motion for a New Trial as to Proximate Cause and Damages Only, or, in the alternative, for Judgment Notwithstanding the Verdict, or, also in the alternative, for a New Trial Absolute. In her Motion, Plaintiff argues that she is entitled to a new trial because the “verdict is inconsistent and indicates the jury was confused” and that invocation of the “Thirteenth Juror” doctrine is warranted because “verdict is contrary to the weight of the evidence.” For the reasons articulated below, the Court denies Plaintiff’s Motion in its entirety.

BACKGROUND

On April 23, 2018, Plaintiff filed this medical malpractice action against Defendants in the Court of Common Pleas for Charleston County, South Carolina. Between November 14, 2022 and November 17, 2022, the parties tried the case to a jury. Contrary to Plaintiff’s Motion, at trial, Plaintiff alleged that the Defendants breached the standard of care in two ways: (i) by selecting the inferior pedicle inverted T surgical approach for her breast reduction and lift surgery, and (ii) by inadequately providing Plaintiff with post-surgical care. Defendants defended that their conduct did not fall below the standard of care in any aspect and that Plaintiff’s issues were instead known

complications of the procedure about which Plaintiff was appropriately informed of and accepted as risks of the surgery prior to the procedure. At the conclusion of the trial, using a verdict form, the jury returned a verdict for Plaintiff on the first question of whether Defendants breached the standard of care and a verdict for Defendants on the second question of whether the breach proximately caused Plaintiff's injuries. Because the jury did not conclude that Defendants proximately caused Plaintiff's injuries, they did not reach the question of or award any damages to Plaintiff.

STANDARD OF REVIEW

a. NEW TRIAL

Whether to grant a new trial is a matter within the discretion of the trial judge. *Daves v. Cleary*, 355 S.C. 216, 231, 584 S.E.2d 423, 430 (Ct. App. 2003) (citing *Stevens v. Allen*, 336 S.C. 439, 446, 520 S.E.2d 625, 628-29 (Ct. App. 1999)). However, a jury's verdict is entitled to "substantial deference." *Mills v. S.C. State Ports Auth.*, 435 S.C. 213, 227, 865 S.E.2d 910, 917 (Ct. App. 2021). "A new trial absolute should be granted only if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive." *Id.* at 226 (internal citation omitted). A so-called inconsistent verdict is not an automatic ground for a new trial. *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 49-50, 691 S.E.2d 135, 149 (2010) (internal citation omitted). To the contrary, where there is a logical reason for reconciling an inconsistent verdict, it is the duty of the court to sustain it. *Id.*; see also *Longshore v. Saber Sec. Servs.*, 365 S.C. 554, 561, 619 S.E.2d 5, 9 (Ct. App. 2005) (affirming the trial court's decision to not overturn a jury verdict in favor of the defendants on an assault and battery claim where the jury found liability for negligent hiring because the verdict could be "harmonized."); *Johnson v.*

Hoechst Celanese Corp., 317 S.C. 415, 422, 453 S.E.2d 908, 912 (Ct. App. 1995) (affirming denial of plaintiffs' motion for new trial where the jury returned a verdict for two other plaintiffs because the moving plaintiffs did not prove each element of their causes of action).

Equally important to medical malpractice cases like this one, the plaintiff must show, through expert testimony that, "in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence . . . [and] when it is the only evidence of proximate cause relied upon, it must provide a significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection." *Daves*, 355 S.C. at 230, 584 S.E.2d at 430 (quoting *James v. Lister*, 331 S.C. 277, 286, 500 S.E.2d 198, 203 (Ct. App. 1998)). In other words, the plaintiff has the burden of proving both a deviation from the standard of care **and** proximate cause through expert testimony. *Id.* (emphasis added); see also *Richardson's Rests. v. Nat'l Bank of S.C.*, 304 S.C. 289, 295, 403 S.E.2d 669, 672 (Ct. App. 1991) (internal citation omitted) ("In order to prevail on a claim of negligence, the plaintiff must show (1) a duty of care owed by the defendant to the plaintiff; (2) a breach of that duty by a negligent act or omission; and (3) damage proximately resulting from the breach. If he fails to establish any one of these elements, his cause of action fails."). Where a jury finds that she did not do so and it is supported by the evidence, the decision of the jury should not be disturbed through a new trial. See *Stevens*, 342 S.C. at 53, 536 S.E.2d at 666 ("[I]f a jury finds the plaintiff has failed to prove damages proximately caused by the defendant's negligence, then its verdict should be for the defendant."); *Dropkin v. Beachwalk Villas Condo. Ass'n*, 373 S.C. 360, 365, 644 S.E.2d 808, 810 (Ct. App. 2007) (affirming denial of the plaintiff's motion for a new trial in a traditional negligence case where plaintiff did not prove proximate cause).

b. JUDGMENT NOTWITHSTANDING THE VERDICT (JNOV)

In reviewing motions for directed verdict and JNOV, the evidence and the reasonable inferences that can be drawn therefrom must be viewed in the light most favorable to the non-moving party, which, at this juncture, is Defendants. *Daves*, 355 S.C. at 229, 584 S.E.2d at 429 (citing *Brady Dev. Co. v. Town of Hilton Head Island*, 312 S.C. 73, 78, 439 S.E.2d 266, 269 (1993)). The motion should not be granted where the “evidence yields more than one inference[,] or its inference is in doubt.” *Id.* (internal citation omitted). As with considering a motion for a new trial, a jury’s verdict is given substantial deference when contemplating a JNOV. *See Mills*, 435 S.C. at 227, 865 S.E.2d at 917.

DISCUSSION

a. THE JURY’S VERDICT WAS NOT INCONSISTENT.

As an initial matter, the jury’s verdict in this case was not “inconsistent” as Plaintiff now attempts to argue. *See e.g., Stevens*, 342 S.C. at 51, 53, 536 S.E.2d at 661, 666 (holding a verdict that found the defendant liable for *proximately causing* the plaintiff’s injuries yet awarding zero dollars in damages was facially inconsistent); *Herring v. Home Depot, Inc.*, 350 S.C. 373, 381, n.16, 565 S.E.2d 773, 777, n.16 (Ct. App. 2002) (internal citation omitted) (illustrating that a verdict in favor of a plaintiff for both revocation of acceptance and breach of warranty would be inconsistent due to their contradictory elements). Instead, it was a verdict indicative that Plaintiff failed to meet her burden of proof as to at least one of the required elements of her medical malpractice cause of action: proximate cause. This kind of verdict is entirely consistent, permissible and appropriate under South Carolina law. *See Dropkin*, 373 S.C. at 365, 644 S.E.2d at 810 (cited above); *see also Vinson v. Hartley*, 324 S.C. 389, 411-12, 477 S.E.2d 715, 727 (Ct. App. 1996) (denying the plaintiff’s motion for a new trial where the jury found for the defendant

on proximate cause although the defendant admitted negligence). Otherwise, a plaintiff would be relieved of its burden to prove each and every element of its cause of action.

Regardless and even assuming *arguendo*, the verdict was somehow “inconsistent,” it was not irreconcilably inconsistent as is required by our jurisprudence and, therefore, this assertion is not a basis for granting a new trial. *Austin*, 387 S.C. at 49, 691 S.E.2d at 149 (internal citation omitted) (holding that verdicts must be irreconcilably inconsistent to warrant a new trial). First, contrary to Plaintiff’s contention in her Motion, Plaintiff did not pursue a single theory of liability. Plaintiff argued that both Defendants’ choice of surgical technique and their post-operative care violated the standard of care. Therefore, it stands to reason that the jury could have found that Defendants’ post-operative care breached the standard of care, but that the choice of surgical technique did not. This likelihood completely undermines Plaintiff’s assertion that “the surgery itself, at least, proximately caused some damages to Plaintiff[.]” which, as discussed below, is not supported by the record anyway. Alternatively and just as likely, the jury could also have reasonably concluded that another surgical option was appropriate, but also concluded that the choice of technique was not to blame for Plaintiff’s complications or claimed damages. Finally, as detailed above, unlike the verdict in *Stevens*, the jury’s verdict in this case confirmed that Plaintiff **did not prove** her damages were proximately caused by Defendants’ breach. Thus, an award of zero damages is entirely consistent with South Carolina law and does merit a new trial as to any issue or JNOV.

Further, the mere fact that the jury did not find proximate cause does not mean that the jury was somehow “confused” on the issue. Indeed, the record supports that the opposite was true. The jury was verbally instructed on Plaintiff’s burden of proof as to all of the required elements and specifically on the issue of proximate cause. Additionally, it was provided with a hard copy of the jury instructions. Furthermore, at Plaintiff’s request, the jury was polled after the verdict was read

and each juror confidently affirmed that the verdict was, in fact, the one that they had reached. Accordingly, the Court finds that any concerns that the jury was somehow confused as to proximate cause is completely without support and likewise does not justify a new trial of any kind or JNOV.

b. THE JURY'S VERDICT IS NOT CONTRARY TO THE WEIGHT OF THE EVIDENCE, BUT, RATHER, IS AMPLY SUPPORTED BY THE PREPONDERANCE OF THE EVIDENCE.

The jury's verdict is amply supported by the overwhelming weight of the evidence, so the Court finds that there is no basis for the application of South Carolina's thirteenth juror doctrine. Plaintiff's Motion mischaracterizes the testimony of Defendants' experts and Dr. Schimpf, as well as Dr. Herrera. Neither Defendants' experts, Dr. Lefkowitz or Dr. Joseph, Dr. Schimpf, nor Dr. Herrera testified that any of Plaintiff's alleged damages were *proximately caused* by any negligent act of Defendants. In fact, Dr. Herrera explicitly refused to testify that Defendants even breached the standard of care. Instead, these experts all testified that despite Defendants' use of the gold-standard surgical technique for this procedure, Plaintiff unfortunately suffered a known complication from her surgery – not due to any negligence, and that Defendants appropriately responded to her concerns.

Notably, Plaintiff's sole expert, Dr. Hultman, also acknowledged that Plaintiff's complications were known to her particular surgery and occur even when the procedure is performed according to the standard of care as it was in this case. Dr. Hultman specifically agreed that Dr. Schimpf met the standard of care in the way that he performed the inferior pedicle approach and that it is the single most-widely used technique for this surgery. He likewise readily admitted that Dr. Schimpf appropriately warned Plaintiff about the inherent risks during the informed consent process and that Defendants' technique is not only the gold standard, but one that he uses himself. Neither the jury, nor the Court is required to accept Dr. Hultman's isolated suggestion that he would have used

a different approach for Plaintiff's surgery. *McCourt by & Through McCourt v. Abernathy*, 318 S.C. 301, 307, 457 S.E.2d 603, 607 (1995) (holding that the jury was properly instructed that "[t]he mere fact that the plaintiff's expert may use a different approach is not considered a deviation from the recognized standard of medical care."); *see also McGrady v. United States*, 650 F. Supp. 379, 381 (D.S.C. 1986) ("The mere fact that a plaintiff's expert witness is of the opinion that he would have chosen a different approach or method in the diagnosis or treatment of a patient is not dispositive of determining the liability issue in a medical malpractice suit.").

Plaintiff's Motion also relies exclusively on evidence of Plaintiff's post-surgical complications. However, South Carolina law is clear that evidence of complication alone is not sufficient to prove liability. *McCourt*, 318 S.C. at 308, 457 S.E.2d at 607 (also holding that jury was properly instructed that negligence may not be inferred from a bad result). Therefore, there is simply no basis in law or fact for the Court to disrupt the jury's verdict under the thirteenth jury doctrine.

Moreover, as referenced above, Defendants' experts testified that Defendants appropriately informed Plaintiff of the risks inherent to her surgery prior to Plaintiff's election of surgery. Plaintiff's expert confirmed this by acknowledging that he did not have any criticisms of Defendants' informed consent process. Plaintiff similarly acknowledged that Defendants properly informed her of the risks of her surgery and testified that she was aware that infection, nipple loss, and the need for additional surgeries were all potential complications of her surgery and agreed to proceed with full knowledge of these potential risks. This goes directly to the application of assumption of the risk, which also supports the jury's verdict of no liability. Simply put, the evidence more than supports the jury's ultimate verdict, so there is no basis for the judicial intervention Plaintiff now seeks.

The Court being fully advised and for the reasons fully set forth above,

IT IS HEREBY ORDERED that Plaintiff's Motion for a New Trial as to Proximate Cause and Damages Only, or, in the alternative, for Judgment Notwithstanding the Verdict, or, also in the alternative, for a New Trial Absolute is **DENIED** in its entirety.

Honorable Maite Murphy
Presiding Circuit Court Judge

December _____, 2022
Charleston, South Carolina



Charleston Common Pleas

Case Caption: Rebecca Turisk VS Dennis K Schimpf M D , defendant, et al
Case Number: 2018CP1002109
Type: Order/Other

So Ordered

s/ Maite Murphy 2166

Electronically signed on 2022-12-12 12:19:32 page 9 of 9

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2018 CP-10-02109

Rebecca Turisk

Dennis K. Schimpf, M.D. and

PLAINTIFF(S)

Sweetgrass Plastic Surgery, LLC
DEFENDANT(S)

Submitted by: Jesse Sanchez

Attorney for : ☒ Plaintiff ☐ Defendant
or
☐ Self-Represented Litigant

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. ☐ See Page 2 for additional information.
- ☐ **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 Verdict Form ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk : _____

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
Dennis K. Schimpf, N.D. and Sweetgrass Plastic surgery, LLC	Rebecca Turisk	\$0
		\$
		\$

If applicable, describe the property, including tax map information and address, referenced in the order: Judgement in favor of the Defendants as the Jury determined that the Plaintiff did not prove by a greater weight or preponderance of the evidence that the Defendant's deviations from the standard of care was the proximate cause of the Plaintiff's injuries.

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.
Note: Title abstractors and researchers should refer to the official court order for judgment details.
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

Circuit Court Judge

Judge Code

Date

For Clerk of Court Office Use Only

This judgment was entered on the _____ day of _____, 20____ and a copy mailed first class or placed in the appropriate attorney's box on this _____ day of _____, 20____ to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter:

E-Filing Note: In E-Filing counties, 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 judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

Verdict for the Defense.

FORM 4C INSTRUCTIONS—JUDGMENT IN A CIVIL CASE
(Instructions for Information Only-Not to be filed with Form 4C)

1. Form 4C-Judgment in a Civil Case has been modified to add order information and enrollment instructions for the clerk of court. The purpose of Form 4 has not changed with the exception that judgment information is provided when applicable.
2. Please note that the Form 4C must be attached to all orders that include information to enroll in the judgment index. The clerk will not be responsible for reading the order to determine enrollment information.

The attorney or prevailing party will prepare and attach the Form 4C when submitting the proposed order that includes judgment enrollment information for the judgment index. The judge will review and sign Form 4C when he or she signs an order that includes judgment enrollment information for the judgment index.

3. Form 4C is not required to be submitted to the Court with orders that do not include information to enroll in the judgment index. If the clerk receives such an order without Form 4C attached, the clerk should enter and process the order pursuant to Rule 58 and Rule 77(d), SC Rules of Civil Procedure (i.e., the clerk should serve notice of entry of the judgment by mail or provide the attorneys with copies of the signed order by other means).
4. The “Information for the Judgment Index” section should be completed when the judgment affects title to real or personal property or if any amount should be enrolled. In the “Judgment in Favor of” column, enter the name of the party to whom the judgment is awarded. In the “Judgment Against” column, enter the name of the person to whom the judgment is against. The judgment amount to be enrolled should be noted in the “Judgment Amount” column. As necessary, describe any property referenced in the order if it is to be enrolled in the judgment index. If there is no judgment information to enroll, indicate “N/A” in one of the boxes in this section of the form.
5. To enter information to accommodate multiple parties, additional Form 4Cs may be used as necessary. Additional space may be inserted on the form as necessary.
6. The section “For the Clerk of Court Office Use Only” should be completed by the clerk as it has been with the previous version of Form 4.
7. If the matter is on appeal to the Circuit Court, then the parties on the form should be changed from Plaintiff and Defendant to Appellant and Respondent.
8. If an arbitrator prepares an order after arbitration, the arbitrator should strike through “Circuit Court Judge” and indicate “Arbitrator” in the signature block.

9. If a Special Circuit Court Judge, Master in Equity, or Special Referee prepares an order after hearing a Circuit Court matter, then he or she should strike through the title "Circuit Court Judge" below the signature line and indicate the appropriate title.
10. When an Order of Foreclosure is filed, neither the parties or debt owed should be listed in the Information for the Judgment Index Section, unless the foreclosure order specifically requires entry of the full judgment amount before the foreclosure sale, pursuant to Section 29-3-650 of the SC Code.
11. If the deficiency judgment is waived in a Foreclosure action, indicate N/A in the "Judgment Amount To Be Enrolled" box.
12. Foreclosure actions should be ended by the Clerk of Court upon receipt of the Order of Foreclosure. Subsequent information, including deficiency judgments, can be added to the action after the case is ended. The Master in Equity should end the action in the MIE system upon the receipt of the Order of Foreclosure.
13. When judgment enrollment information is included in the Information for the Judgment Index Section (for example, when there is a deficiency judgment), only the parties who the judgment is for and against should be included in the Section. Subordinate parties and lienholders should not be included in the box if there is not a judgment amount specifically for or against them.
14. Form 4C is not required to be attached to Transcripts of Judgment and Confession of Judgment.



Charleston Common Pleas

Case Caption: Rebecca Turisk VS Dennis K Schimpf M D , defendant, et al
Case Number: 2018CP1002109
Type: Order/Form 4

So Ordered

s/ Maite Murphy 2166

Electronically signed on 2023-01-17 14:49:42 page 6 of 6

ELECTRONICALLY FILED - 2023 Jan 17 2:52 PM - CHARLESTON - COMMON PLEAS - CASE#2018CP1002109

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Rebecca Turisk,

Plaintiff,

vs.

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

Defendants.

IN THE COURT OF COMMON PLEAS

C.A. No.: 2018-CP-10-2109

VERDICT FORM

JULIE J. ARISTARCO
CLERK OF COURT

2023 JAN 17 PM 2:55

FILED

1. Did the Plaintiff prove by a greater weight or preponderance of the evidence that the Defendants deviated from the standard of care?

☒ YES

☐ NO

If your answer to Question 1 is NO, you are finished. You have found for the Defendants. Please sign the certification below. If your answer is YES, please continue to Question 2.

2. Did the Plaintiff prove by a greater weight or preponderance of the evidence that the Defendants' deviation from the standard of care was the proximate cause of Plaintiff's injuries?

☐ YES

☒ NO

If your answer to Question 2 is NO, you are finished. You have found for the Defendants. Please sign the certification below. If your answer is YES, please continue to Question 3.

3. What do you find as the damages for the Plaintiff?

ACTUAL DAMAGES: \$ _____

NON-ECONOMIC DAMAGES: \$ _____

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

Katina McFadden 179
Foreperson

November 17, 2022

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

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

) IN THE COURT OF COMMON PLEAS
) NINTH JUDICIAL CIRCUIT
) CASE NO.: 18-10-CP- 2109

REBECCA TURISK,
Plaintiff,

vs.

DENNIS K. SCHIMPF, M.D. AND
SWEETGRASS PLASTIC SURGERY,
LLC

Defendants.

SUMMONS
(Jury Trial Demanded)

FILED
2018 APR 23 PM 4:31
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

TO THE DEFENDANTS ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to the said complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the complaint, judgment by default will be rendered against you for the relief demanded in the Complaint.

MARK C. TANENBAUM, P.A.

By _____


Mark C. Tanenbaum #5470
mark@tanenbaumlaw.com
1017 Chuck Dawley Blvd., Suite 101
Mt. Pleasant, SC 29464
Telephone: (843) 577-5100
Facsimile: (843) 722-4688

and

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ATTORNEYS FOR PLAINTIFF

April 18, 2018

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

) IN THE COURT OF COMMON PLEAS
) NINTH JUDICIAL CIRCUIT
) CASE NO.: 18-10-CP- 2109

REBECCA TURISK,

Plaintiff,

vs.

DENNIS K. SCHIMPF, M.D. AND
SWEETGRASS PLASTIC SURGERY,
LLC

Defendants.

COMPLAINT
(Jury Trial Demanded)

FILED
2018 APR 23 PM 4:31
JULIE J. ARISTONOG
CLERK OF COURT
BY _____

Plaintiff hereinabove complaining of the Defendants would show as follows:

Plaintiff is a citizen and resident of Berkeley County, South Carolina.

1. Upon information and belief, Defendant Dennis K. Schimpf, M.D. is a citizen and resident of Charleston County, South Carolina and is present and doing business in Charleston County, South Carolina.

2. Sweetgrass Plastic Surgery, LLC is a limited liability corporation, present and doing business in Charleston County, South Carolina.

3. Plaintiff Rebecca Turisk (hereinafter "Plaintiff") was seen and treated by Dennis Schimpf, MD and Sweetgrass Plastic Surgery, LLC (both hereinafter referred to as "Defendants") from July 2016 to and through December 2016.

4. In July of 2016 Plaintiff presented to the Defendants due to long standing issues of neck and back pain due to her pendulous and fibrous breasts. She gave a complete history, including that she had breast implants in place from earlier surgery. These were also observed by Defendants.

5. On November 1, 2016 Plaintiff presented to the Defendants for two procedures, a reduction mammoplasty and an abdominoplasty. Pre-surgery, the Defendants planned to remove both of her breast implants as part of the procedure.

6. At the conclusion of the surgery on November 1, 2016, Plaintiff was picked up by a friend and taken to her friend's home. Later that evening the Defendants called her friend to check on Plaintiff's condition.

7. On November 2, 2016 Defendants communicated with Plaintiff's caregivers and were informed that Plaintiff was experiencing lightheadedness, low blood pressure, and tachycardia. Defendants advised that Plaintiff could come in to see the Defendants or visit an outpatient clinic but she declined both. Defendants advised Plaintiff's caregivers to continue to monitor her blood pressure and to increase Plaintiff's hydration.

8. Plaintiff's caregivers again communicated with Defendants on November 3rd. At that time Plaintiff was doing better. Her heartrate and blood pressure had become stable.

9. On November 7, 2016 Plaintiff's caretakers reported to the Defendants that the drainage from her breast had changed from clear to dark red, and that she had a fever of 102. She was told to take pain medicines, and to take ibuprofen if the fever persisted.

10. On November 8, 2016 Plaintiff was examined in the Defendants' offices. According to the Defendants' records, Plaintiff's wounds were intact, healing well, and there was no erythema or drainage. The physical exam revealed

that she had mild to moderate swelling, no seroma, and that her right areola complex was very bruised. The drains from her breasts were removed.

11. By November 15, 2016, however, when Plaintiff returned for her next office visit, her right areola complex was very bruised and eschar, which is dead tissue formed and sloughed off due to gangrene or infection, had formed on her right areola complex. She was assured there was nothing to be concerned with, that she would continue to heal, and that she should be seen again in two weeks.

12. On November 28, 2016, despite having been assured by the Defendants there was nothing to be concerned with, she sought another medical opinion. Her wound was described as an open wound right breast 5 days, moderate oozing, but without fever, and she was given an antibiotic. Blood was drawn to check for infection. She was given an injection of an antibiotic and oral antibiotic to take thereafter. She was encouraged to follow up with Defendants.

13. Later that same day, November 28th, Plaintiff saw the Defendants where it was noted she had had fever the previous weekend, and that eschar had formed and was still present throughout her right nipple complex. Dr. Schimpf noted then he had been contacted by the clinic where she was earlier seen and that he had spoken to the doctor who saw her. He noted that her right breast had an open wound and an odor was coming from it. He debrided the wound and left it open to allow it to drain.

14. On November 29, 2016 Plaintiff returned to the clinic where she had been seen on November 28th. At that time the blood that had been drawn had

grown two types of very serious and virulent bacteria. She was advised to return to Defendants the next day.

15. On November 30, 2016 Plaintiff returned to the Defendants. Her wound was debrided, packed with gauze and dressed. She was given additional medications.

16. On the evening of November 30, 2016 Plaintiff went to the Medical University of South Carolina's Emergency Department. There it was noted that her right nipple was necrotic, and her right breast had an area with purulent drainage.

17. On December 3, 2016 Plaintiff presented at Health First with ongoing concerns and problems from her infected breast wounds.

18. Later on December 3, Plaintiff returned to the MUSC ED where she was admitted to the general internal medicine practice for treatment of her infected wounds.

19. Thereafter, Plaintiff has continued to have a difficult course, and has undergone multiple procedures for tissue removal as well as multiple courses of antibiotics. At this point, Plaintiff has not been able to have her breasts reconstructed, and has incurred over \$300,000 in medical expenses to date, and continues to need medical care.

20. Defendants acted in a negligent, reckless, willful and wanton manner and breached the standard of care in the following particulars:

- a. By interrupting the fragile vascularity that was left by the prior bilateral breast implant procedures;

- b. In failing to timely diagnose and recognize the infectious condition that was fulminating on November 7th and 8th in her left breast as an infection;
- c. In failing to appropriately treat her fulminating infection; and
- d. In such other particulars as the evidence and proof shall reveal.

21. Had there been no negligent, reckless, willful, and wanton acts and omissions constituting breaches of the standard of care, it is most probable that she would not have suffered the severe infection and loss of tissue that she did in both breasts, which made her condition such that she was forced to seek more extensive debridement and will need significant reconstructive surgery.

22. As a direct and proximate result of the Defendants' acts and omissions, Plaintiff has incurred more than \$300,000 in medical expenses to date, which amount is continuing to grow, she has suffered scarring and disfigurement, she has suffered mental anguish, great pain, and a significant loss of income; upon information and belief said injuries and resulting damages shall continue to accrue for the foreseeable future; all to her injury and damage in an amount to be determined by a jury.

Wherefore your Plaintiff prays that she recovers an amount of actual and punitive damages from the Defendants in an amount to be determined at the trial of this case, together with the costs and disbursements of this action.

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By


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ATTORNEYS FOR PLAINTIFF

April 20, 2018

) IN THE COURT OF COMMON PLEAS

) C.A. No.: 2018-CP-10-2109

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(Jury Trial Requested)

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- Record on Appeal - 026

6. As to the allegations contained in Paragraph 4 of Plaintiff's Complaint, the Defendants admit only that Plaintiff presented to Dr. Schimpf's office on or about July 8, 2015 to discuss complaints associated with macromastia and did report long-standing neck and upper back pain secondary to large, pendulous breasts that had been unrelieved by conservative measures and that she had breast implants. The Defendants are without information sufficient to admit or deny whether Plaintiff gave a complete medical history at this time and, therefore, deny the same and leave Plaintiff to her proof. Further responding, the Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her diagnoses, care and treatment.

7. As to the allegations contained in Paragraphs 5, 6, 7, 8 and 9 of Plaintiff's Complaint, the Defendants admit the same, but crave reference to the Plaintiff's medical records for a more complete and accurate account of her diagnoses, care and treatment.

8. As to the allegations contained in Paragraph 10 of Plaintiff's Complaint, the Defendants admit only that these allegations reflect a portion of the symptoms reported and treatment provided at that visit, and crave reference to the Plaintiff's medical records for a more complete and accurate account of her condition, diagnoses, care and treatment.

9. As to the allegations contained in Paragraph 11 of Plaintiff's Complaint, the Defendants deny the same as written and demand strict proof thereof. Further responding, the Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her diagnoses, care and treatment.

10. As to the allegations contained in Paragraph 12 of Plaintiff's Complaint, these allegations do not pertain to care provided by the Defendants and the Defendants are without information sufficient to admit or deny the allegations and therefore deny the same and leave Plaintiff to her burden of proof. Further responding, the Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her diagnoses, care and

treatment and to the extent these allegations differ from what is contained therein, the Defendants deny the same.

11. As to the allegations contained in Paragraph 13 of Plaintiff's Complaint, the Defendants admit only that these allegations reflect only a portion of the symptoms reported, the clinical findings and the treatment and recommendations provided at that visit. Further responding, the Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her condition, diagnoses, care and treatment.

12. As to the allegations contained in Paragraph 14 of Plaintiff's Complaint, the Defendants deny the same upon information and belief and demand strict proof thereof.

13. As to the allegations contained in Paragraph 15 of Plaintiff's Complaint, the Defendants admit only that these allegations reflect a portion of the symptoms reported and treatment provided at that visit, and crave reference to the Plaintiff's medical records for a more complete and accurate account of her condition, diagnoses, care and treatment.

14. As to the allegations contained in Paragraphs 16, 17, 18, and 19 of Plaintiff's Complaint, these allegations do not pertain to care provided by the Defendants and the Defendants are without information sufficient to admit or deny the allegations and therefore deny the same and leave Plaintiff to her burden of proof. Further responding, the Defendants crave reference to the Plaintiff's medical records for a more complete and accurate account of her diagnoses, care and treatment and to the extent these allegations differ from what is contained therein, the Defendants deny the same.

15. As to the allegations contained in Paragraph 20 (including all subparts a-d), 21 and 22 of Plaintiff's Complaint, the Defendants deny the same and demand strict proof thereof.

16. As to the allegations contained in the WHEREFORE paragraph of Plaintiff's Complaint, the Defendants deny the same.

WHEREFORE, having fully answered and denied the allegations of negligence in the Plaintiff's Complaint, the Defendants assert the following additional defenses:

ADDITIONAL DEFENSES

1. Plaintiff's Complaint fails to state a claim upon which relief can be granted against the 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 injuries complained of are a known complication of the procedure that are known to and, in this instance, did occur in the absence of negligence. Therefore, Plaintiff is barred from recovery against the Defendants.

3. The Plaintiff was properly informed about the potential risks, benefits and complications associated with the procedure at issue, and voluntarily accepted those risks and consented to undergo with this knowledge. Therefore, Plaintiff is barred from recovery against the Defendants.

4. That the care and treatment administered by the 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 the Defendants.

5. At the time under the circumstances of the occurrence of the incident described in the Complaint, the Defendants could not have foreseen or anticipated in the exercise of ordinary care the circumstances which arose and/or became evident immediately prior to the incident and, therefore, said incident was under the circumstances unavoidable so as to bar recovery against the Defendants.

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

7. Plaintiff's alleged injuries and damages may have been the result of an independent, intervening, and superseding cause over which the Defendants had no control. Any alleged action or alleged omission on the part of the Defendants was not the proximate cause of the alleged damages.

8. To the extent 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, then Plaintiff is not entitled to any recovery from the Defendants.

9. 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.

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

11. Plaintiff's alleged injuries and damages, if any, were caused in whole or in part by Plaintiff's 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 precluded and/or diminished proportionally according to Plaintiff's culpable conduct.

12. With respect to Plaintiff's demands for punitive damages, the 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 the 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 the 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 the Defendants.

Further, the 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.

13. Punitive damages are a punishment, a quasi-criminal sanction for which the 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.

14. That even if the Defendants were negligent as alleged in the Complaint, which is specifically denied, the acts of the Defendants are not the direct and proximate cause of Plaintiff's alleged injuries and damages, so as to bar the Plaintiff from recovery against the

Defendants.

15. To the extent allowed by law, the 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.

16. To the extent allowed by law, the 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.

17. To the extent allowed by law, the 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.

18. Plaintiff's recovery must be reduced and/or precluded to the extent Plaintiff has failed to properly mitigate her alleged damages.

19. The 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 reserves the right to amend this Answer to assert any such defenses.

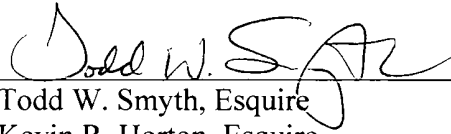
WHEREFORE, having fully answered the Plaintiff's Complaint and asserted the foregoing additional defenses, the Defendants respectfully request:

- (1) a trial by jury of twelve;
- (2) this Court to dismiss this matter with prejudice as to the Defendants and enter judgment in its favor and against Plaintiff; and
- (3) this Court to award the Defendants their costs and expenses, including attorney's fees incurred in this matter and grant whatever additional relief the Court deems appropriate.

[signature page to follow]

Respectfully submitted,

SMYTH WHITLEY, LLC

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

Todd W. Smyth, Esquire

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*Attorneys for Defendants Dennis K. Schimpf, M.D.
and Sweetgrass Plastic Surgery, LLC*

May 22, 2018
Charleston, South Carolina

**IN THE COURT OF COMMON PLEAS
STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON**

CIVIL ACTION NO.: 18-10-CP-2109

REBECCA TURISK,	)
	)
Plaintiff,	)
	)
vs.	)
	)
DENNIS K. SCHIMPF, M.D. and	)
SWEETGRASS PLASTIC	)
SURGERY, LLC,	)
	)
Defendants.	)
	)

**PLAINTIFF’S MOTION IN LIMINE TO EXCLUDE
CERTAIN EVIDENCE FROM TRIAL**

COMES NOW Plaintiff Rebecca Turisk, who, by and through undersigned counsel, and pursuant to South Carolina Rules of Evidence and applicable case law, moves this Court to exclude the following matters from the trial of this case:

1. Any testimony or other evidence concerning witness Mary Ackerman’s surgery performed by Defendant Dennis K. Schimpf, M.D.;
2. Any testimony or other evidence concerning Plaintiff’s comments or social media posts expressing dissatisfaction with medical providers other than Defendants;
3. Any evidence or testimony that Plaintiff is disabled;

4. Any testimony or other evidence concerning Plaintiff's use of pain medication, narcotics, or other opioids;
5. Any evidence or testimony concerning Plaintiff's symptoms, diagnosis, and treatment of fibromyalgia;
6. Any testimony or evidence suggesting that Plaintiff was immunocompromised;
7. Any evidence or testimony indicating that the source of Plaintiff's infection was fecal bacteria; and
8. Any testimony or evidence of the Plaintiff's informed consent of the risks involved with the surgical procedures at issue in this case.

BACKGROUND

This is a medical negligence case, and trial is currently set to begin November 14, 2022. Plaintiff alleges, among other claims, that: (1) Dr. Schimpf deviated from the standard of care while performing Plaintiff's bilateral breast implant removal and reduction mammoplasty on November 1, 2016, (2) wherein he interrupted the fragile vascularity that was left by the prior bilateral breast implant procedures, (3) resulting in Plaintiff contracting an infectious disease that escalated post-operatively, and (4) leading to necrosis of the tissue and an accrument of significant medical expenses in excess of \$500,000 for repeated treatment and care after the procedure. Plaintiff

filed a Notice of Intent to File Suit on January 8, 2018. Thereafter, when resolution was not reached, Plaintiff filed her Summons and Complaint on April 23, 2018.

LEGAL STANDARD

The first step in this Court's analysis concerning the admissibility of the evidence herein must, in each case, begin with a determination as to the relevancy of the evidence being offered and whether it has the "tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." S.C. R. EVID. 401. Several of the evidentiary issues discussed below, are, on their face, irrelevant to any of the facts or issues of consequence in this case. In those circumstances where the evidence discussed herein is arguably relevant, any probative value of such evidence is vastly outweighed by the risk of unfair prejudice, confusion of the issues, or misleading the jury and should, nevertheless, be excluded pursuant to S.C. R. EVID. 403.

ARGUMENT

I. Witness Mary Ackerman's surgery performed by Defendants should be excluded.

Mary Ackerman, who is expected to testify at trial, is a friend of Plaintiff's and helped provide care for Plaintiff after her surgery. Ms. Ackerman also had surgery performed by Defendant Schimpf prior to Plaintiff's surgery, and any

testimony or evidence concerning Ms. Ackerman's surgery should be excluded as inadmissible. Ms. Ackerman testified as follows at her deposition:

Q. So, were you involved in the process of discussing with [Plaintiff] getting a breast reduction? Is that something you all had talked about before the surgery at issue in this case?

A. Yes.

Q. And what was the nature of you all's discussion?

A. I had some surgery by Dr. Schimpf, and I actually recommended him.

Q. Okay. Were you satisfied with whatever procedure it was you had with Dr. Schimpf?

A. In general, I've been happy with it. I would say the breast reduction that I had, I'm not really thrilled with where the scars appear. He doesn't operate on the crease, he operates a little higher on the breast, so I can see my scars. I had my eyelids done and I'm very happy with that. So, I basically recommended him.

Q. And you wouldn't have recommended him if you didn't think that he had the clinical capability to take care of your friend, would you?

A. I wouldn't have.

Ackerman Dep. 26:17-27:13 (Ex. A).

Rule 402 of the South Carolina Rules of Evidence provides that "[e]vidence which is not relevant is not admissible." As noted above, this is a medical malpractice case wherein Plaintiff asserts that Defendants breached the standard of care by, *inter alia*, interrupting the fragile vascularity that was left by the prior bilateral breast implant procedures, thereby inhibiting Plaintiff's post-operative

healing capabilities. *See generally* Complaint. The issue in this case is whether Defendants deviated from the standard of care in the treatment of *Plaintiff*. Whatever surgery or medical treatment Ms. Ackerman received is not relevant to whether Defendants deviated from the standard of care in treating Plaintiff. Moreover, Ms. Ackerman testified that her surgery was a breast reduction, while Plaintiff underwent both implant removal and breast reduction. The two procedures require different techniques, approaches, and considerations. Any attempt to compare – directly or indirectly – the surgery performed on Ms. Ackerman to the surgery performed on Ms. Turisk would be comparing apples and oranges. As explained in *Hollman v. Woolfson*, 384 S.C. 571, 579, 683 S.E.2d 495, 499 (S.C. 2009), “evidence relating to treatment of . . . nonparty patients is irrelevant to [a plaintiff’s] negligence claims in that it cannot be used to show [the defendants] breached the standard of care with a particular patient.” Had Ms. Ackerman suffered an unfavorable result from her surgery by Dr. Schimpf, Defendants would likely agree that such testimony or evidence is irrelevant.

Indeed, as the Court of Appeals stated in *Faile v. Bycura*, 297 S.C. 58, 62, 374 S.E.2d 687, 689 (S.C. Ct. App. 1988), where the issue is negligent performance of a surgery, “evidence of other cases where the physician correctly performed the procedure would not be relevant to a particular case where negligent performance was alleged.” Just as Defendants would oppose the introduction of evidence of other

allegations or findings of medical negligence for the purpose of suggesting a similar breach of the standard of care in Plaintiff's case, the inverse must also be true; a similar, yet distinct, surgical procedure with a positive outcome cannot be used as evidence to suggest that Plaintiff's injuries must have somehow been her fault, rather than Defendants'. Accordingly, any and all evidence related to Ms. Ackerman's surgery should be excluded because it is irrelevant to the claims and defenses in the present case and would potentially mislead the jury.

II. Plaintiff's comments or social media posts expressing dissatisfaction with medical providers other than Defendants should be excluded.

Plaintiff had surgery on her back at Southeastern Spine Institute in 2008 and 2009. In 2013, she subsequently posted on the practice's social media page certain issues with the practice and the care she was receiving there. *See* SSI_00882 to 00883 (Ex. B, redacted to omit personal identifiers). Any testimony or evidence concerning Plaintiff's dissatisfaction with medical providers other than Defendants is irrelevant and should be excluded from evidence. *See* S.C. R. EVID. 401; S.C. R. EVID. 402. Plaintiff's dissatisfaction with prior, unrelated medical treatment she received does not have any tendency to make any fact of consequence in this case more or less probable; it is not relevant to whether Defendants breached the standard of care in treating Ms. Turisk and is irrelevant to the damages that she claims.

Furthermore, this evidence should be excluded pursuant to Rule 403 of the South Carolina Rules of Evidence because any probative value associated with Ms.

Turisk's dissatisfaction with a previous medical provider at a *separate* practice *more than five years before* filing the present action is substantially outweighed by the danger of unfair prejudice, as it could lead a jury to believe Ms. Turisk has unreasonable expectations and would be unhappy with any medical care she received, even if such treatment met the standard of care.

III. Plaintiff's status as disabled should be excluded from evidence.

Plaintiff has suffered from a disability since 2012 as a result of a lower back injury. The fact that Plaintiff is disabled is not relevant to whether Defendants violated the standard of care in treating Plaintiff. Furthermore, this evidence has no bearing on the damages in this case, as Plaintiff is not seeking damages for lost income or loss of earning capacity. Finally, this evidence should be excluded pursuant to Rule 403, as any probative value is substantially outweighed by the risk of unfair prejudice, confusion of the issues, and/or misleading the jury. There is a risk that the jury may view Ms. Turisk's status as disabled as "milking the system" or that the jury may conflate the very real and separate injuries related to her breast surgery as somehow related to or exacerbated by her preexisting disability.

IV. Plaintiff's use of pain medication, narcotics, or other opioids should be excluded.

Several years prior to the surgery at issue in this case, Ms. Turisk suffered a serious injury to her back; she underwent a partial corpectomy/discectomy in 2008 and a cervical fusion surgery in 2009. In fact, her back pain is the underlying reason

for her disability discussed above. Over the course of managing her back pain, Plaintiff has taken and tried several pain medications, at times including opioids and morphine, as prescribed by her physicians in an effort to arrive at a medication regimen that was effective at alleviating her back pain.

Plaintiff's use of pain medications, and particularly opioids and narcotics, should be excluded from evidence. Use of these medications – especially prior to the surgery at issue – bears no relevance as to whether Defendants breached the standard of care in treating Plaintiff. It is very clear from Plaintiff's records that she suffered from preexisting back pain which required management with medication, and Plaintiff's only allegation regarding her back relates to the necessity of replacing her spinal stimulator following its motor burning out due to her many breast surgeries. Turisk-ECMC-0584 to 0585, Ex. O, redacted to omit personal identifiers. Other than this isolated incident, Plaintiff makes no allegation that this preexisting back pain was caused or exacerbated by the injuries that she suffered from the surgery performed by Dr. Schimpf. As such, Plaintiff's use of pain medications has no bearing on the damages of her case. The scarring and disfigurement of Ms. Turisk's breasts at the November 1, 2016, surgery are completely distinct from the pain associated with her back injuries. Moreover, Dr. Schimpf was well aware of the medications Plaintiff was taking prior to the procedure, and Plaintiff's use of pain

medication does not have any tendency to make the existence of any fact that is of consequence more or less probable.

Rule 403 of the South Carolina Rules of Evidence “requires a court to exclude relevant evidence upon a showing that its admission would be more prejudicial than probative.” *Jamison v. Ford Motor Co.*, 373 S.C. 248, 269, 644 S.E.2d 755, 766 (S.C. Ct. App. 2007) (quotation marks and citation omitted). “Unfair prejudice means an undue tendency to suggest [a] decision on an improper basis.” *State v. Spears*, 403 S.C. 247, 253, 742 S.E.2d 878, 881 (S.C. Ct. App. 2013) (quotation marks and citation omitted).

If there is any probative value attributed to evidence of Ms. Turisk’s use of pain medications, and there is not, it is substantially outweighed by the risk of unfair prejudice, confusion of the issues, and/or misleading the jury. Ms. Turisk takes her medication as prescribed by her physicians. However, due to the widespread prevalence of opioid addiction throughout the country and recent media attention surrounding opioid litigation, any evidence or testimony regarding Ms. Turisk’s use of pain medication, especially opioids and/or narcotics, is likely to attach a negative stigma to her character that a jury will nonetheless consider, regardless of whether the medications are or have been taken solely according to prescribed instructions for a condition unrelated to the injuries claimed.

Therefore, because the evidence and testimony of Ms. Turisk’s regular use of pain medication, narcotics and opioids is not relevant to the standard of care or the damages associated with Ms. Turisk’s breast injuries and such evidence is also highly prejudicial and likely to mislead or confuse the jury, it should be excluded from evidence and deemed inadmissible. *See Dailey v. Hecht*, 757 F. App’x 664, 669 (10th Cir. 2018) (affirming district court’s exclusion of opioid use, noting the “probative value of this evidence is substantially outweighed by the prejudicial impact such evidence would have, given the negative connotations surrounding opioid use. Evidence of drug use—including prescription drug use—carries the risk that a jury could make negative assumptions about the party or the party’s character.” (citations omitted)).

V. Plaintiff’s fibromyalgia should be excluded from evidence.

Plaintiff was diagnosed with fibromyalgia in 2008, and when asked how it affects her, she stated that she has “body aches and pains.” Turisk Dep. 62:2-63:14, Ex. C. She testified that she takes Cymbalta regularly for that condition and that she “ha[s] it pretty much under control.” *Id.* at 63:7-64:21. She stated that she has flare-ups of her fibromyalgia approximately three times a year and takes prednisone when that happens. *Id.* at 63:25-65:5.

Similar to Plaintiff’s disability status for back pain, Plaintiff’s fibromyalgia has no bearing on the present medical malpractice claim. This evidence is irrelevant

because Plaintiff was diagnosed with fibromyalgia long before the surgery at issue, she testified in her deposition that it was under control, and Plaintiff has not claimed Defendants' treatment exacerbated her fibromyalgia symptoms. Moreover, such evidence should be excluded pursuant to Rule 403, as any probative value is substantially outweighed by the danger of confusing and/or misleading the jury, again by potentially conflating Plaintiff's fibromyalgia symptoms with those caused by her breast surgery.

Plaintiff's rheumatologist, Dr. Gary Fink, was questioned as to whether fibromyalgia patients generally don't do well with surgery:

Q. Okay. And you said that fibromyalgia patients don't typically do as well with any kind of surgery. Is there a particular reason for that, or is that just based on your experience in seeing them?

A. No. I think that's documented in the literature, and when you go and you listen to orthopaedic surgeons and other doctors talk about procedures, you know, that's frequently mentioned. And it may just because of the fact that the stress of the surgery is another stress. Fibromyalgia is a stress-influenced condition. Patients with fibromyalgia tend to have a very low pain threshold, in my experience. And so there's, obviously, discomfort associated with -- with surgery that can sort of, you know, get the whole pattern of hurting and discomfort, you know, worse for a period of time, but not -- but not with -- not with infection. There is not an increased risk of in -- you know, an infection in the knee or, you know, in the hip or in the back. It's more of just the subjective, how patients, you know, feel in terms of their recovery, how much discomfort they report.

Fink Dep. 19:6-20:5 (Ex. D).

Although Dr. Fink made it clear that any alleged patient difficulty from surgery associated with fibromyalgia would relate to a fibromyalgia patient's

perception of post-operative pain, rather than a systemic increased risk of infection, such evidence is highly likely to confuse the jury and lead them to believe that Ms. Turisk, just by nature of having fibromyalgia, would be at greater risk of post-surgical complications – something that the evidence simply does not support. In fact, Dr. Fink stated earlier in his deposition that he does not believe that infection is associated with fibromyalgia and that he saw no contraindication for Plaintiff having a breast implant removal and breast reduction surgery. Fink Dep. 18:23-19:5¹; 17:20-23. *See, e.g., Agan v. BNSF Ry. Co.*, Civ. A. No. CV 19-83-BLG-SPW, 2022 U.S. Dist. LEXIS 155388, at *27-28 (D. Mont. Aug. 26, 2022) (excluding evidence of “unrelated medical issues,” stating, “Discussion during trial will be cabined to the injuries claimed and directly flowing from the accident at issue. Evidence of other, unrelated medical issues would be irrelevant and misleading.”).

VI. Testimony or evidence suggesting that Plaintiff was immunocompromised should be excluded from evidence.

Over the course of depositions taken prior to the trial of this case, Defendants have repeatedly introduced into evidence or attempted to elicit testimony that Plaintiff was immunocompromised at the time of her surgery performed by Dr.

¹ “Q. Has -- to your knowledge, has Ms. Turisk had a history of infections, or is that something that comes along with the fibromyalgia or is that –

A. No, I don't -- I don't think infection associates with fibromyalgia, but I think infection associates with that particular procedure.”

Schimpf and that her alleged immunocompromised state inhibited her ability to heal and fight the infections that she developed post-operatively. This suggestion is based, in part, on Plaintiff's intermittent use of steroids and diagnosis of adrenal fatigue. While at first glance, the evidence seems relevant, a closer look at the underlying facts of the case belies this portrayal of the evidence.

First, pursuant to the instructions provided to her by Dr. Schimpf's nurse, Plaintiff provided a hand-written list of the medications she was taking at the time of her November 1, 2016, surgery, which did not include any steroids. Turisk-SwtgrsPlasSur-0011 (Ex. E, redacted to omit personal identifiers and phone numbers). Further, Plaintiff testified that she was not taking Prednisone when she had her breast surgery by Dr. Schimpf. Turisk Dep. 64:19-21. Defendants consistently attempt to conflate her oral and injectable steroid use, painting both as equally likely to cause an increased risk of infection and difficulty healing, and portraying Plaintiff as "prone to infection." Herrera Dep. Oct. 24, 2022 at 99:8, Ex. F.

Q. You are aware that Ms. Turisk also has adrenal insufficiency and requires steroids for that?

A. Correct.

Q. And are steroids known to suppress the immune system's response to antibiotics?

A. I believe so.

Q. And that can make it harder to fight infections?

A. Yes.

Id. at 99:13-22.

Again, Plaintiff's rheumatologist, Dr. Gary Fink, distinguishes a patient's risk of infection associated with steroid injections versus oral steroids, noting "the general risk of infection with typical steroid injections is absolutely negligible and... not really a problem. Where it could be -- become a problem is if someone is getting multiple steroid injections from either the same doctor or from different doctors, you know, perhaps right before a procedure.... But even -- even then, the likelihood of infection is low." Fink Dep. 36:14-24. Dr. Fink also acknowledged that Ms. Turisk had no prior history of infections. *Id.* at 18:23-19:3.

Second, Dr. Schimpf, as well as his own experts, discounted the effect that Plaintiff's adrenal fatigue and associated oral steroid use would have had on Ms. Turisk's ability to heal. Defendants' records from October 31, 2016—one day prior to her surgery—note that Ms. Turisk "has adrenal fatigue." Turisk-SwtgrsPlasSur-0016, Ex. G, redacted to omit personal identifiers. Dr. Schimpf testified during his deposition that nothing on this form indicated Plaintiff would have complications. Schimpf Dep. 74:14-25, Ex. H. As to the adrenal fatigue, he stated such "folks are generally dosed with a small amount of steroid before the surgery or during the surgery." *Id.* at 75:1-9. When asked whether any of the medications she was taking

interfered with her healing, he noted she was on a low-dose steroid and stated, “At that dose it’s kind of questionable what kind of affect it has, especially on somebody that’s been on it for a long period of time, whether or not it does, but there is some question of it in some instances if it can affect it.” *Id.* at 140:20-142:6. He noted the dose was “pretty low” and that he knew what she was taking prior to the surgery and allowed Plaintiff to stay on that medication. *Id.* When asked if this “low” dose had “anything to do with her complications after the surgery,” he said that he did not know and that “if it were a large dose that she were on, [he] would have been more concerned.” *Id.* at 140:20-142:23.

Defendants’ suggestion that Plaintiff’s “bad result” is due to her prescription steroid use or adrenal fatigue is not supported by the evidence and should be excluded pursuant to Rule 403. Dr. Schimpf was aware of Plaintiff’s recurrent steroid use; he did not direct her to discontinue any use of this medication and noted the dosage was low. No one in this case, expert or otherwise, has testified that Plaintiff’s use of steroids had any relation to the complications she suffered, despite repeated attempts to elicit such testimony by counsel for Defendants.

Instead, the evidence indicates the disruption of Plaintiff’s vasculature was the cause of her complications; Defendants’ expert Dr. Joseph testified that “once there is vascular insufficiency to adipose tissue, the result is fat necrosis,” and there was no point in time—to his knowledge—that “this yearlong process could have

been stopped.” Joseph Dep. 21:7-15, Ex. I. In his deposition, Dr. Lefkowitz agreed when asked whether he thought “that the patient did anything to cause or contribute to the outcome she’s had”; he stated, “Nothing that I saw or would be concerned about.” Lefkowitz Dep. 21:17-20, Ex. J.

Accordingly, any testimony or evidence suggesting that Plaintiff suffered from adrenal fatigue, was immunocompromised as a result of her taking prescription steroid medication, or that Plaintiff’s injuries were caused by her use of steroids, should be excluded pursuant to Rule 403, as whatever minimal probative value it has is substantially outweighed by the danger of unfair prejudice, confusion of the issues, and/or misleading the jury.

VII. Evidence or testimony indicating that the bacterial source of Plaintiff’s breast infections included enterococcus faecalis should be excluded from evidence.

During her treatment for her post-operative breast infections, the wounds on Ms. Turisk’s breasts were cultured, and the results revealed the presence of three forms of bacteria: *Acinetobacter baumannii*/haemol², *enterococcus faecalis* and MSSA, the sensitive form of *staph aureus*³ bacteria. Herrera Dep. Oct. 28, 2019 at 14:5-25, Ex. K. Dr. Schimpf was asked during his deposition where “the Enterococci Bacteria came from,” and he stated, “[Ms. Turisk] grew, if I remember correctly,

² *Acinetobacter baumannii*/haemol is an opportunistic bacterial pathogen primarily associated with hospital-acquired infections. It may ... cause ... surgical wound infections. *Virulence*. 2012 May 1; 3(3): 243–250 (Exhibit M).

³ *Staph aureus* also causes wound infections. BMC Infect Dis. 14:328; 2014 (Exhibit N).

Fecalysis [sic] -which is feces-based-so it has something to do with stool, either washing hands or whoever was helping her wasn't washing hands or contaminating somehow." Schimpf Dep. 155:3-17. During a line of questioning in Dr. Herrera's 2022 deposition, defense counsel insinuates that Ms. Turisk suffered infections after her surgery because she allegedly had poor hygiene. Herrera Dep. Oct. 24, 2022 at 97:7-98:25.

Evidence or testimony indicating that the source of Plaintiff's infection was fecal bacteria should be excluded from evidence pursuant to Rule 403. The type of bacteria growing in Plaintiff's wound is of little probative value on the facts of this case, as there is no dispute from either Plaintiff or Defendants that Ms. Turisk developed a post-operative infection by three different bacteria in her breasts. First, Plaintiff's culture did not reveal the presence of *only* enterococcus faecalis; the culture also revealed MSSA bacteria and Acinetobacter baumannii/haemol, each capable of causing the extreme infection she did suffer. Second, the expert evidence in this case reveals that bacteria growth was unavoidable once the blood flow to the area had been compromised. One of Defendants' experts, Dr. Joseph, testified during his deposition that "[v]ascular insufficiency lead[s] to necrosis. Necrotic tissue has no immune system. And so it—there is no way to prevent bacterial invasion." Joseph Dep. 35:5-7. He stated that "once there is vascular insufficiency to adipose tissue, the result is fat necrosis," and there was no point in time—to his knowledge—that

“this yearlong process could have been stopped.” *Id.* at 21:7-15. He stated, “This is the usual, drawn out case of an infection complicating fat necrosis.” *Id.*

Finally, there is no evidence to support Defendants’ suggestion that Ms. Turisk’s infections resulted from poor hygiene. Defendants’ expert in infectious diseases, Dr. Joseph, stated he had no criticism of anything Ms. Turisk or her caretakers “did or failed to do.” *Id.* at 13:23-14:4. Defendants’ expert Dr. Lefkowitz agreed; in his deposition, he was asked whether he thought “that the patient did anything to cause or contribute to the outcome she’s had”; he stated, “Nothing that I saw or would be concerned about.” Lefkowitz Dep. 21:17-20. Mr. Long, one of Plaintiff’s caretakers, testified during his deposition that he “had to change [Ms. Turisk’s] bandages” and that he was taught to use rubber gloves, presumably to prevent contamination of her wounds. Long Dep. 54:5-10, Ex. L.

While the fact that Plaintiff suffered from an infection is relevant, the type of bacteria is of little—if any—probative value, particularly in light of the fact that two other different types of bacteria were also present. However, the prejudicial effect and the likelihood to confuse and mislead the jury are enormously high when counsel for Defendants will claim, either outright or by insinuation, that Plaintiff and/or her caregivers were essentially dirty, filthy people who failed to wash their hands and brought this on Plaintiff as a result.

VIII. Plaintiff's informed consent of the risks involved with the surgical procedures at issue in this case should be excluded.

Plaintiff asserts Defendants breached the standard of care while performing Plaintiff's implant removal and reduction mammoplasty; this case does not involve a claim of lack of informed consent. The informed consent form and the testimony described herein should be excluded ahead of trial in order to prevent the jury from being exposed to unfairly prejudicial and misleading evidence because such evidence is highly likely to be perceived by the jury as an assumption of the risk. Pursuant to Rules 401 and 402 of the South Carolina Rules of Evidence, the informed consent form and testimony regarding such consent are irrelevant to the matters at issue because Plaintiff does not allege lack of informed consent, and the informed consent form and testimony does not have any tendency to make material facts at issue more or less probable. Further, pursuant to Rule 403, evidence of informed consent should not be presented at trial, as it is likely to mislead and confuse the jury.

Here, Plaintiff was required to sign and initial informed consent forms, stating she understood the risks of the medical and surgical procedures she was undergoing. Amongst the various risks and complications associated with the surgery and procedures at issue included scarring, dissatisfaction with outcome, and risk of infection. However, Plaintiff is not alleging there was a lack of informed consent. Thus, any evidence concerning informed consent is irrelevant because the forms or

any other evidence of consent do not make Defendants' actions or omissions falling below the standard of care any more or less probable. Additionally, the introduction of such forms and any other evidence of consent would only serve to confuse and mislead the jury against Plaintiff by suggesting Ms. Turisk consented to all risks and complications that may arise from the implant removal and reduction mammoplasty, even if Defendants' negligence caused those complications. Plaintiff was not informed of, nor did she consent to, the surgical approach that Defendant Schimpf would take, nor that it was an incorrect approach.

In the context of medical negligence cases, in a sister state case, the Virginia Supreme Court found consent is irrelevant and non-admissible in *Wright v. Kaye*, 593 S.E.2d 307 (Va. 2004). Reversing the trial court's decision to deny plaintiff's motion in limine to exclude evidence of pre-operative discussions concerning the risks of surgery, the Virginia Supreme Court held "evidence of information conveyed to [the plaintiff] concerning the risks of surgery in obtaining her consent is neither relevant nor material to the issue of the standard of care." *Wright*, 593 S.E.2d at 317. It has no relevance to causation. *Id.* Not only did the *Wright* court find no probative value in the pre-operative discussions, but also found "awareness of the general risks of surgery is not a defense available to [defendant] against the claim of a deviation from the standard of care." *Id.*

Additionally, the court in *Hayes v. Camel*, 927 A.2d 880 (Conn. 2007), found evidence of a plaintiff's consent "'could only serve to confuse the jury because the jury could conclude, contrary to the law and evidence, that consent to the surgery was tantamount to consent to the injury which resulted from that surgery.'" 927 A.2d at 889 (quoting *Wright*, 593 S.E.2d at 317). Moreover, a jury "could conclude that consent amounted to a waiver, which is plainly wrong." *Hayes*, 283 Conn. at 486. Essentially, while a plaintiff "'may consent to risks, [they] do not consent to negligence.'" *Id.* (quoting *Wright*, 593 S.E.2d at 317). The *Hayes* court stated, "[A]lthough evidence of the risks of a surgical procedure is relevant in the determination of whether the standard of care was breached, it was unduly prejudicial to admit such evidence in the context of whether and how they were communicated to the plaintiff." *Id.* at 890.

South Carolina recognizes a distinction between malpractice for negligence in the performance of a procedure and malpractice for failure to obtain informed consent. *See, e.g., Fletcher v. Med. Univ.*, 390 S.C. 458, 462-70, 702 S.E.2d 372, 374-78 (S.C. Ct. App. 2010). The instant case simply does not involve an informed consent claim. Both the informed consent forms and evidence of informed consent are wholly irrelevant to the claims against Defendants because there is no assertion that there was a lack of informed consent. Rather, Ms. Turisk's claims are directly related to Defendants' failure to provide the required standard of care, regardless of

the knowledge or consent of general risks. Even if evidence concerning the general risks of the procedures is relevant, this evidence need not be admitted under the guise of informed consent, as doing so risks unfairly prejudicing Ms. Turisk, confusing the issues, and misleading the jury.

As stated in *Hayes*, patients do not consent to negligence when they consent to a medical procedure. Similarly, Ms. Turisk may have consented to general risks of the procedures, but she certainly did not consent to negligent and inadequate care. Admitting evidence of Ms. Turisk's "informed consent" to the general risks of the surgical procedures would greatly prejudice her and confuse and mislead the jury to believe such consent was tantamount to consenting to the subsequent injuries, even if those injuries were caused by Defendants' negligence. The repeated mention of or production of evidence of "consent" would open a Pandora's box of incorrect conclusions by the jury to erroneously determine the injuries suffered by Ms. Turisk were of the "general risk" sort and fail to properly distinguish the connection between Dr. Schimpf's negligent actions and proximate cause of those actions. Such evidence should be excluded.

CONCLUSION

For the reasons set forth above, Plaintiff requests that this Court grant the present Motion in Limine, and preclude Defendants from introducing into the record the evidence described herein or eliciting testimony concerning such evidence.

Plaintiff also requests that counsel be required to instruct witnesses prior to testifying as to the inadmissibility of such evidence.

Respectfully submitted,

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s:/ Mark C. Tanenbaum

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ATTORNEYS FOR PLAINTIFF

November 11, 2022

EXHIBIT A

1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
2 COUNTY OF CHARLESTON) CASE NO. 2018-CP-10-2109
3
4 Rebecca Turisk,)
5 Plaintiffs,)
6 -vs) DEPOSITION
7 Dennis K. Schimpf, M. D.) OF
8 And Sweetgrass Plastic) Mary Ackerman
9 Defendants.)
10
11 DATE: Thursday, August 8, 2019
12 TIME: 12:33 P.M.
13 LOCATION: Mark C. Tanenbaum, PA
14 1017 Chuck Dawley Blvd
15 Suite 101
16 Mt. Pleasant, SC 29464
17 REPORTER: Lisa Kerns
18 Professional Court Reporter
19
20 -----
21 RES COURT REPORTING SERVICES
22 243 NELLIEFIELD CREEK DRIVE
23 CHARLESTON, SC 29492
24 (843) 818-9396
25 (843) 654-9534
LISAKERNS.CRS@GMAIL.COM

1 just didn't want to work that much.

2 Q. Yeah. Did you work as a paid employee?

3 A. Yes.

4 Q. Does Ms. Turisk work on the landscape lot?

5 A. No.

6 Q. Okay.

7 A. She goes out to the front office periodically;
8 she goes outside and maybe weeds some flowers but that's
9 about it.

10 Q. When you first met her was she was working on
11 the landscape lot?

12 A. No. I think they had employees working at the
13 different, they had two different businesses --

14 Q. Right.

15 A. -- at the time she was married so, they had
16 employees that worked there.

17 Q. So, were you involved in the process of
18 discussing with her getting a breast reduction? Is that
19 something you all had talked about before the surgery at
20 issue in this case?

21 A. Yes.

22 Q. And what was the nature of you all's
23 discussion?

24 A. I had had some surgery by Dr. Schimpf, and I
25 actually recommended him.

1 Q. Okay. Were you satisfied with whatever
2 procedure it was you had with Dr. Schimpf?

3 A. In general, I've been happy with it. I would
4 say the breast reduction that I had, I'm not really
5 thrilled with where the scars appear. He doesn't
6 operate on the crease, he operates a little higher on
7 the breast, so I can see my scars. I had my eyelids
8 done and I'm very happy with that. So, I basically
9 recommended him.

10 Q. And you wouldn't have recommended him if you
11 didn't think that he had the clinical capability to take
12 of your friend, would you?

13 A. I wouldn't have.

14 Q. And what was your understand for why she
15 wanted that breast reduction?

16 A. Because her breast were hurting her back. She
17 had back pain from, they were pretty large, and she had
18 implants.

19 Q. Right. Prior to this surgery, what was your
20 understanding of her health history, generally?

21 A. I didn't know a lot about it. I know she had
22 a stimulator for back pain.

23 Q. Right.

24 A. And she'd talk about that every so often and
25 it wasn't working right.

EXHIBIT B

TURISK, REBECCA

January 22, 2013

Ms. Turisk comes in today for a follow-up visit on January 22, 2013. She has a diagnosis of lumbar radiculitis, degenerative disc disease and fibromyalgia and she states "I'm bad." She is having pain in her neck and her upper extremities as well as her low back and her legs. She describes it as dull, aching and numbing. She rates it as a 10/10 on the Numeric Analog Scale. It is worse with sitting, standing, increased activity, long periods and arm use. It is better with rest, meds and walking.

Review of Systems: She has neck and back pain. She endorses some numbness as stated above in her arms. She denies any chest pain, shortness of breath, GI or GU incontinence, weakness or fever.

Past Surgical/Medical History: Reviewed and unchanged.

Social History: The patient does not smoke, drink alcohol or smoke marijuana. She is married and her husband does accompany her to the visit today.

Allergies: She has no known drug allergies.

She is not on a blood thinner.

Her last procedure was a C6-C7 cervical epidural on 10/30/12, which gave her about 50% relief.

Current Medication: We had to change her Roxicodone to Opana ER 10 mg and Opana 10 mg q. day. I did do a conversion at the last visit with a 50% cross tolerance. She states that this medicine makes her feel like an elephant is sitting on her chest and that she is a zombie and she doesn't really feel well. She also takes Celebrex, which she hasn't taken in a while and she is very frustrated because she states that she had Zipsor approved; however, we would not fill out the paper work which I assured her was not true. She also takes Ambien, Backofen and Flector patches and these do help her pain somewhat.

Vital Signs: Height 5'4, weight 180, blood pressure 158/91, pulse 101, oxygen saturation 96% on room air.

Physical Examination: On exam, she is a well-developed, well-nourished female who is well-groomed with a normal affect. She is emotional. She has 5/5 strength in her right upper extremity and 4/5 strength in her left upper extremity. Grip strength is 4/5 and equal bilaterally. She has positive cervical loading bilaterally. Her muscle tone is normal. The patient does ambulate into our clinic today with an antalgic gait, alert and oriented x 3 and cranial nerves II through XII are grossly intact.

Assessment:

1. Lumbar radiculitis.
2. Lumbar degenerative disc disease.
3. Fibromyalgia.

Plan:

1. She was selected for a random urine drug screen today, which we are happy to perform.
2. After a lengthy discussion, Ms. Turisk is very frustrated with our office. She is very frustrated with the communication.

(Continued)

SSI_00882

TURISK, REBECCA

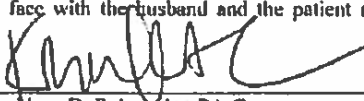
January 22, 2013

Page 2

She is very frustrated with the fact that we are no longer writing Roxicodone 30 mg. She states that this is the only thing that worked for her and she wants to go back to Dr. Poletti because he has done surgery on her and he will write her this medicine. I did explain to her that her last scan, which we did review today, was in September 2011 and I would be more than happy to get another cervical MRI with and without contrast with 3D imaging to evaluate her for possible surgery, and the patient stated that she wants Dr. Poletti to order this, Dr. Poletti to see her, and Dr. Poletti to talk to her and write her medicines. She "wants to go back to the Southeastern Spine Institute." I explained to Ms. Turisk that I was informed that she did write on the Southeastern Spine Institute Facebook wall how unhappy in so many words she was with our practice. I do try to treat my patient's the way that I would like for my mother or grandmother to be treated, and if they were as unhappy as she seemed to be with our practice, I felt that her care would be best served elsewhere and that I would be more than happy to treat her and help her. I do care about her pain and her pain control. Her husband seemed to be agreeable to this and the patient did just cry. We would like to get an MRI; however, after we did order this MRI Ms. Turisk somehow contacted Dr. Poletti's office and wanted Dr. Poletti to order a scan and have him review it, which in fact I did tell them that we did order this scan.

3. We did discuss her medicines at length today. We did discuss that we would not know that the Opana did not work for her if we didn't try it. She was very disgusted that the Opana was very hard to find, which I did give it to her a great length in advance for her to find it. We have had much success on this medicine with other patients, therefore, I thought it may work for her; however, it has not so we discussed going to Methadone. We discussed going to MSIR and to Morphine, MS Contin and to OxyContin as well. However, the patient does not want to do any of these. She is not really willing to comply with any medicines except her husband did suggest that we go to Roxicodone 15 mg. They ask that we write 8 and I did explain to them that that was too many to write. They then asked if we would write 6 this month to bridge her; however, I did state that Dr. Richardson would prefer her not to be on any narcotics; however, the most that I feel comfortable writing is 4 for her to take as I am scared that she may take more than that. I offered her some Clonidine to take this month for the next two weeks to help her with any withdrawal and she did seem agreeable to this. We would also like to write her some Phenergan to help her with any nausea or withdrawal that she may be having. We will have her return to the clinic in four weeks for follow-up. If she would like to reassess her medicines I hope that she does get the scan during this time so that we may send it to Dr. Poletti and have an answer for her at the next visit or hopefully before.

My supervising physician Dr. Mark Netherton has reviewed this plan and is in agreement. It is of note that I did spend greater than 45 minutes face to face with the husband and the patient regarding her treatment plan and diagnosis.



Kathleen D. Bukowsky, PA-C

KDB/pr
T-2/1/13

SSI_00883

EXHIBIT C

1
2 STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

3 COUNTY OF CHARLESTON

4 REBECCA TURISK,

5 Plaintiff,

6 vs. CASE NO. 2018-CP-10-2109

7 DENNIS K. SCHIMPF, M.D. and SWEETGRASS PLASTIC
8 SURGERY, LLC,

9 Defendants.
10
11
12

13 DEPOSITION OF: REBECCA CUZICK TURISK

14 DATE: February 13, 2019

15 TIME: 10:00 a.m.

16 LOCATION: 1037 Chuck Dawley Boulevard,
17 Building A
Mt. Pleasant, SC

18 TAKEN BY: Counsel for the Defendants

19 REPORTED BY: Roxanne Easterwood, RPR
20
21
22
23
24
25

1 if we can cover a few of the others.

2 Fibromyalgia, when were you diagnosed with that?

3 A. Shortly after my back surgery in 2008.

4 Q. Who made that diagnosis? Was that Dr.
5 Poletti?

6 A. Dr. Fink, F-I-N-K, University
7 Boulevard, North Charleston.

8 Q. What is his specialty?

9 A. Rheumatoid arthritis.

10 Q. So he's a rheumatologist?

11 A. Rheumatologist, yes, sir.

12 Q. Is he someone that you continue to see
13 on a regular basis?

14 A. I continued to see him until this past
15 year, and I transferred over to my primary care.

16 Q. That would be Ms. Pinckney?

17 A. Yes.

18 Q. I think I saw in the records, she's a
19 nurse practitioner, right?

20 A. Yes.

21 Q. Was Dr. Fink serving as your internal
22 medicine doctor prior to that?

23 A. Yes, sir.

24 Q. You started treating with him in 2008?

25 A. Yes, until I guess 2017 or '18. He's

1 becoming older, so. I'll leave it at that.

2 Q. Okay. Did you have any problems with
3 Dr. Fink?

4 A. I felt like he wanted to talk about
5 politics more than anything else. Other than
6 that, he is a fine doctor.

7 Q. How does the fibromyalgia affect you?

8 A. I have body aches and pains.

9 Q. Is that a daily occurrence?

10 A. I have it pretty much under control.
11 So as long as I watch myself. You know, don't
12 have too much stress. I watch my sugar intake,
13 and I watch what I eat. And I just do not overdo
14 it.

15 Q. I think you told me you take Cymbalta
16 for that condition?

17 A. I do.

18 Q. Anything else?

19 A. For that condition?

20 Q. Right.

21 A. No, sir.

22 Q. You said you have it under control
23 now. How long do you believe you've had it under
24 control?

25 A. I have flare-ups of it. I still deal

1 with it every day, but I have it to where I can
2 live with it and where I feel like I'm more in
3 charge than it is in charge.

4 Q. How often do you have the flare-ups?

5 A. Maybe three times a year.

6 Q. What do you do when you have a
7 flare-up?

8 A. Usually a round of prednisone,
9 steroids, just take it easy.

10 Q. When you say a round of steroids or
11 prednisone?

12 A. A long dose of prednisone.

13 Q. How long?

14 A. Usually about 14 days.

15 Q. How often do you take steroids or
16 prednisone?

17 A. Maybe three times a year, when I have
18 flare-ups.

19 Q. Were you taking prednisone in 2016
20 when you had this surgery?

21 A. No, sir.

22 Q. Am I gathering correctly then that you
23 only use the prednisone when you're having an
24 active flare?

25 A. Yes, sir. That's the only one that's

1 prescribed to me when I have an active flare.

2 Q. Anything else that you use to treat
3 the fibromyalgia?

4 A. No, sir.

5 Q. Was the fibromyalgia part of the basis
6 for your disability rating?

7 A. Yes, sir.

8 Q. Do you have a history of it in your
9 family?

10 A. No, sir.

11 Q. Has anybody ever told you what they
12 thought caused it or what it was related to?

13 A. It was the trauma from the spinal
14 operation.

15 Q. Let's talk about the spine next. You
16 said you injured your back playing racketball?

17 A. Uh-huh. Yes, sir.

18 Q. Did you damage discs? How did you
19 injure it?

20 A. I do not remember exactly how I
21 injured it. I mean, I was reaching for a ball
22 that was out of my reach and tore I think it's two
23 discs in my back.

24 Q. I think you told me you had a cage
25 placed in your back?

EXHIBIT D



Deposition of:
Gary E. Fink , MD

November 1, 2019

In the Matter of:
**Turisk, Rebecca v. Dennis K Schimpf,
MD, et al**

A. William Roberts, Jr & Assoc.
800-743-3376 | calendar-awr@veritext.com | www.veritext.com

1 reporting the same kind of complaints of
2 longstanding, severe fibromyalgia; is that
3 correct?

4 A. That is correct.

5 Q. All right. And did you make any
6 changes to her treatment plan at this point, or
7 did you continue her on the same treatment plan?

8 A. I think, according to the note, she
9 had been off the Cymbalta, which was stopped in
10 early September. It was worse, and I put her back
11 on the Cymbalta at the 60-milligram, twice-a-day
12 dose.

13 Q. Was there any discussion at -- during
14 this visit of her undergoing bilateral breast
15 reduction and removal of implants? I didn't see
16 that referenced in --

17 A. Not that -- when I looked at the chart
18 before, I found no reference of that. No
19 reference in this note.

20 Q. Would there be any contraindication,
21 from your perspective as a rheumatologist, for her
22 undergoing that kind of procedure?

23 A. No. But I -- I mean, there -- there
24 are two things with that procedure that I've
25 talked about as a rheumatologist, since I've been

1 asked to give opinions about that procedure in a
2 number of fibromyalgia patients. One is that
3 fibromyalgia patients just don't do nearly as well
4 with any type of surgery. That's true of knee
5 replacement, hip replacement, neck surgery, back
6 surgery.

7 There -- I mean, I make sure the
8 patients understand that the fibromyalgia itself
9 seems to have a negative effect on the whole
10 process of what happens.

11 And the second is that it's an
12 operation that in my experience -- I mean, not
13 infrequently infections occur with that. I mean,
14 it could be some infections that could be very
15 difficult to treat with sometimes multiple
16 procedures having to be done, just in my
17 experience.

18 Q. Are those things you would have shared
19 with Ms. Turisk had she raised that issue with
20 you?

21 A. I certainly would have, since it's
22 been an issue in my practice all along.

23 Q. Has -- to your knowledge, has
24 Ms. Turisk had a history of infections, or is that
25 something that comes along with the fibromyalgia

1 or is that --

2 A. No, I don't -- I don't think infection
3 associates with fibromyalgia, but I think
4 infection associates with that particular
5 procedure.

6 Q. Okay. And you said that fibromyalgia
7 patients don't typically do as well with any kind
8 of surgery. Is there a particular reason for
9 that, or is that just based on your experience in
10 seeing them?

11 A. No. I think that's documented in the
12 literature, and when you go and you listen to
13 orthopaedic surgeons and other doctors talk about
14 procedures, you know, that's frequently mentioned.
15 And it may just because of the fact that the
16 stress of the surgery is another stress.
17 Fibromyalgia is a stress-influenced condition.

18 Patients with fibromyalgia tend to
19 have a very low pain threshold, in my experience.
20 And so there's, obviously, discomfort associated
21 with -- with surgery that can sort of, you know,
22 get the whole pattern of hurting and discomfort,
23 you know, worse for a period of time, but not --
24 but not with -- not with infection.

25 There is not an increased risk of in-

1 -- you know, an infection in the knee or, you
2 know, in the hip or in the back. It's more of
3 just the subjective, how patients, you know, feel
4 in terms of their recovery, how much discomfort
5 they report.

6 Q. Is there anything different that you
7 would do to treat her fibromyalgia had you known
8 she was going to have this surgery?

9 A. No.

10 Q. And then it looks like she did not
11 come back to see you again until after her
12 surgery, and it looks like that next note was the
13 last visit, is May 25, 2017?

14 A. Right. That's correct.

15 Q. Were there any visits in the interim
16 between October 18 and May 25, 2017?

17 A. No. No. No.

18 Q. So looking at the note of May 25,
19 2017, what were her complaints to you at that
20 time?

21 A. She was complaining of her
22 fibromyalgia being active and having --
23 specifically having some pain in her upper
24 trapezius area, which is the, you know, the back
25 part of the neck and into the shoulder blade area.

1 being cognizant of not putting her immune system
2 at any kind of risk?

3 A. Can you further clarify exactly what
4 you mean by that?

5 Q. Sure. And for- -- forgive me because
6 I'm --

7 A. Because I really don't -- I really
8 don't -- I really don't -- the question, the way
9 that you asked it, is not -- I mean, there's a
10 risk-benefit ratio of any, you know, type of
11 procedure that gets done, and doing injections is
12 a type of procedure. There is a, you know, a risk
13 of steroids.

14 I think the risk -- the general risk
15 of infection with typical steroid injections is
16 absolutely negligible and not really -- you know,
17 not really a problem. Where it could be -- become
18 a problem is if someone is getting multiple
19 steroid injections from either the same doctor or
20 from different doctors, you know, perhaps right
21 before a procedure.

22 Q. Sure.

23 A. But even -- even then, the likelihood
24 of infection is low. When I had -- when I had
25 knee replacement, unfortunately, I developed an

EXHIBIT E

Rebecca Turisk
DOS: 11/01/2016
Dennis Schimpf

"Count On Us"

Cymbalta 120mg (Oct 26)
Celebrex 200mg (last taken 10-26)
Oxycodone 5mg this morning 4:00
testosterone 3mg 10-31 last taken
progesterone 10-31 " "
estradiol 10-31 " "
multi-vitamin 10-31 last taken
levothyroid 120 this morning

Mary Ackerman

Driver

DS 25h

TURISK_00011
Turisk-SwtgrsPlasSur-0011

Turisk-SwtgrsPlasSur-0011
CONFIDENTIAL MEDICAL RECORDS

EXHIBIT F

1 STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

2 COUNTY OF CHARLESTON

3 REBECCA TURISK,

4 Plaintiff,

5 vs. CASE NO. 2018-CP-10-2109

6 DENNIS K. SCHIMPF, M.D., AND

7 SWEETGRASS PLASTIC SURGERY, LLC,

Defendants.

8
9 DEPOSITION OF: FERNANDO A. HERRERA, M.D.

10 DATE: October 24, 2022

11 TIME: 2:20 p.m.

12 LOCATION: Medical University of South Carolina
13 College of Medicine
14 Department of Plastics
96 Jonathan Lucas Street
Suite 404, MSC 613
Charleston, SC 29425

15 TAKEN BY: Counsel for the Plaintiff

16 REPORTED BY: KAREN NELLIUS, RPR
17
18
19
20
21
22
23
24
25

1 THE WITNESS: I'm aware of one
2 infection that she needed a drainage for.

3 BY MR. SMYTH:

4 Q. Did she have other infections with
5 regard to any other procedures that you know of?

6 A. Not that I'm aware of specifically.

7 Q. The infection that you were asked about
8 earlier when she presented to the hospital in
9 December of 2016, were you aware that the bacteria
10 that grew out of that infection was enterococcus
11 faecalis?

12 A. I think that was reviewed in her
13 records earlier.

14 Q. Okay. Are you familiar with what that
15 strand of bacteria -- where it originates?

16 A. I think it's a GI flora.

17 Q. And the use of the Latin term faecalis,
18 is that a reference to the fact that it is often
19 found in human feces?

20 A. Possibly.

21 Q. And so the bacteria that she had in her
22 breast is one that's associated with fecal matter?

23 MS. BURKE: Objection. Leading.

24 THE WITNESS: Possibly.

25 BY MR. SMYTH:

1 Q. And is it something that's known to
2 occur that maybe when patients go to the bathroom
3 and don't use proper hygiene or wash their hands
4 appropriately you can spread that type of bacteria
5 to other areas of your body?

6 MS. BURKE: Objection. Leading.

7 THE WITNESS: I don't know.

8 BY MR. SMYTH:

9 Q. Are you aware of poor hygiene being
10 related to infection with that bacteria?

11 MS. BURKE: Objection. Leading and
12 relevance.

13 THE WITNESS: Aware, meaning? I don't
14 understand that question.

15 BY MR. SMYTH:

16 Q. All right. Are you aware of any
17 instances where there has been an association with
18 poor hygiene and an enterococcus faecalis
19 infection?

20 MS. BURKE: Objection. Relevance.

21 THE WITNESS: Not specifically, no.

22 BY MR. SMYTH:

23 Q. How else would the bacteria from the
24 gut get into a breast wound?

25 A. I don't know.

1 Q. Okay. Did you begin prescribing
2 antibiotics to Ms. Turisk before fat grafting
3 procedures because of her prior incident of
4 infection?

5 A. I -- hard to say. I tend to give
6 prophylactic antibiotics to most of my patients.

7 Q. And would that be particularly
8 important to someone that's prone to infection?

9 A. Yes.

10 MS. BURKE: Objection. Lack of
11 foundation.

12 BY MR. SMYTH:

13 Q. You are aware that Ms. Turisk also has
14 adrenal insufficiency and requires steroids for
15 that?

16 A. Correct.

17 Q. And are steroids known to suppress the
18 immune system's response to antibiotics?

19 A. I believe so.

20 Q. And that can make it harder to fight
21 infections?

22 A. Yes.

23 Q. You talked earlier about some of the
24 options that you presented Ms. Turisk with in terms
25 of restoring her breast volume, and I think you

EXHIBIT G



Sweetgrass
PLASTIC SURGERY
1000 1/2 ST. N.E.
ATLANTA, GA 30309

Rebecca Turisk
DOS: 11/01/2016
Dennis Schimpf

Pre-Surgical Nursing Phone Instructions

0830

	Completed	Comments
1. Confirm date, arrival time and patient's phone #. Explain the hour difference between arrival and OR time.	☒	
2. Remind patient of need to have someone drive him/her home (that procedure WILL NOT be done if no one available) and length of stay. Driver Name: <u>Mary</u> Relationship: <u>Friend</u> Driver Location: _____ Driver's Phone: _____	☒	
3. All patients are to bring complete list of their medication, dosages and frequency. (Include herbs and Vitamins), wear all cotton underwear and sports bra and no jewelry.	☒	
4. Are you on a blood thinner (Coumadin, ASA, Plavix etc.) and if so confirm stop for 2 weeks? Last dose?	☒	
5. Remind patient to take heart and blood pressure meds with small sip of water the morning of the procedure. PLEASE do bring inhalers to the center with them.	☒	
6. Remind patient not to eat or drink past 12 midnight, unless directed otherwise by their physician. No smoking for 2 weeks prior and 2 weeks after the day of surgery. No alcohol for 48 hours prior to surgery.	☒	
7. Patients with Sleep Apnea should bring their CPAP machine.	☒	
8. Does the patient have allergies? Are you allergic/sensitivity to latex, sulfites, soy, peanuts, or eggs?	☒	
9. Does patient have an Internal Defibrillator- If so needs to be rescheduled to hospital setting.	☒	
10. Has the patient traveled outside the country in the last 30 days, or been exposed to anyone whom has? If yes, where? (review signs and symptoms EBOLA / TB)	☒	
Patient Contacted: ☒ Yes ☐ No ☐ Left Message	☐	
Spoke with: ☒ Patient ☐ Other _____	☐	
Verbalized understanding of instruction	☒	*pt has adrenal fatigue*
Staff: <u>Meghan Smith</u>	Date: <u>10/31/16</u>	Time: <u>4:17pm</u>
First Attempt: Date/Time: <u>10/31/16 @ 12:45</u>	Left Message with: <u>pt</u>	RN: <u>Good</u>
Second Attempt: Date/Time: _____	Left Message with: _____	RN: _____
Third Attempt: Date/Time: _____	Left Message with: _____	RN: _____

13

TURISK_00016

Turisk-SwtgrsPlasSur-0016

Turisk-SwtgrsPlasSur-0016
CONFIDENTIAL MEDICAL RECORDS

EXHIBIT H

1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
2 COUNTY OF CHARLESTON) CASE NO. 18-CP-10-2109
3
4 Rebecca Turisk,)
5 Plaintiff,)
6 -vs) DEPOSITION
7 Dennis K. Schimpf, M. D.) OF
8 And Sweetgrass Plastic) Dennis K. Schimpf, MD
9 Surgery, LLC,)
10 Defendants.)
11 DATE: Monday, July 1, 2019
12 TIME: 10:07 a.m.
13 LOCATION: Smyth Whitley, LLC
14 126 Seven Farms Drive
15 Suite 260
16 Charleston, SC 29492
17 REPORTER: Lisa Kerns
18 Professional Court Reporter
19 -----
20 RES COURT REPORTING SERVICES
21 243 NELLIEFIELD CREEK DRIVE
22 CHARLESTON, SC 29492
23 (843) 818-9396
24 (843) 654-9534
25 LISAKERNS.CRS@GMAIL.COM

RES COURT REPORTING SERVICES (843) 818-9396 OR (843) 654-9534

1 be happy.

2 Q. Yeah.

3 A. And the last thing I want is somebody unhappy.

4 Q. Right.

5 A. So --

6 Q. Okay.

7 A. -- we do everything we can to make them happy.

8 Q. All right. And I think the series of questions
9 I just asked you would be that, that, I think there are
10 three Releases in this file, or three Consents to Surgery,
11 three or four. It's, what we've just been through is true
12 of all of them, correct?

13 A. Yes.

14 Q. Okay. Now, did you, let's see, Sweetgrass 16 is
15 the next thing I have. And that's dated October 31st. And
16 this would be what, the Pre-Surgical Instructions,
17 correct?

18 A. Yes.

19 Q. This is your standard form?

20 A. Yes.

21 Q. Okay. And, anything outstanding here, anything
22 stand out here that gives you any idea that this patient
23 is gonna have complications?

24 A. No.

25 Q. Okay. All right.

1 A. She has Adrenal Fatigue, which we, which I
2 talked with her and her caregiver about, her boyfriend.
3 And, they, she was being treated sort of homeopathically
4 I guess in some degree by a OBGYN. So, that's more
5 important for Anesthesia to know. If somebody has true
6 adrenal insufficiency or fatigue, they can have blood
7 pressure swings inter-operatively. And so, folks are
8 generally dosed with a small amount of steroid before the
9 surgery or during the surgery.

10 Q. Okay. And, Page 11, I think is next? And
11 that's a handwritten list of medications that she's
12 taking. Which I assume, well it's dated at the top, it
13 says date of service, 11/1, and the name and telephone
14 number of the driver?

15 A. Yes.

16 Q. Any medications here that would interfere with
17 her successful surgery?

18 A. No, sir.

19 Q. Okay. And I think Page 23 is another Surgical
20 Consent, which is signed that day, same series of
21 questions and answers?

22 A. Yes.

23 Q. Pre-Surgical Assessment is at Page Eight; who
24 did the Pre-Surgical Assessment?

25 A. This is a sheet that's done that morning. The

1 what else you did that day?

2 A. I can't, but we can get it for you, I, I don't
3 know.

4 Q. If you would, just give it to Todd.

5 A. Sure.

6 Q. I don't want to know names.

7 A. Okay.

8 Q. Okay.

9 A. Just the type of procedures?

10 Q. Yeah.

11 A. Sure.

12 Q. Yup, yup, yup, yup.

13 A. I believe she's, hers was the first of the day

14 --

15 Q. Okay.

16 A. -- or early in the morning.

17 Q. All right. 7:30 in the morning she got there,
18 so?

19 A. Yeah, yeah, I'm sure.

20 Q. All right. I asked you about the medications
21 she was taking. And I think whether any, any of them
22 presented any, any issues for the day. How about in terms
23 of her healing?

24 A. Yeah, so they're, the, she was on low-dose
25 steroid.

1 Q. Uh-huh.

2 A. At that dose it's kind of questionable what
3 kind of affect it has, especially on somebody that's been
4 on it for a long period of time, whether or not it does,
5 but there is some question of it in some instances if it
6 can affect it.

7 Q. Because of it's anti-immunity, immune --

8 A. Inflammatory.

9 Q. -- properties?

10 A. Uh-huh. Yeah. Anti-inflammatory properties.

11 Q. So, I know that it, it, it does suppress
12 inflammation --

13 A. Uh-huh.

14 Q. -- correct?

15 A. Yes.

16 Q. But, it also has some immunity compromise as
17 well, steroids?

18 A. It does through the inflammatory process
19 because obviously the cascade of how you heal.

20 Q. So --

21 A. That does is pretty low, so it's.

22 Q. -- Did you tell her not to take it before her
23 surgery?

24 A. No.

25 Q. All right. You knew what she was taking before

1 --

2 A. I did.

3 Q. -- her surgery?

4 A. Yes, sir.

5 Q. Okay. So, you let her stay on it?

6 A. Yes.

7 Q. Okay.

8 A. We, we very regularly operate on people on
9 that, especially when I was at Hollings. Running a
10 Breast Cancer Reconstruction because those patients are
11 at immunosuppressed obviously, so.

12 Q. Right. Right. And, that was less, how much, 20
13 milligrams, 50 milligrams, what was it?

14 A. It was a low, I thought it was five milligrams
15 actually.

16 Q. Five milligrams, even better, okay. But, in any
17 case, do you, do you think that that had anything to do
18 with her complications after the surgery?

19 A. I don't know.

20 Q. Okay.

21 A. It is, if it were a large dose that she were
22 on, I would have been more concerned. But I don't know
23 if actually if it did or did not.

24 Q. Okay.

25 A. The left side healed reasonably well. So

1 it. They, they do, they all have it. So, I don't know
2 what the volume difference would have been.

3 Q. Okay. Do you have any, any thoughts on where
4 the Enterococci Bacteria came from?

5 A. She grew, if I remember correctly, Fecalysis --

6 Q. Uh-huh.

7 A. -- which is feces-based --

8 Q. Uh-huh.

9 A. -- so it has something to do with stool, either
10 washing hands or whoever was helping her wasn't washing
11 hands or contaminating somehow. Which when you have poor
12 blood flow or lack of some you know immune response, then
13 that's what can happen. But you can get bacteria from
14 anywhere, door handle, you can get that from a door
15 handle, this table --

16 Q. Right. Right. Right.

17 A. -- any number of places.

18 Q. Okay. And, and again, I just want to be sure I
19 understand your answer and everything else. The outcome
20 she's got today, are you able to say what is a result of
21 the surgery you performed versus the debridement,
22 debridement procedures at MUSC?

23 A. I'm not. I, I haven't, I don't know how much
24 they debrided, and you know the volumes and stuff. I
25 mean I've, and I really can't tell from that photograph.

EXHIBIT I



Deposition of:
William Patrick Joseph , MD

December 4, 2019

In the Matter of:
**Turisk, Rebecca v. Dennis K Schimpf,
MD, et al**

A. William Roberts, Jr & Assoc.
800-743-3376 | calendar-awr@veritext.com | www.veritext.com

1 And I was the lead author and wrote the words.

2 Q Is this the Open Forum publication?

3 A Yes.

4 Q Okay. And did that article have anything to do
5 with the issues in this case?

6 A No, sir.

7 Q And I think the last thing you published before
8 that was a 2013 paper, Improved Diagnostics for Infectious
9 Diseases.

10 Did that -- that was in 2013. Did that have
11 anything to do with any of the issues in this case?

12 A No, sir.

13 Q Have you ever published anything that has -- that
14 relates in any way to the issues as you see them in this
15 case?

16 A Not to my role in this case; no, sir. Or to
17 anybody's role in this case.

18 Q Okay. All right.

19 Do you have any criticism of any of the providers
20 that Ms. Turisk saw for treatment up to the present for
21 her disease process?

22 A No, sir.

23 Q And do you have any criticism of anything that
24 Ms. Turisk did or failed to do in this matter?

25 A No, sir.

1 Q Any of her, I guess, caretakers? The lay people
2 who helped to take care of her? Any criticism of any of
3 them?

4 A I do not.

5 Q Okay. All right.

6 The treatment of patients with vascular
7 insufficiency that leads to fat necrosis, have you treated
8 patients like that before?

9 A Yes, sir. Many.

10 Q That looks like I can see me moving but not you.
11 So something...

12 All right. I guess, yeah.

13 And I'm sorry. So the answer was "Yes"? Is that
14 correct?

15 A Correct.

16 Q And would that be after breast reduction surgery?

17 A I have seen patients after breast surgery. I
18 can't recall if it was reduction surgery or removal or
19 placement of implants. But I have seen and treated
20 infectious complications of fat necrosis of the breast.

21 Q And, generally, can you tell me when you're
22 called into those cases and who brings you in?

23 A Either the primary care physician or the surgeon.
24 But I would be requested to see a patient by another
25 physician who is already on the case.

1 diagnosis of fat necrosis could have been made much before
2 the week of November 28th, but it may have been brewing.

3 Q And is there anything that you would have done or
4 recommended to be done to prevent the vascular
5 insufficiency from eventually causing the fat necrosis?

6 A No, sir.

7 Q All right. And you think that once the vascular
8 insufficiency began, this was going to end up in fat
9 necrosis no matter what?

10 A Well, once there is vascular insufficiency to
11 adipose tissue, the result is fat necrosis.

12 Q And was there a point in time where this yearlong
13 process could have been stopped?

14 A Not to my knowledge. This is the usual, drawn
15 out case of an infection complicating fat necrosis.

16 Q Okay. I think that there was a point in time
17 when Dr. Schimpf decided to debride -- to do a debridement
18 of the tissue?

19 A I believe that was on November 28th.

20 Q Okay. And was that appropriate at that time?

21 A Oh. That was -- that's not in my practice.
22 That's a surgical standard of care question.

23 Q Okay. And so I understand, the fat necrosis
24 begins with the tissue dying; is that correct?

25 A Yes.

1 that occurred at the time of surgery, but rather this is a
2 secondary infection because of dying tissue.

3 MR. TANENBAUM: Right.

4 Q Because of the vascular insufficiency?

5 A Yes. Vascular insufficiency lead to necrosis.
6 Necrotic tissue has no immune system. And so it -- there
7 is no way to prevent bacterial invasion.

8 Q All right. The dates of diagnosis, significance
9 of those?

10 A Not for the purposes of what I will be
11 discussing.

12 Q Okay. Do you know Dr. Schimpf?

13 A No, sir.

14 Q How did you become involved in this case?

15 A I believe Mr. Smyth contacted my office.

16 Q And have you testified before in any matters
17 where Mr. Smyth played a role?

18 A No, sir.

19 Q Have you testified before in any cases in South
20 Carolina?

21 A Certainly not within the past five or ten years.
22 I don't think I ever have.

23 Q Okay.

24 A I've never testified in South Carolina. I really
25 don't know if I've ever given a deposition here in

EXHIBIT J



Deposition of:
Todd Samuel Lefkowitz

November 27, 2019

In the Matter of:
Turisk, Rebecca Vs. Schimpf, Dennis

A. William Roberts, Jr & Assoc.
800-743-3376 | calendar-awr@veritext.com | www.veritext.com

1 from implant surgery because he wasn't aware of where
2 that incision was, correct?

3 MR. HORTON: Objection.

4 THE WITNESS: Again, this is pure
5 speculation. It could have been -- a lot of times
6 when we see patients that many years out, the scar
7 has healed so well, it's sometimes difficult to tell
8 whether or not that was an actual scar from that
9 particular surgery.

10 BY MR. TANENBAUM:

11 Q. Okay. Now, the other -- what other
12 criticism do you understand Dr. Holzman had?

13 A. Per his deposition, that was his -- and I
14 believe he reiterated that that was his main
15 criticism, was the choice of pedicle that Dr. Schimpf
16 utilized based on the presumed previous scar.

17 Q. Do you think that the patient did anything
18 to cause or contribute to the outcome she's had?

19 A. Nothing that I saw or would be concerned
20 about.

21 Q. So, for example, I think Dr. Schimpf had
22 some question about whether she should have come back
23 in the day of the surgery or the day after the
24 surgery, that sort of thing. She didn't feel well
25 enough to go in. That made no difference in the

EXHIBIT K



Deposition of:
Fernando A Herrera, Jr. , MD

October 28, 2019

In the Matter of:
**Turisk, Rebecca v. Dennis K Schimpf,
MD, et al**

A. William Roberts, Jr & Assoc.
800-743-3376 | calendar-awr@veritext.com | www.veritext.com

1 involvement?

2 A. I believe so. I'm not a hundred
3 percent certain. I'd have to go through the notes
4 in detail.

5 Q. And I think you can refer to some of
6 these prior notes. There was a note from a
7 Dr. Schumann. It looks like it's on the same day
8 there. It's about four pages, three pages earlier
9 than that. It's the 84.

10 A. Um-hum.

11 Q. Do you see that?

12 A. Um-hum.

13 Q. Okay. And his note indicates that she
14 had --

15 A. Right. Correct.

16 Q. -- wound cultures that were positive
17 for enterococcus --

18 A. Correct.

19 Q. I think it was faecalis and then the
20 methicillin staph.

21 A. MSSA, correct.

22 Q. MSSA. That's the staph -- the
23 resistant form of the bacteria; is that right?

24 A. Sensitive.

25 Q. Sensitive. Okay. All right. And she

EXHIBIT L

1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
2 COUNTY OF CHARLESTON) CASE NO. 2018-CP-10-2109
3
4 Rebecca Turisk,)
5 Plaintiffs,)
6 -vs) DEPOSITION
7 Dennis K. Schimpf, M. D.) OF
8 And Sweetgrass Plastic) William Long
9 Surgery, LLC,)
10 Defendants.)
11
12 DATE: Thursday, August 8, 2019
13 TIME: 9:59 a.m.
14 LOCATION: Mark C. Tanenbaum, PA
15 1017 Chuck Dawley Blvd
16 Suite 101
17 Mt. Pleasant, SC 29464
18 REPORTER: Lisa Kerns
19 Professional Court Reporter
20
21 -----
22 RES COURT REPORTING SERVICES
23 243 NELLIEFIELD CREEK DRIVE
24 CHARLESTON, SC 29492
25 (843) 818-9396
(843) 654-9534
LISAKERNS.CRS@GMAIL.COM

RES COURT REPORTING SERVICES (843) 818-9396 OR (843) 654-9534

1 backwards, so I'm pretty sure it's on that side. It's,
2 it's the side that, that doesn't have a nipple.

3 Q. Right. Well, that's a good way to refer to
4 it.

5 A. Yeah, that side. And, I had to change the
6 bandages and that, and they taught me how to do it,
7 rubber gloves and all this stuff. And they call it wet
8 to dry and you moisten the gauze pads into, with saline.
9 And you take a Q-tip and put it up in there and fill it
10 up, and cover over everything. It was, it's hard to do.

11 Q. Do you want to take a break?

12 A. I'm okay.

13 Q. Okay. And this wound care treatment that you
14 provided to Rebecca, you're talking about in the period
15 where you were treating at the Wound Care Clinic --

16 A. Uh-huh.

17 Q. -- right? Is that all in that period of time?

18 A. That was part of it. And, and I, I'm pretty
19 sure before that it, she already had the, the tunnel up
20 in there. They, a surgeon at Summerville Med Center
21 went in and, and removed a lot of tissue, bad tissue and
22 that helped her. And, it, maybe, maybe that's why there
23 was this big tunnel up in there because after he removed
24 all the tissue, it just left this big hole. And when
25 they put the wound vac on there they said they, it

EXHIBIT M

Acinetobacter baumannii

An emerging opportunistic pathogen

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Acinetobacter baumannii is an opportunistic bacterial pathogen primarily associated with hospital-acquired infections. The recent increase in incidence, largely associated with infected combat troops returning from conflict zones, coupled with a dramatic increase in the incidence of multidrug-resistant (MDR) strains, has significantly raised the profile of this emerging opportunistic pathogen. Herein, we provide an overview of the pathogen, discuss some of the major factors that have led to its clinical prominence and outline some of the novel therapeutic strategies currently in development.

Introduction

Acinetobacter baumannii is a Gram-negative bacillus that is aerobic, pleomorphic and non-motile. An opportunistic pathogen, *A. baumannii* has a high incidence among immunocompromised individuals, particularly those who have experienced a prolonged (> 90 d) hospital stay.¹ Commonly associated with aquatic environments,² it has been shown to colonize the skin as well as being isolated in high numbers from the respiratory and oropharynx secretions of infected individuals.³ In recent years, it has been designated as a “red alert” human pathogen, generating alarm among the medical fraternity, arising largely from its extensive antibiotic resistance spectrum.⁴

This phenomenon of multidrug-resistant (MDR) pathogens has increasingly become a cause for serious concern with regard to both nosocomial and community-acquired infections.⁵ Indeed, the World Health Organization (WHO) has recently identified antimicrobial resistance as one of the three most important problems facing human health.⁶ The most common and serious MDR pathogens have been encompassed within the acronym “ESKAPE,” standing for *Enterococcus faecium*, *Staphylococcus aureus*, *Klebsiella pneumoniae*, *Acinetobacter baumannii*, *Pseudomonas aeruginosa* and *Enterobacter* spp.⁷

While in the 1970s *A. baumannii* is thought to have been sensitive to most antibiotics, today the pathogen appears to exhibit extensive resistance to most first-line antibiotics.⁸ More

recently, *A. baumannii* has become a major cause for concern in conflict zones, and has gained particular notoriety in the recent desert conflicts in Iraq, earning it the moniker “Iraqibacter.” In particular, high incidences of MDR bacteremia (bloodstream infections) have been noted among US Army service members following Operation Iraqi Freedom (OIF).⁹ Interest from the scientific community over the past 15 years has led to significant advances of our understanding of this organism.¹⁰

Genus Acinetobacter

The Dutch microbiologist Beijerinck first isolated the organism in 1911 from soil using minimal media enriched with calcium acetate.¹¹ Originally described as *Micrococcus calco-aceticus*, the genus *Acinetobacter* (coming from the Greek “akinetos,” meaning non-motile) was proposed some 43 years later by Brisou and Prevot¹² to differentiate it from the motile organisms within the genus *Achromobacter*. The genus *Acinetobacter* was widely accepted by 1968 after Baumann et al.¹³ published a comprehensive study of organisms such as *Micrococcus calco-aceticus*, *Alcaligenes hemolyans*, *Mima polymorpha*, *Moraxella lwoffii*, *Herellea vaginicola* and *Bacterium anitratum*, which concluded that they belonged to a single genus and could not be further sub-classified into different species based on phenotypical characteristics.¹³ In 1971, the sub-committee on the Taxonomy of *Moraxella* and Allied Bacteria officially acknowledged the genus *Acinetobacter* based on the results of Baumann's 1968 publication.¹⁴

The genus *Acinetobacter*, as currently defined, comprises Gram-negative, strictly aerobic, non-fermenting, non-fastidious, non-motile, catalase-positive, oxidase-negative bacteria with a DNA G + C content of 39% to 47%.⁵ Following DNA-DNA hybridization studies performed by Bouver and Grimnot in 1986, the *Acinetobacter* genus now consists of 26 named species and nine genomic species.¹⁵ Four species of *Acinetobacter* (*A. calcoaceticus*, *A. baumannii*, *Acinetobacter* genomic species 3 and *Acinetobacter* genomic species 13TU) have such phenotypic similarities that they are difficult to differentiate, and as such are often referred to as the *A. calcoaceticus*-complex.¹⁶ This nomenclature can be misleading as the environmental species *A. calcoaceticus* has not been implicated in clinical disease, while the other three species in the *A. calcoaceticus*-complex are perhaps the most clinically significant species, being implicated in both community-acquired and nosocomial infections.⁵

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Species

Acinetobacter may be identified presumptively to the genus level as Gram-negative, catalase-positive, oxidase-negative, non-motile, non-fermenting coccobacilli. However, the organisms are often difficult to de-stain and, as such, are often incorrectly identified as Gram-positive (see Fig. 1). There is no definitive metabolic test that can distinguish *Acinetobacter* from other non-fermenting Gram-negative bacteria.⁵ A method which is often used to identify to the genus level relies on the ability of the mutant *A. baylyi* strain BD413 trpE27 to be transformed by crude DNA of any *Acinetobacter* species to a wild-type phenotype (i.e., the transformation assay of Juni¹⁷). While for species level identification, the 28 available phenotypic tests have proven to be 95.6% effective in identifying human skin-derived *Acinetobacter*s.¹⁸ However, phenotypic tests alone have proven to be ineffective in identifying more recently discovered genomic strains of *Acinetobacter*s.⁵

More advanced molecular diagnostic methods have been developed for identification of *Acinetobacter*s to the species level, these include:

- Amplified 16S rRNA gene restriction analysis (ARDRA)¹⁹
- High-resolution fingerprint analysis by amplified fragment length polymorphism (AFLP)²⁰
- Ribotyping²¹
- rRNA spacer fingerprinting²²
- Restriction analysis of the 16S–23S rRNA intergenic spacer sequences²³
- Sequence analysis of the 16S–23S rRNA gene spacer region²⁴
- Sequencing of the *rpoB* (RNA polymerase β -subunit) gene and its flanking spacers²⁵

Natural Habitat

Organisms belonging to the genus *Acinetobacter* are often considered to be ubiquitous in nature given that they can be

recovered from almost all soil and surface water samples.¹³ This understanding has contributed to the common misconception that *A. baumannii* is also ubiquitous.²⁶ While not all *Acinetobacter*s find their habitat in the natural environment, a thorough and systematic study to investigate the natural occurrence of the various *Acinetobacter* species in the environment has yet to be performed.⁵

As a pathogen, *A. baumannii* specifically targets moist tissues such as mucous membranes or areas of the skin that are exposed, either through accident or injury. Skin and soft tissues infected with *A. baumannii* initially present with a “peau d’orange” appearance (similar to the skin of an orange) followed by a sandpaper-like presentation which eventually gives way to clear vesicles on the skin.³ In areas of skin disruption hemorrhagic bullae can be seen, with a visible necrotizing process followed by bacteremia.³ If left untreated, this infection can lead to septicemia and death. Although it is likely that *A. baumannii* is responsible for these recognizable features, co-pathogens, such as *Klebsiella pneumoniae*, *Candida albicans* and *Enterococcus faecalis*, are thought to be a contributing factor. These co-pathogens may cause necrotizing infection and may create a nidus of entry into the bloodstream for *A. baumannii*.³

Despite its association with skin infections, *A. baumannii* is found only rarely as part of the normal skin microflora, with one study estimating that only 3% (at most) of the population are colonized by the bacterium.¹⁸ Interestingly, *Acinetobacter* was recovered from 22% of body lice sampled from homeless people, suggesting another potentially important reservoir for the pathogen.²⁵

A key risk group for *A. baumannii* infection is members of the armed forces who have been deployed to conflict zones, particularly Iraq, earning *A. baumannii* the notorious moniker of ‘Iraqibacter.’ The dry, sandy conditions associated with these desert campaigns provide an ideal environment for the physiologically robust *A. baumannii*, making it the main source of infection among injured soldiers.⁹ A 2003 study on board the US Navy

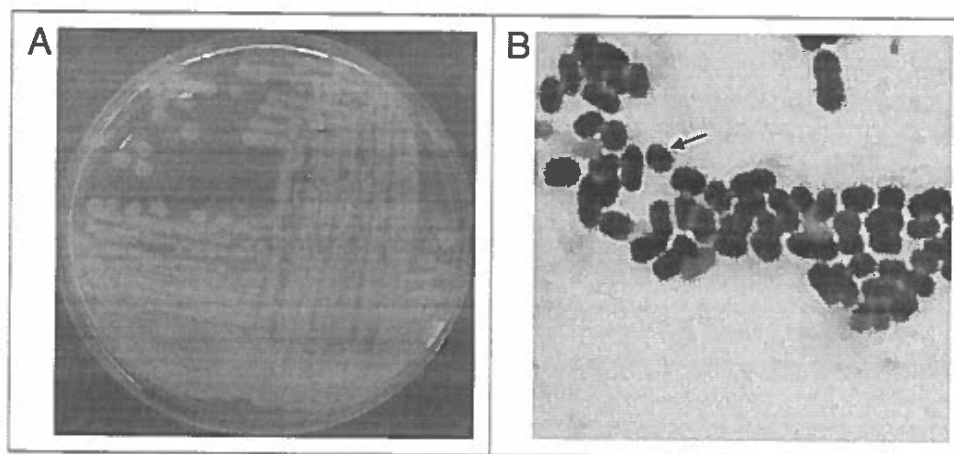


Figure 1. (A) Complex streak of *Acinetobacter baumannii* following overnight growth on Luria-Bertani agar at 37°C. (B) Gram-stain of log phase *A. baumannii* cells grown in Luria-Bertani broth. Arrow indicates an individual *A. baumannii* cell.

hospital ship USNS Comfort (T-AH-20) providing emergency on-site care for injured US combat forces situated on the Persian Gulf, revealed that 4.1% of all skin and soft-tissue infections (SSTIs) encountered were *A. baumannii* related, with the axilla, groin and toe webs being the areas of highest colonization.⁹

Furthermore, although originating in isolated conflict zones, the incidence of *A. baumannii* infections is on the increase, particularly in the UK and the US, as the coalition troops exposed to the bacterium in field hospitals return home to convalesce,²⁷ making it a formidable emerging pathogen.²⁸ Once *A. baumannii* is isolated in a hospital environment, this poses a significant risk, particularly in ICU wards where patients are chronically ill. As most of these patients are immunocompromised and spend a prolonged period of time in hospital, they represent a high risk group for *A. baumannii* infection.¹ Patients that acquire artificial devices such as catheters, sutures, ventilators and those who have undergone dialysis or antimicrobial therapy within the past 90 days are also at risk of developing *A. baumannii* infections.¹ The respiratory tract, blood, pleural fluid, urinary tract, surgical wounds, CNS, skin and eyes may be sites for infection or colonization.^{29,30} Pneumonia may pose a threat to those patients who require mechanical ventilation as *A. baumannii* has the ability to form biofilms on the surface of the endotracheal tube, which may account for the relatively high levels of colonization in the lower part of the respiratory tract.³¹

Pathogenesis-Virulence Potential

Despite extensive research into the virulence potential of this emerging pathogen, little is still known about its true pathogenic potential or virulence repertoire. While it is believed that several factors may contribute to the virulence potential of *A. baumannii*, one factor in particular, OmpA, a member of the Outer membrane proteins (OMPs), has been determined to contribute significantly to the disease causing potential of the pathogen.³² *A. baumannii* OmpA bind to the host epithelia and mitochondria, once bound to the mitochondria, OmpA induces mitochondrial dysfunction and causes the mitochondria to swell. This is followed by the release of cytochrome c, a heme protein, which leads to the formation of apoptosome. These reactions all contribute to apoptosis of the cell.³² OmpA, being the most abundant surface protein on the pathogen, is also involved in resistance to complement and the formation of biofilms^{33,34}—two key stress survival strategies and potentially important virulence associated factors that help to promote bacterial survival both inside and outside the host. The ability of *A. baumannii* to form biofilms allows it to grow persistently in unfavorable conditions and environments. Indeed, *A. baumannii* has been shown to form biofilms on abiotic surfaces, which can include glass and equipment used in intensive care units, and/or on biotic surfaces such as epithelial cells.³³ The most common factors that control biofilm formation can include nutrient availability, the presence of pili and outer membrane proteins and macromolecular secretions. Pili assembly and production of biofilm-associated protein (BAP) both contribute to the initiation of biofilm production and maturation after *A. baumannii* attach to particular

surfaces.³³ When pili attach to abiotic surfaces, they initiate the formation of microcolonies, followed by the full development of biofilm structures. BAP are present on the surface of bacterial cells and they contribute to biofilm development and maturation by stabilizing the mature biofilm on abiotic or biotic surfaces. Environmental signals, such as metal cations, also play a role in controlling the formation of biofilms, increasing the ability of *A. baumannii* to adhere to particular surfaces.³³

Other key proteins that have been shown to contribute to *A. baumannii* virulence include phospholipase D and C. While phospholipase D is important for resistance to human serum, epithelial cell evasion and pathogenesis,³⁵ phospholipase C enhances toxicity to epithelial cells.³⁶ Along with OmpA, fimbria, also expressed on the surface of the bacterial cell, contribute to the adhesion of the pathogen to host epithelia.

Antibiotic Resistance

The rapid emergence of multi- and pandrug-resistant strains of *Acinetobacter* highlights the organism's ability to quickly acclimatize to selective changes in environmental pressures. The upregulation of the organism's innate resistance mechanisms coupled with the acquisition of foreign determinants have played a crucial role in the express route the organism has taken to becoming a multidrug-resistant pathogen.⁵

A 2006 study undertaken by Fournier et al.⁸ compared the genome of AYE and SDF *Acinetobacter* using whole shotgun genome sequences. In France, the epidemic AYE strain had a 26% mortality rate in infected patients,³⁷ while the SDF strain came from the same geographical region, but was associated with human body lice, and was fully susceptible to antimicrobial agents. The genomic comparisons revealed that the genome of the virulent AYE strain contained an 86 kb region called a resistance "island" that contained a cluster of 45 resistance genes. The homologous location in the susceptible strain exhibited a 20 kb genomic island that is devoid of these resistance markers. This ability to "switch" its genomic structure goes some way to explaining the speed with which *Acinetobacter* captures resistance markers when under antibacterial pressure, such as may occur in a high risk environment, such as in hospital intensive care units³ (where broad spectrum antimicrobials are commonly used). Sequence similarity and phylogenetic analyses confirmed that most of the resistance genes found in the *Acinetobacter* strain AYE had been recently acquired from bacteria of the genera *Pseudomonas*, *Salmonella* or *Escherichia*.⁸

All genomic variants of *A. baumannii* contain a non-inducible chromosomal AmpC cephalosporinase, also known as *Acinetobacter*-derived cephalosporinases (ADCs).³⁸ The presence of an upstream IS element known as ISAbal determines the regulation of the AmpC gene. Overexpression of AmpC cephalosporinase and resistance to extended spectrum cephalosporin is intrinsically linked to the presence of ISAbal.³⁹ Cefepime and carbapenems, however, appear to be stable in response to these enzymes.³⁸

A. baumannii also possess an intrinsic class D oxacillinase belonging to the OXA-51-like group of enzymes that constitutes

over 40 sequence variants.⁴⁰ The ubiquitous nature of OXA-51-like genes in *A. baumannii* has led to this gene becoming an important genetic marker in identification of the organism to the species level.² OXA-51-like enzymes are able to hydrolyze penicillins (benzylpenicillin, ampicillin, ticarcillin and piperacillin) and carbapenems (imipenem and meropenem) but do so only very weakly.³ A significant contribution to lactam resistance by OXA-51-like enzymes therefore requires the presence of an insertion element ISAbal upstream of the gene, which acts as a strong transcriptional promoter.² The most common enzymatic mode of carbapenem resistance is the production of oxacillinases encoded by genes of the blaOXA-23, blaOXA-40 and blaOXA-58-like lineage.

In Europe, the spread of multidrug-resistant *Acinetobacter* is not confined to hospitals within a city but also occurs on a national scale, mostly through inter-hospital patient transfers, for example the spread of the so-called Southeast clone and the Oxa-23 clones 1 and 2 in southeast England.⁴¹ International transfer of colonized patients has led to the introduction and subsequent epidemic spread of multidrug-resistant *A. baumannii* strains from southern into northern European countries, such as Belgium and Germany.⁴²

In an industry-supported surveillance report (MYSTIC) from 48 European hospitals for the period 2002–2004, just 73.1% of *A. baumannii* isolates were susceptible to meropenem and 69.8% were susceptible to imipenem. Susceptibility to other antibiotics was also very low, with 32.4%, 34.0% and 47.6% being susceptible to ceftazidime, ciprofloxacin and gentamicin, respectively.⁴³

There is a long history of multidrug-resistant *A. baumannii* infections occurring in the United States. In 1991 and 1992, outbreaks of carbapenem-resistant *A. baumannii* were observed in a hospital in New York City.⁴⁴ This followed an outbreak of infections due to ESBL-producing *Klebsiella pneumoniae* during which use of imipenem increased substantially.⁴⁵ In a more recent industry-supported surveillance study including isolates of *Acinetobacter* collected between 2004 and 2005 from 76 centers throughout the United States, only 60.2% were susceptible to imipenem.⁴⁶

Numerous outbreaks of pandrug-resistant *A. baumannii* have been documented in Asian and Middle Eastern hospitals. Rates of non-susceptibility in SENTRY (Anti-microbial Surveillance Program) isolates (2001–2004) exceeded 25% for imipenem and meropenem, 40% for cefepime and ceftazidime, 40% for ampicillin-sulbactam, 35% for amikacin, and 45% for ciprofloxacin.⁴⁷ It is worth noting that resistance to tigecycline and polymyxin B (drugs relied on heavily to treat infection with *A. baumannii*) both already exist in this region.⁴⁸

Clinical Symptoms

A. baumannii infections are implicated across a wide range of anatomical regions and with varying severity and patient outcomes.⁴⁹ There is considerable debate relating to the actual clinical impact of infection and its relationship to patient mortality. While a number of studies have concluded that infection with *Acinetobacter* has a detrimental effect on patient outcome,^{50,51} other similar studies implied little or no effect on patient outcome as a result of infection.^{52,53}

The lack of consensus is most likely due to the difference in the approaches of the various studies; some being prospective while others have been of retrospective samples.⁴⁹ The results generated by some studies have also only identified the organism to genus level but not to species level, with many referring to infection with *Acinetobacter calcoaceticus-baumannii* complex which could conceivably indicate colonization with the environmental species *Acinetobacter calcoaceticus* coupled with a polymicrobial infection, rather than a monomicrobial infection with a virulent *Acinetobacter* species such as MDR *Acinetobacter*.⁵⁴

Hospital-acquired pneumonia. Ventilator associated pneumonia (VAP) is commonly linked to infection.⁵⁵ Longer periods of hospitalization, longer time on mechanical ventilation and prior use of antibiotics are the recognized factors increasing the risk of VAP due to *Acinetobacter*. Nosocomial outbreaks have also been described due to health care professionals with colonized hands and poor personal hygiene;⁵ such individuals may act as opportunist carriers of an epidemic strain. Contaminated ventilators or respiratory care equipment as well as intra-hospital transmission may also contribute to the beginning of an outbreak.⁵⁶

Community-acquired pneumonia. Pneumonia acquired outside of the hospital setting and caused by *Acinetobacter* has been noted in Australia and Asia.⁵⁷ The source of infection may be throat carriage, which occurs in up to 10% of community residents with excessive alcohol consumption.⁵⁷ It is characterized by a severe and sudden onset coupled with secondary bloodstream infection and has a mortality rate of between 40% and 60%.⁵⁸

Bloodstream infections. In a seven year review (1995–2002) of nosocomial bloodstream infections in the United States, *Acinetobacter* accounted for 1.3% of all monomicrobial bloodstream infections.⁵⁹ *Acinetobacter* was a more common cause of ICU-acquired bloodstream infection than of non-ICU-ward infection (1.6% vs. 0.9% of bloodstream infections, respectively, in those locations). Crude mortality figures overall from *Acinetobacter* bloodstream infection was 34.0% to 43.4% in the ICU and 16.3% outside the ICU.⁵⁹ *Acinetobacter* bloodstream infection had the third highest crude mortality rate in the ICU, exceeded only by *P. aeruginosa* and *Candida* spp infections.⁵⁹ It is notable that 102 patients had bloodstream infections at sites treating US military personnel injured in Iraq or Afghanistan from January 1, 2002 and August 31, 2004.⁹

Battlefield trauma and other wounds. *Acinetobacter* is a well-documented pathogen of burns units and is difficult to treat in patients with severe burns.⁶⁰ However, infection of the skin and soft tissue outside of a military environment is uncommon.⁶¹ A retrospective review of 57 patients with SSTI revealed that eight cases were infected with *Acinetobacter*.³ In this instance all patients were male, ranging in age from 13 to 55 and of both American and Iraqi nationality. The median time from trauma to diagnosis with *Acinetobacter* infection was 15 d. All eight patients had a similar clinical presentation of SSTI; characteristic cellulitis with “peau d’orange” appearance, severe infection resulted in formation of bullae on the skin surface. The mortality rate in this instance was 12.5% (i.e., one of the eight died; however given that the patient was admitted with a gunshot wound to the groin, mortality cannot be solely assigned to infection).

Meningitis. Nosocomial, post-neurosurgical *Acinetobacter* meningitis is becoming increasingly more common with many other Gram-negative bacteria also becoming problematic in post-operative care.⁶² Installation of an external ventricular drain becomes a site for opportunistic infection. The mortality rate may be as high as 70%; however it is not possible to discern the definitive cause of mortality.⁶³

Therapeutic Strategies

Existing antimicrobials. As mentioned previously, one of the distinguishing features of *A. baumannii* is its impressive array of acquired antibiotic resistance mechanisms, which although beyond the scope of this review, includes degradation enzymes against β -lactams, modification enzymes against aminoglycosides, altered binding sites for quinolones, and a variety of efflux mechanisms and changes in outer membrane proteins (see Peleg et al.⁵ for a detailed overview). Any and all of these elements can be combined to result in a highly drug-resistant pathogen; making selection of an appropriate empirical antimicrobial agent extremely difficult. Indeed, given the probability that *A. baumannii* would be most likely resistant to one of the common first line antibiotics, treatment of the infection should be performed following sound consideration of antimicrobial susceptibility testing. Nevertheless, as a delay in accessing correct treatment may have adverse consequences for a patient's health, carbapenems such as Imipenem are often given as a drug of preference for serious and suspected *Acinetobacter* infections.⁶⁴ However, despite its utility short-term, this prescription method jeopardizes future efficacy of such drugs as effective antimicrobial agents.

Future therapies. Given the rapid and extensive development of antibiotic resistance, several attempts have been made to develop alternative control strategies for dealing with *A. baumannii* including, but not limited to the following:

Bacteriophage. Recently renewed interest in the area of antibacterial phage therapy has gained some traction.⁶⁷ Due to the high specificity of phage and their ability to work quickly, bacteriophage therapy is being re-examined as an alternative treatment to help counteract the phenomenon of antibiotic resistance.⁶⁸ Indeed, a recent study by Yang et al.⁶⁹ has resulted in the isolation and characterization of the virulent AB1 bacteriophage which has been shown to be effective against *A. baumannii* and as such represents a novel therapeutic of some potential.

Bactericidal gene transfer therapy. The design and delivery of vectors containing bactericidal genes that can be introduced into recipient pathogenic organisms by conjugation using attenuated donor cells is referred to as bactericidal gene transfer therapy. While the therapeutic potential of this approach is limited by the requirement for donor cells to be in contact with the pathogen (to facilitate vector transfer), positive effects have nonetheless been observed using murine burn infection models. Using this approach, Shankar et al.⁶⁵ have shown that mice treated with a single dose of 10^{10} CFU of donor cells containing bactericidal genes had lower levels of *A. baumannii* in burn wounds compared with untreated mice.

Cathelicidins. Marsupials give birth to immunologically naïve, altricial young that reside in the maternal pouch for 9–10 mo while being supported by a sophisticated lactation system. In the pouch, cathelicidins interact with and destroy Gram-positive and Gram-negative bacteria, protozoa and fungi via electrostatic interactions between their positively charged peptides and the negatively charged molecules found in the cell membranes of their targets.⁷⁰ The best studied cathelicidin is human LL-37; the only human cathelicidin, it exhibits both anti-tumor and anti-HIV activity.⁷¹ The Tammar Wallaby cathelicidin WAM1 has been shown to be effective against *Acinetobacter*, and is 3–80 times more potent than LL-37 against a host of bacterial pathogens. WAM1 was not hemolytic against human red blood cells indicating potential for parenteral use in humans.⁷⁰ Indeed, WAM1's anti-microbial activity and tolerance to salt concentrations similar to those found in the human body make it seem a likely candidate for further in vivo studies.⁷²

Radioimmunotherapy. Although not yet not exploited as a therapeutic antimicrobial strategy in the clinic, radioimmunotherapy can target microorganisms as quickly and efficiently as cancer cells.⁶⁶ This approach takes advantage of the specificity of antigen-antibody interactions to deliver radionuclides that emanate lethal doses of cytotoxic radiation directly to the target cell. Producing only transient hematological toxicity in experimental animals, radioimmunotherapy has been successfully adapted for the treatment of bacterial,⁷³ fungal⁷⁴ and viral⁷⁵ infections. Given that previous studies have already described the development of antibodies against *A. baumannii*,^{76,77} the application of radioimmunotherapy as a novel therapeutic strategy for *A. baumannii* is a definite possibility.

Photodynamic therapy. Involves the combination of nontoxic photosensitizers (PSs) with oxygen and visible to produce reactive oxygen species that oxidize biomolecules thereby killing cells.⁷⁸ The use of photodynamic therapy (PDT) to treat localized bacterial infections generally involves the topical application of a PS into the infected tissue, followed by illumination with red (or near-infrared) which is capable of penetrating the infected tissue.⁷⁹ Using a murine burn wound model, this technique has previously been shown to be effective against *A. baumannii* while having no obvious effects on wound healing.⁸⁰ Recently, Tsai et al.⁸¹ investigated the effect of chitosan, a polycationic biopolymer, on increasing the efficacy of PDT against a number of pathogens including *A. baumannii*. Under conditions in which hematoporphyrin-PDT exhibited a bacteriocidal effect on a 2- to 4-log scale, subsequent treatment with chitosan (0.025%) for a further 30 min completely eradicated the bacteria (at a starting inoculum of 10^8 CFU/ml). Chitosan alone did not exert significant antimicrobial activity, without prior PDT, suggesting that the potentiated effect of chitosan worked only after the bacterial damage induced by PDT. Furthermore, the potentiated PDT effect of chitosan appears to be related to the level of PDT damage and the deacetylation level of the chitosan.

Nanoparticle technology. Nitric oxide (NO) has been shown to exhibit potent antimicrobial activity as well as playing an important role in modulating immunity⁸² and regulating wound healing.⁸³ Using nanotechnology based on a silane hydrogel,

Friedman et al.⁸⁴ have designed a stable nitric oxide (NO)-releasing nanoparticle (NO-np) platform. With the potential to serve as a novel, inexpensive and easily applied topical class of antimicrobials, this technology has been shown to be effective for the treatment of complex cutaneous infections such as those caused by *A. baumannii*. Indeed, Mihiu et al.⁸⁵ recently demonstrated the effect of NO-np against *A. baumannii* using murine wound and soft tissue models. Compared with control animals, NO-np-treated mice exhibited significant reductions in bacterial burden, enhanced wound healing rates and less collagen degradation by bacterial collagenases.

Conclusions

In conclusion, *A. baumannii* is an important opportunistic and emerging pathogen that can lead to serious nosocomial infections. Its pathogenic potential includes the ability to adhere to surfaces, form biofilms, display antimicrobial resistance and acquire genetic

material from unrelated genera, making it a versatile and difficult adversary to control and eliminate.⁵⁷ The optimal treatment for *A. baumannii*, especially nosocomial infections resulting from multiple resistant strains, remains to be established. It is thus a clinical imperative that well-designed procedures are put in place to help guide clinicians on decisions regarding the current best therapeutic practice.⁸⁶ Furthermore, new experimental approaches are warranted to develop and evaluate novel therapeutic strategies for dealing with *A. baumannii* infections.

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EXHIBIT N

RESEARCH ARTICLE

Open Access

Prevalence and factors associated with wound colonization by *Staphylococcus spp.* and *Staphylococcus aureus* in hospitalized patients in inland northeastern Brazil: a cross-sectional study

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Abstract

Background: Infections by *Staphylococcus spp.* are often associated with wounds, especially in hospitalized patients. Wounds may be the source of bacteria causing cross-contamination, and are a risk factor for methicillin-resistant *Staphylococcus aureus* (MRSA) infection. The aim of this study was to investigate the prevalence of wound colonization by *Staphylococcus spp.*, especially *S. aureus* and MRSA, in hospitalized patients, and to identify the factors associated with such colonization.

Methods: This cross-sectional study enrolled patients with wounds who were hospitalized in a remote and underdeveloped inland region of northeastern Brazil with extreme poverty. Samples were collected using sterile swabs with 0.85% saline solution, and coagulase-negative *Staphylococcus spp.*, *S. aureus*, and MRSA were identified using standard laboratory procedures. Data regarding the sociodemographic characteristics, antibiotic use, and comorbidities of the patients were collected using the medical records and a questionnaire.

Results: A total of 125 wounds were analyzed. The patients had a mean age of 63.88 years and a mean 3.84 years of school education. Eighty-one wounds (64.80%) were colonized by *Staphylococcus spp.* Twenty-five wounds (20%) were colonized by *S. aureus*, 32% of which were colonized by MRSA. Wound colonization by *Staphylococcus spp.* was associated with pneumonia or other respiratory disease ($p = 0.03$). Wound colonization by *S. aureus* was associated with nasal colonization by *S. aureus* ($p < 0.001$), fewer days of prior antibiotic use ($p = 0.04$), admission to a medical ward ($p = 0.02$), and age > 65 years ($p = 0.05$). Among patients with wound colonization by MRSA, 37.50% had a history of prior antibiotic use, 75% had two or more comorbidities, 25% had cancer or diabetes, 50% had cardiovascular disease, and 50% died.

Conclusions: Wounds can be the source of *Staphylococcus spp.* infection, and high proportions of wounds are colonized by *S. aureus* and MRSA. Nasal colonization by *S. aureus* may be a source for wound colonization by *S. aureus*, illustrating the importance of preventing cross-contamination in hospital environments, especially among elderly patients. Wounds should be carefully managed to prevent microbial spread, thereby assisting patient recovery and reducing healthcare costs.

Keywords: *Staphylococcus spp.*, *Staphylococcus aureus*, MRSA, Wounds, Hospitalization

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Background

Infections by *Staphylococcus spp.* are common in developing countries [1]. Variations in antimicrobial susceptibility make it difficult to determine the infection patterns of *Staphylococcus spp.* in socioeconomically underdeveloped regions [2,3]. Hospitalization of patients increases their risk of infection, and hospital-acquired infections are associated with higher mortality rates, longer hospitalization periods, and increased healthcare costs compared with community-acquired infections [4,5].

The wounds of hospitalized patients may result from surgery, pressure ulcers, diabetic ulcers, or hospital- or community-acquired injuries, and wound infections can result in recurrent hospitalization. The relative frequencies of organisms causing wound infections varying greatly among studies. *Staphylococcus aureus* and *Pseudomonas aeruginosa* are among the organisms most commonly isolated from severe wounds, and colonization by these organisms requires careful management because of their ability to acquire antibiotic resistance and their association with nosocomial infections [6-13]. Wounds are a risk factor for colonization with methicillin-resistant *S. aureus* (MRSA) and other multidrug-resistant organisms, especially in hospital environments [14-18]. Bacterial colonization of wounds can increase wound severity and interfere with healing [6,11].

Even though skin and soft tissue infections are common in hospitalized patients [19], few epidemiological or clinical studies of these infections have been reported [4], especially studies focusing on the characteristics of specific healthcare systems or regions. Infections with antibiotic-resistant bacteria are associated with prolonged hospitalization, increased morbidity and mortality, and increased healthcare costs [4,5,20]. Investigation of the pattern of infection by *Staphylococcus spp.* in a hospital environment is therefore warranted, especially in wounds, which may be a source of cross-contamination by MRSA and coagulase-negative *Staphylococcus spp.* [11,15,18].

Lack of infrastructure and research funding have resulted in a lack of healthcare studies in northeastern Brazil, which has some of the poorest socioeconomic conditions in the country [21], especially in inland regions that are far from state capitals. The aim of the present study was to investigate the prevalence of wound colonization by *Staphylococcus sp.*, especially *S. aureus* and MRSA, in patients admitted to a public hospital in an inland region of northeastern Brazil, and to evaluate the factors associated with such colonization.

Methods

Study area and design

This 1-year cross-sectional study enrolled patients with wounds who were admitted to the Hospital Regional do Serido, municipality of Caico, state of Rio Grande do

Norte, Brazil. Caico is located in an inland region of northeastern Brazil and covers an area of 1228.6 km². The Hospital Regional do Serido is a referral hospital for patients from the inland part of Rio Grande do Norte, which treats patients from more than 14 municipalities, with an average of 2,000 admissions per year. The hospital includes 29 medical beds, 47 surgical beds, and 5 intensive care unit (ICU) beds. The study population lives in a remote and underdeveloped region.

Study population, sample size, and sampling procedures

All patients aged 18 years or older who were admitted to the medical ward, surgical ward, or ICU of the Hospital Regional do Serido with one or more infected wounds on days allocated for data gathering during 2012 were included in the study. Patients with wounds treated only in the outpatient clinics were not included in the study. Most patients (71.80%) had only one wound, and the remaining patients had two or more wounds each. As each wound was swabbed and included in the study, some patients were included more than once. The sampling unit of the survey was the wound. Data collection occurred on Monday, Tuesday, and Wednesday of each week, to enable performance of routine laboratory procedures. A total of 125 infected wounds were swabbed. Nasal swabs were also taken from all enrolled patients, as nasal colonization by *Staphylococcus spp.* and *S. aureus* were independent variables in the study.

Data collection procedures and collection of microbiological samples

A structured questionnaire was used to collect socioeconomic and demographic data from patients, including age, sex, years of school education, area of residence (rural or urban), marital status, number of children, and number of consumer goods available at home (car or motorcycle, internet access, and electronic goods including television, mobile phone, computer, DVD player, and stereo). The questionnaire also collected data regarding prior hospital admissions (within the past year), prior antibiotic use (within the past 6 months), and the time the wound was acquired. The medical records were reviewed to obtain information regarding the time of hospitalization, reason for hospitalization, antibiotic use, wound characteristics, and comorbidities. Chronic diseases (such as diabetes mellitus, hypertension, and liver dysfunction), conditions causing immunocompromise (such as organ transplantation, immunosuppressant medication, cancer, HIV infection, leukemia, and anemia), and opportunistic diseases were recorded.

After debridement of the wound edges and cleaning with physiological saline, the deepest part of the wound was swabbed with a sterile swab dipped in 0.85% saline solution. Both nostrils of each patient were also swabbed

with a sterile swab dipped in 0.85% saline solution. The diameter and characteristics (pus, edema, erythema, and necrosis) of each wound, the hospitalization period, and the clinical outcome (discharge, transfer, or death) were recorded.

Culture and microbial identification

All swabs were placed in sterile tubes containing brain heart infusion broth, and transported to the microbiology laboratory of the Caico Campus of the Universidade do Estado do Rio Grande do Norte in a cooler with ice. At the laboratory, the samples were incubated at 37°C for 24 h, after which 0.1-mL samples were seeded onto mannitol salt agar and incubated in a bacterial incubator at 37°C for 48 h. Colonies suggestive of staphylococci underwent Gram staining and catalase and coagulase testing. Colonies with Gram-positive cocci that were catalase-positive and coagulase-positive were classified as presumptive *S. aureus*, and colonies with Gram-positive cocci that were coagulase-negative were classified as coagulase-negative *Staphylococcus spp.* [22]. As it was not possible to perform polymerase chain reaction (PCR) amplification to confirm the species at this stage, colonies were classified as presumptive *S. aureus*, and PCR was performed for MRSA strains only.

MRSA screening and PCR amplification for detection of the *mecA* gene

Colonies identified as presumptive *S. aureus* underwent susceptibility testing using the disc diffusion method in Mueller–Hinton agar. Resistance to cefoxitin 30 µg (DME-Sensidisc®, Brazil) was tested to identify colonies as MRSA or methicillin-sensitive *S. aureus*, in accordance with the Clinical and Laboratory Standards Institute guidelines (2013) [22]. *S. aureus* ATCC 25923 was used as the quality control for antimicrobial susceptibility tests. To identify MRSA colonies, total DNA extraction was performed on the samples that were resistant to cefoxitin [23], followed by PCR amplification for detection of the *mecA* gene as described by Oliveira and De Lencastre in 2002 [24].

Statistical analysis

Wound colonization with *Staphylococcus spp.* and *S. aureus* were considered as dependent variables. Relationships between variables were analyzed using the chi-square test or Fisher's exact test, with the crude prevalence ratio used to determine the magnitude of associations. To analyze the relationships between variables, the quantitative variables were converted to categorical variables using their median values. Multivariable analysis was performed using the Poisson regression model with robust variance [25,26], including the variables with values of $p < 0.20$ on bivariate analysis and important

adjustment variables. The adjusted prevalence ratio was used to determine the magnitude of associations on multivariable analysis. Differences were considered significant at $p < 0.05$ in all tests. All statistical analyses were performed using Stata statistical software, release 10.0 (College Station, TX).

Ethical considerations

All patients gave written informed consent for inclusion in the study. The study was approved by the Research Ethics Committee of the Universidade do Estado do Rio Grande do Norte (protocol number 001/11).

Results

The sociodemographic characteristics of the enrolled patients are shown in Table 1. There were no significant associations between sociodemographic characteristics and wound colonization by *Staphylococcus spp.* or *S. aureus*. Eighty-five of the 125 wounds swabbed (68%) were from patients in the medical ward, 20 (16%) were from patients in the surgical ward, and 20 (16%) were from patients in the ICU. The mean period of hospitalization was 8.60 ± 6.35 days, and the mean number of antibiotics used was 2.08 ± 0.92 . Among patients with wound colonization by *Staphylococcus spp.*, 72% were prescribed more than one antibiotic, including a cephalosporin in 90% of cases (usually third or fourth generation), ciprofloxacin in 48% of cases, and oxacillin in 23% of cases. However, there was no established pattern

Table 1 Sociodemographic characteristics of hospitalized patients

Sociodemographic characteristics	n (%) or Mean $\pm$ SD
Sex	
Male	63 (50.40)
Female	62 (49.60)
Marital status	
Married	47 (37.60)
Single/separated/divorced	40 (32.00)
Widowed	38 (30.40)
Area of residence	
Rural	20 (16.00)
Urban	105 (84.00)
Age	63.88 ± 18.57
School education (years)	3.84 ± 3.70
Persons per household	4.40 ± 3.12
Children per household	3.18 ± 3.23
Number of consumer goods	8.00 ± 3.95

Urban area = inside the city limits of a town or village, defined by a municipal area. Rural area = a municipality outside the city limits. An area of agricultural activities and livestock, rural tourism, forestry, or environmental conservation (Instituto Brasileiro de Geografia e Estatística).

for the treatment of wound colonization by *Staphylococcus spp.*, with more than 20 antibiotics in eight groups used.

Among wounds colonized by *Staphylococcus spp.*, 79 (63.20%) were in patients with prior hospitalization, 49 (39.20%) were in patients with prior antibiotic use, 59 (47.20%) were in patients with diabetes mellitus, 66 (52.80%) were in patients with cardiovascular disease, 26 (20.80%) were in patients with pneumonia or other respiratory disease, 18 (14.40%) were in patients with cancer, 35 (28%) were in patients with paralysis or other mobility disorder, and 18 (14.40%) were in patients with septicemia. The mean wound diameter was 7 ± 6.19 cm, and 63 wounds (50.40%) had been acquired within the past 30 days. Only 21 (25.92%) of the wounds colonized by *Staphylococcus spp.* were acquired in hospital.

The prevalence of *Staphylococcus spp.* colonization in wounds was 64.80% ($n = 81$; 95% confidence interval [CI] 56.40–73.20), the prevalence of *S. aureus* colonization was 20% ($n = 25$; 95% CI 12.98–27.02), and the prevalence of MRSA colonization was 6.40% ($n = 8$; 95% CI 6.30–6.50). Among wounds colonized by *Staphylococcus spp.*, 30.86% were colonized by *S. aureus*, of which 32% were colonized by MRSA. The majority ($n = 5$; 62.50%) of wounds colonized by MRSA were in female patients, and 2 (25%) were in patients with prior hospitalization. Among wounds colonized by MRSA, 3 (37.50%) were in patients with prior antibiotic use, 6 (75%) were in patients with two or more comorbidities, 2 (25%) were in patients with cancer or diabetes mellitus, 4 (50%) were in patients with cardiovascular disease, 6 (75%) were in patients who received two or more antibiotics, and 4 (50%) were in patients who died. Among wounds colonized by MRSA, necrosis occurred in 4 (50%) and septicemia occurred in 1 (12.50%). All patients with wound colonization by MRSA also had nasal colonization by MRSA. Most of the wounds ($n = 6$; 75%) colonized by MRSA were acquired in the community.

There were no significant associations between wound colonization by *Staphylococcus spp.* and comorbidities, except for pneumonia or other respiratory disease ($p = 0.03$). There were also no significant associations between wound colonization by *S. aureus* and comorbidities. However, there were significant associations between nasal colonization by *S. aureus* and wound colonization by *Staphylococcus spp.* ($p = 0.05$) and *S. aureus* ($p = 0.003$). The relationships between wound colonization by *Staphylococcus spp.* and *S. aureus* and hospitalization variables and wound characteristics are shown Table 2. Wound colonization by *S. aureus* was significantly associated with nasal colonization by *S. aureus*, fewer days of prior antibiotic use, and admission to the medical ward. Acquisition of the wound in the community was close to the threshold for significant association with wound colonization by *S. aureus*.

Although there were no significant associations between wound colonization by *Staphylococcus spp.* or *S. aureus* and the duration of hospitalization, the hospitalization period was longer in patients with hospital-acquired wounds than in patients with community-acquired wounds ($p = 0.04$).

The multivariable analysis included sex in addition to the variables with $p < 0.20$ on bivariate analysis, as this was an important adjustment variable in multiple models. Multivariable analysis found that wound colonization by *S. aureus* was independently associated with nasal colonization by *S. aureus*, fewer days of prior antibiotic use, and admission to the medical ward. Age was close to the threshold for independent association with wound colonization by *S. aureus* (Table 3).

Discussion

The frequency of wound colonization by *S. aureus* was lower in the present study than the frequency of >30% in the majority of previously reported studies [4,9,11,27,28]. This can be attributed to almost 40% of the wounds in the present study being in patients with prior antibiotic use, of which more than 60% had a history of prior hospitalization, which may have decreased the rate of colonization by methicillin-sensitive *S. aureus*. However, slightly over 30% of the wounds colonized by *Staphylococcus spp.* were colonized by *S. aureus*, which is higher than the proportion of 18% reported in a study of isolates from blood cultures and secretions of hospitalized patients in a teaching hospital in Natal, the capital city of the state where the present study was conducted [29]. This confirms that regional characteristics of the population and healthcare processes influence the microbial profiles of hospitals.

In this study, slightly over 30% of the wounds colonized by *S. aureus* were colonized by MRSA, which is similar to previously reported findings [3,28,30–32]. Even though the present study found a lower rate of wound colonization by *S. aureus* than in studies conducted in other regions and other countries, the rate of antibiotic resistance was high, which may be attributed to prior antibiotic use by more than a third of the patients, the majority of whom were elderly with comorbidities, and use of multiple antibiotics. Some of the patients also had a history of prior hospitalization. All of these factors may have resulted in selection of weaker bacterial strains, which are generally associated with the presence of MRSA [33–35]. The colonization of wounds by MRSA indicates a need for greater control to ensure the proper use of antibiotics, and careful management of hospitalized patients and the hospital environment to avoid cross-contamination and the spread of antibiotic-resistant bacteria in the hospital. In the present study, half of the wounds colonized by MRSA were in patients with cardiac

Table 2 Associations between wound colonization by *Staphylococcus* spp. and *Staphylococcus aureus*, and hospitalization variables and wound characteristics

	Wound colonization by <i>Staphylococcus</i> spp.				Wound colonization by <i>S. aureus</i>			
	Yes n (%)	No n (%)	p	PR (95% CI)	Yes n (%)	No n (%)	p	PR (95% CI)
Type of ward								
Medical	55 (65.90)	29 (34.10)	0.87	1.05	22 (25.90)	63 (74.10)	0.03	3.45
Surgical or ICU	25 (62.50)	15 (37.50)		(0.79-1.40)	3 (7.50)	37 (92.50)		(1.10-10.86)
Length of hospitalization								
≥7 days	36 (57.10)	27 (42.90)	0.10	0.79	10 (15.90)	53 (84.10)	0.35	0.66
<7 days	45 (72.60)	17 (27.40)		(0.60-1.02)	15 (24.20)	47 (75.80)		(0.32-1.35)
Prior antibiotic use								
≥3 days	37 (58.70)	26 (41.30)	0.21	0.83	6 (9.50)	57 (90.50)	0.01	0.31
<3 days	44 (71.00)	18 (29.00)		(0.64-1.07)	19 (30.60)	43 (69.40)		(0.13-0.73)
Clinical outcome								
Death	31 (64.60)	17 (35.40)	1.00	1.01	11 (22.90)	37 (77.10)	0.60	1.32
Discharge or transfer	48 (64.00)	27 (36.00)		(0.77-1.32)	13 (17.30)	62 (82.70)		(0.65-2.71)
Prior hospitalization								
Yes	49 (62.00)	30 (38.00)	0.51	0.89	12 (15.20)	67 (84.80)	0.13	0.54
No	32 (69.60)	14 (30.40)		(0.69-1.15)	13 (28.30)	33 (71.70)		(0.27-1.08)
Prior antibiotic use								
Yes	28 (57.10)	21 (42.90)	0.21	0.82	8 (16.30)	41 (83.70)	0.55	0.73
No	53 (69.70)	23 (30.30)		(0.62-1.09)	17 (22.40)	59 (77.60)		(0.34-1.56)
Wound acquisition								
Hospital	21 (67.70)	10 (32.30)	0.86	1.06	2 (6.50)	29 (93.50)	0.05	0.26
Community	60 (63.80)	34 (36.20)		(0.80-1.41)	23 (24.50)	71 (75.50)		(0.07-1.05)
Wound type								
Pressure ulcer	40 (63.50)	23 (36.50)	0.90	0.96	11 (17.50)	52 (82.50)	0.62	0.77
Diabetic foot or other	41 (66.10)	21 (33.90)		(0.74-1.24)	14 (22.60)	48 (77.40)		(0.38-1.57)
Wound site								
Lower limb	43 (66.20)	22 (33.80)	0.89	1.04	17 (26.20)	48 (73.80)	0.12	1.96
Sacral or other	38 (63.30)	22 (36.70)		(0.81-1.35)	8 (13.30)	52 (86.70)		(0.91-4.21)
Wound duration								
≤30 days	43 (68.30)	20 (31.70)	0.53	1.11	10 (15.90)	53 (84.10)	0.35	0.66
>30 days	38 (61.30)	24 (38.70)		(0.86-1.44)	15 (24.20)	47 (75.80)		(0.32-1.35)
Wound diameter								
>5 cm	36 (58.10)	26 (41.90)	0.17	0.81	13 (21.00)	49 (79.00)	0.79	1.10
≤5 cm	45 (71.40)	18 (28.60)		(0.62-1.06)	12 (19.00)	51 (81.00)		(0.55-2.22)
Wound pus								
Yes	22 (71.00)	9 (29.00)	0.54	1.13	9 (29.00)	22 (71.00)	0.23	1.71
No	59 (62.80)	35 (37.20)		(0.86-1.49)	16 (17.00)	78 (83.00)		(0.80-3.46)
Wound necrosis								
Yes	41 (57.70)	30 (42.30)	0.09	0.78	13 (18.30)	58 (81.70)	0.75	0.82
No	40 (74.10)	14 (25.90)		(0.60-1.00)	12 (22.20)	42 (77.80)		(0.41-1.66)

Table 2 Associations between wound colonization by *Staphylococcus spp.* and *Staphylococcus aureus*, and hospitalization variables and wound characteristics (Continued)

Foul wound odor								
Yes	13 (56.50)	10 (43.50)	0.50	0.85	6 (26.10)	17 (73.90)	0.40	1.40
No	68 (66.70)	34 (33.30)		(0.58-1.24)	19 (18.60)	83 (81.40)		(0.63-3.11)

disease, and the great majority were in patients with two or more comorbidities.

It is worth noting that *Staphylococcus spp.* are not the only organisms that colonize wounds. Wound infections can also be caused by various other microorganisms, such as group A streptococci (particularly *Streptococcus pyogenes*), *Escherichia coli*, *Pseudomonas aeruginosa*, and other Gram-negative bacteria, which may present in isolation or may cause polymicrobial infections that include *Staphylococcus spp.* [36-39].

A study conducted in Denmark found that patients with nasal colonization by *S. aureus* had the same clone of *S. aureus* in their chronic ulcers [40], indicating that nasal colonization is an important source of wound contamination in the same patient, as well as cross-contamination among patients. In the present study, nasal colonization by *S. aureus* was associated with wound colonization by *Staphylococcus spp.* and *S. aureus*, and all patients with wound colonization by MRSA also had nasal colonization by MRSA. These results indicate that nasal colonization is an important source

of cross-contamination by multidrug-resistant bacterial strains [41].

Some studies reported that community-acquired wounds are often poorly managed and may be colonized by multidrug-resistant organisms [42,43]. Most of the wounds included in the present study were acquired in the community, which may contribute to the high frequency of colonization by antibiotic-resistant strains. However, it is difficult to determine whether colonization by *Staphylococcus spp.* occurred in the community or the hospital, even when the wounds were acquired in the community, because most patients had a history of prior hospitalization and the great majority had other systemic diseases. To determine that colonization by MRSA is community-acquired, MRSA must be isolated from a patient who has not recently been hospitalized, used antibiotics, or had a catheter placed [44].

In the present study, half of the wounds colonized by MRSA were in patients who died, and the majority were in patients with two or more comorbidities, and who received two or more antibiotics during their hospitalization.

Table 3 Multivariable analysis of factors associated with wound colonization by *Staphylococcus aureus*

Independent variables		Wound colonization by <i>S. aureus</i>		p	PR (95% CI)	p	PR _{adjusted} (95% CI)
		Absent n (%)	Present n (%)				
Nasal <i>S. aureus</i>	Present	6 (28.60)	15 (71.40)	<0.001	7.43 (3.88-14.21)	<0.001	4.39 (2.22-8.66)
	Absent	94 (90.40)	10 (9.60)				
Prior antibiotic use	≥3 days	57 (90.50)	6 (9.50)	0.01	0.31 (0.13-0.73)	0.04	0.49 (0.25-0.99)
	<3 days	43 (69.40)	19 (30.60)				
Type of ward	Medical	63 (74.10)	22 (25.90)	0.03	3.45 (1.10-10.86)	0.02	3.06 (1.15-8.14)
	Surgical or ICU	37 (92.50)	3 (7.50)				
Marital status	Unmarried	58 (74.40)	20 (25.60)	0.07	2.41 (0.97-5.99)	0.64	1.27 (0.46-3.45)
	Married	42 (89.40)	5 (10.60)				
Wound acquisition	Hospital	29 (93.50)	2 (6.50)	0.05	0.26 (0.07-1.05)	0.16	0.38 (0.10-1.46)
	Community	71 (75.50)	23 (24.50)				
Prior hospitalization	Yes	67 (84.80)	12 (15.20)	0.13	0.54 (0.27-1.08)	0.40	0.76 (0.40-1.44)
	No	33 (71.70)	13 (28.30)				
Age	≥65 years	46 (74.20)	16 (25.80)	0.17	1.81 (0.86-3.78)	0.05	1.92 (0.99-3.75)
	<65 years	54 (85.70)	9 (14.30)				
Sex	Male	48 (76.20)	15 (23.80)	0.39	1.48 (0.72-3.30)	0.90	1.04 (0.52-2.10)
	Female	52 (83.90)	10 (16.10)				

Model fit (chi-square test): p = 0.79.

This illustrates the relationship between colonization by antibiotic-resistant bacterial strains and the presence of comorbidities that cause systemic vulnerability. Educational campaigns can reduce the spread of MRSA in the community [43], and such campaigns should be promoted in public hospitals, especially when the population has a limited education. The patients enrolled in the present study had a mean period of education of 4 years, and more than a third of the local population works in agriculture.

Strategies for prevention and control of infection are very important in the region studied, where wound infections caused by MRSA are not common and many patients with wound colonization by MRSA have previously been hospitalized or used antibiotics. Moreover, patients with wound colonization by MRSA had a high mortality rate. It is therefore necessary to investigate the routines of the staff responsible for wound care, and use the results of such investigations to promote training regarding the prevention of cross-contamination in hospitals.

The present study provides a profile of wound colonization by *Staphylococcus spp.* in patients in an undeveloped region of Brazil with extreme poverty. However, the study has some important limitations. PCR amplification for identification of *S. aureus*, and molecular type classification for identification of MRSA strains were not performed. The nasal swab results may give an indication of the prevalence of methicillin-sensitive *S. aureus* and MRSA in the community, but the MRSA strains in the community were not identified. Other skin areas could be also have been investigated as potential carriers of MRSA. Moreover, it was not possible to collect swabs on all days of the week, or to include wounds treated in outpatient clinics, which may have introduced selection bias.

Conclusions

The present study found a high frequency of wound colonization by *Staphylococcus spp.* and moderate frequency of wound colonization by *S. aureus*. The proportion of wounds colonized by MRSA was high in this study compared with other studies. Knowledge about the colonization patterns of these microorganisms in the hospital environment is important, because of their ability to acquire resistance, which can lead to prolonged hospitalization and treatment difficulty. Nasal colonization by *S. aureus* is an important source of wound colonization by *S. aureus*, which illustrates the importance of preventing cross-contamination. Our results reinforce the need for prevention and control of hospital- and community-acquired infections, especially among elderly patients, who may need longer treatment and larger numbers of medications, and may have more comorbidities, than

younger patients. In conclusion, wounds are a source of *Staphylococcus spp.* infection, and should be the focus of prevention and control strategies to avoid microbial spread, assist in patient treatment, and minimize hospitalization costs.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

GCMA participated in all stages of the research (design, data collection, data analysis, and interpretation of data) and drafted the manuscript. MMS, NGML, and TAC assisted with data collection and participated in the laboratory analyses. MCNM and KCL helped with the conception and design of the study and the analysis and interpretation of data, participated in critical revision of the manuscript, and contributed to the final version of the manuscript. All authors read and approved the final manuscript.

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EXHIBIT O

East Cooper Medical Center
2000 Hospital Drive
Mt Pleasant, SC 29464-3764

Patient: TURISK, REBECCA C

Attending Provider: RICHARDSON MD, WILLIAM B

Admission Date: 3/27/2017

Discharge Date: 3/27/2017

Lab Medical Director(s): Anne S. Flynn, MD

/ Female

Operative/Procedure Reports

Document Type: Operative Report
Document Subject: ECH-Operative Record
Document Date/Time: 3/28/2017 09:05 EDT
Document Status: Auth (Verified)
Performed By:
Authenticated By:

ECH-Operative Record

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Document Type: Procedure Note
Document Subject: ECH-Procedure Note
Document Date/Time: 3/27/2017 09:09 EDT
Document Status: Modified
Performed By: RICHARDSON MD, WILLIAM B (3/27/2017 08:43 EDT)
Authenticated By: RICHARDSON MD, WILLIAM B (4/10/2017 11:33 EDT)

ECH-Procedure Note

DATE OF PROCEDURE: 3/27/2017.

LOCATION: East Cooper Regional Medical Center.

PROCEDURES: Spinal cord stimulator revision utilizing a St. Jude system.

PREPROCEDURE DIAGNOSES:

1. Chronic pain syndrome.
2. Post impingement, lumbar spine.
3. Nonfunctional generator.

POSTPROCEDURE DIAGNOSES:

1. Chronic pain syndrome.
2. Post impingement, lumbar spine.
3. Nonfunctional generator.

INDICATIONS: This is a 50-year-old female with significant history of lower back and lower extremity pain, who has failed medical interventional therapy with greater than 50% relief from a spinal cord stimulator trial and subsequent implantation, who had extensive surgery over the last year with a large amount of _____ that burned out the generator and is now here for replacement of the generator system.

PROCEDURE SUMMARY: After being checked in by the nursing staff, vital obtained, saline lock started. Consent was obtained. She was evaluated by anesthesia, ensured that she got 2 g of Ancef preoperatively 30 minutes before

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ED305B0A16FF4F3FBE27, TURISK, 584
Turisk-ECMC-0584

Turisk-ECMC-0584
CONFIDENTIAL MEDICAL RECORDS

East Cooper Medical Center
2000 Hospital Drive
Mt Pleasant, SC 29464-3764

Patient: TURISK, REBECCA C

Attending Provider: RICHARDSON MD, WILLIAM B

Admission Date: 3/27/2017

Discharge Date: 3/27/2017

Lab Medical Director(s): Anne S. Flynn, MD

/ Female

Operative/Procedure Reports

incision. She was taken to the OR, placed in the prone position on the table.

She was monitored in usual fashion with continuous physiologic monitoring consisting of blood pressure, respiratory and pulse oximetry throughout the procedure. We will defer to the anesthesia notes for vital signs, as well as medications.

ANESTHESIA TYPE: MAC, monitored anesthetic care.

PROCEDURE IN DETAIL: Her back was prepped in a 3-layer fashion with alcohol scrub, Betadine wash and chlorhexidine prep. Full sterile technique was utilized. The C-arm fluoroscopy was brought in to visualize the old generator system. The old lumbar incision was identified and marked and anesthetized with 10 mL of Hagerty solution and then 10 mL of 0.25% bupivacaine with 1:200,000 epinephrine down the deeper tissue. At this point, a 10-blade scalpel was utilized to make an elliptical incision around the old lumbar incision. I then dissected out a full-thickness graft, dissected down to the thoracodorsal fascia using blunt and sharp dissection. The old anchor system was dissected out and identified with no signs of infection or purulent material around the anchoring system sutures then dissected out the old generator pocket and removed the primary generator using blunt and sharp dissection. The leads were removed from the grommets with supplied hexagonal screwdriver. Then a new Eon rechargeable generator was hooked up to the initial lead with the hexagonal screwdriver, 6 clicks past tightness. The patient requested a moving out the generator to slightly caudal region from the initial _____ line, we dissected out new generator pocket just cephalad of the initial pocket using the same single lumbar incision using blunt and sharp dissection approximately 2 cm below the skin surface. The new generator pocket and old generator pocket was copiously irrigated with double antibiotic solution. The new Eon rechargeable generator was placed and a Tybex antimicrobial mesh pocket with excess lead coiled behind the generator inside the pocket. The entire unit was then placed in the new generator pocket with excess lead again coiled behind the generator. The new generator pocket was closed with a single 2-0 silk suture to ensure that the generator did not migrate back towards the midline. The single incision was then closed in a 3-layer fashion with 2-0 Vicryl in interrupted stitch at the deep and middle layer and the skin closed in a 3-0 Monocryl subcuticular stitch. The skin incision was dressed with Steri-Strips, bacitracin and a stack of 4 x 4 gauze.

Patient was placed supine on a stretcher and abdominal binder and taken to PACU for recovery and discharged home with a prescription of Keflex 500 mg q.i.d. for 2 weeks as well as Nucynta p.r.n. for postop pain. Patient tolerated the procedure nicely. We will see her back in 1 week for reassessment.

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Printed: 8/16/2018 14:48 EDT

ED305B0A16FF4F3FBE27, TURISK, 585
Turisk-ECMC-0585

Turisk-ECMC-0585
CONFIDENTIAL MEDICAL RECORDS

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	C.A. No.: 2018-CP-10-2109
	)	
Rebecca Turisk,	)	
	)	
Plaintiff,	)	PLAINTIFF’S MOTION
	)	FOR A NEW TRIAL AS TO PROXIMATE
	)	CAUSE AND DAMAGES ONLY, OR IN THE
v.	)	ALTERNATIVE FOR JUDGMENT
	)	NOTWITHSTANDING THE VERDICT OR
Dennis K. Schimpf, M.D., and	)	ALTERNATIVELY FOR A NEW TRIAL
Sweetgrass Plastic Surgery, LLC,	)	ABSOLUTE
	)	
Defendants.	)	
	)	

Plaintiff Rebecca Turisk (“Plaintiff”), by and through her undersigned counsel, hereby files the instant Motion for a New Trial as to proximate cause and damages only, and a Motion for Judgment Notwithstanding the Verdict. Alternatively, Plaintiff moves for a New Trial Absolute. Plaintiff’s motion should be granted because, in light of the evidence presented at trial, the verdict is inconsistent and indicates the jury was confused. In addition, a new trial is warranted pursuant to the “Thirteenth Juror” doctrine because the verdict is contrary to the weight of the evidence.¹

BACKGROUND

This case was filed on April 23, 2018, in the Court of Common Pleas of Charleston County, South Carolina. Plaintiff brought this medical malpractice action against Defendants for the loss of adequate blood flow sustained during her November 1, 2016, surgery, as well as injuries and damages she sustained following that surgery.

¹ Plaintiff respectfully seeks leave to fully brief the instant motions once Plaintiff receives a copy of the trial transcript. Plaintiff has ordered a copy of the rough transcript from the court reporter and will, with the Court’s permission, file a supplemental brief upon receipt of the rough transcript or final transcript, as the court orders.

This matter was tried November 14 thru November 17, 2022, before this Court. At the conclusion of the trial, the jury returned a verdict for Plaintiff finding the Defendants breached the Standard of Care but finding that although the Defendants deviated from the standard of care, the deviation was not the proximate cause of Plaintiff's injuries. Plaintiff seeks relief via the instant motion because, in light of the evidence presented at trial, the verdict is inconsistent and indicates the jury was confused, and because the verdict is contrary to the weight of the evidence.

STANDARDS OF REVIEW

This Court has authority, upon motion of a party or *sua sponte*, to grant a new trial “for any of the reasons for which new trials have heretofore been granted in actions at law in the courts of th[is] State.” S.C. R. CIV. P. 59(a), (d). “The decision to grant or deny a motion for a new trial rests within the sound discretion of the trial court, and the trial court’s decision will not be disturbed absent an abuse of discretion.” *Fields v. J. Haynes Waters Builders, Inc.*, 376 S.C. 545, 569, 658 S.E.2d 80, 93 (S.C. 2008) (citation omitted). This verdict was inconsistent, unclear, and against all of the evidence. “When a verdict is so confused that the jury’s intent is unclear, the safest and best course is to order a new trial.” *Johnson v. Parker*, 279 S.C. 132, 135, 303 S.E.2d 95, 97 (S.C. 1983) (citation omitted); *see also Johnson v. Hoechst Celanese Corp.*, 317 S.C. 415, 421-22, 453 S.E.2d 908, 912 (S.C. Ct. App. 1995) (noting “a new trial may be granted if the verdict is inconsistent and reflects the jury’s confusion” (citation omitted)).

Additionally, in ruling on a motion for judgment notwithstanding the verdict (JNOV), the circuit court views the evidence and all reasonable inferences in the light most favorable to the nonmoving party. *See Jones v. Builders Inv. Grp., LLC*, 415 S.C. 321, 328, 781 S.E.2d 737, 741 (S.C. Ct. App. 2015) (citing *Elam v. S.C. Dep’t of Transp.*, 361 S.C. 9, 27-28, 602 S.E.2d 772, 782 (S.C. 2004)); *see also* S.C. R. CIV. P. 50(b). While where the “evidence yields more than one

reasonable inference or its inference is in doubt,” the motion for JNOV should be denied. *See Jones*, 415 S.C. at 328, 781 S.E.2d at 741 (citing *Strange v. S.C. Dep’t of Highways & Pub. Transp.*, 314 S.C. 427, 429-30, 445 S.E.2d 439, 440 (S.C. 1994)). Further, the motion may be granted if no reasonable jury could have reached the challenged verdict. *Id.* at 328, 781 S.E.2d at 741 (citing *Gastineau v. Murphy*, 331 S.C. 565, 568, 503 S.E.2d 712, 713 (S.C. 1998)).

EVIDENCE AT TRIAL

There was but one dispute at this trial: whether Defendants breached the Standard of Care in planning and executing the surgical technique for this particular patient, the Plaintiff. That dispute was decided by the jury in favor of the Plaintiff. Plaintiff’s expert also testified, and it was uncontroverted by the Defendants, Defendants’ expert Plastic Surgeon, and Defendants’ expert Infectious Diseases doctor that the loss of adequate blood flow of the nipple areola complex (NAC), whether into or from, was caused by and a result of the surgery, causing the Plaintiff’s right NAC to become necrotic. The Plaintiff’s expert, the Defendants themselves, and the Defendants’ experts further agreed to the following: the necrotic NAC developed by the loss of blood flow caused by the surgery, allowed a colony of three types of bacteria to become colonized in the NAC and then below in the fatty tissue of the breast; in turn that caused the death of the surrounding tissues which also, because of the lack of blood flow, could not be treated with anything but debridement; and eventually a double mastectomy, as well as the many subsequent surgeries to restore as much as possible to both breasts. The testimony of Plaintiff’s expert and her subsequent treating MUSC Plastic Surgeon was further uncontroverted by Defendants and their expert Plastic Surgeon that the multiple debridement procedures, the mastectomy, the surgical procedures, and the fat grafting were all reasonable, medically necessary, and caused by the cascading events described above.

ARGUMENT

As set forth above, Plaintiff moves this Court for an Order granting her a New Trial on Proximate Cause and Damages only, or in the alternative granting her Judgment Notwithstanding the Verdict. Alternatively, Plaintiff seeks a New Trial Absolute.

A. Plaintiff's Motion Should Be Granted Because the Verdict Is Inconsistent and Indicates the Jury Was Confused.

In this case, the jury found that Defendants breached the standard of care in treating the Plaintiff but that such breach did not proximately cause Plaintiff's damages. This verdict is inconsistent with the specific finding of deviation and the uncontroverted facts presented at trial and indicates the jury was confused regarding proximate cause. Plaintiff's Motion for a New Trial as to Proximate Cause and Damages Only, Judgment Notwithstanding the Verdict, or alternatively, a New Trial Absolute, should therefore be granted.

"Verdicts which are irreconcilably inconsistent should not stand, and a new trial should be granted, because the parties and the judge 'should not be required to guess as to what a jury sought to render.'" *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 49, 691 S.E.2d 135, 149 (S.C. 2010) (quoting *Prego v. Hobart*, 287 S.C. 116, 118, 336 S.E.2d 725, 726 (S.C. Ct. App. 1985)). "When the jury assesses liability to a defendant but awards zero damages, the verdict is facially inconsistent and contrary to South Carolina law." *Longshore v. Saber Sec. Servs.*, 365 S.C. 554, 562, 619 S.E.2d 5, 10 (S.C. Ct. App. 2005) (citing *Stevens v. Allen*, 342 S.C. 47, 53, 536 S.E.2d 663, 666 (2000)).

In this case, the jury found that Defendants violated the standard of care in treating the Plaintiff. The only theory of the breach presented to the jury was that Defendants selected and performed Plaintiff's surgery using the inferior pedicle inverted T approach because this approach interrupted the fragile vascularity that was left by Plaintiff's prior bilateral breast implant

procedures. The case involved a “battle of the experts,” where Plaintiff’s expert testified Defendants breached the standard of care in using this specified surgical approach for this Plaintiff, and Defendant Schimpf and Defendants’ expert testified that using this surgical approach met the standard of care. It was undisputed that the surgery itself, at least, proximately caused some damages to Plaintiff. All expert witnesses agreed that the surgery interrupted the blood flow surrounding Plaintiff’s NAC, thereby causing her right NAC to become necrotic and necessitating debridement and eventually a double mastectomy. The issue was whether this surgical approach violated the standard of care. The jury unanimously found that it did.

On the evidence before the Court, the jury’s finding that Defendants breached the standard of care is inconsistent with its finding that Defendants’ deviation from the standard of care was not the proximate cause of Plaintiff’s damages and reflects the jury’s confusion. The only evidence before the Court is that the surgery was the proximate cause of the damages to Plaintiff. Accordingly, given the jury’s finding that Defendants’ surgical approach violated the standard of care, the jury’s verdict is inconsistent with that finding. Plaintiff’s Motion for a New Trial on Proximate Cause and Damages Only, or in the alternative Judgment Notwithstanding the Verdict or New Trial Absolute should therefore be granted. *See, e.g., Tuten v. Joel*, 410 S.C. 104, 116, 763 S.E.2d 54, 61 (S.C. Ct. App. 2014) (“Although proximate cause is ordinarily a jury question, the court may decide proximate cause as a matter of law when the evidence is susceptible to only one inference.” (internal quotation marks and citation omitted)). Alternatively, Plaintiff seeks a New Trial Absolute.

B. Plaintiff’s Motion Should Be Granted Because the Verdict Is Contrary to the Weight of the Evidence.

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, 254, 387 S.E.2d 265, 267

(S.C. 1990). “‘Under the “thirteenth juror doctrine,” a trial judge may grant a new trial absolute when he finds the evidence does not justify the verdict. This ruling has also been termed a granting of a new trial upon the facts.’” *Haselden v. Davis*, 341 S.C. 486, 506, 534 S.E.2d 295, 306 (S.C. Ct. App. 2000) (quoting *Vinson v. Hartley*, 324 S.C. 389, 402, 477 S.E.2d 715, 722 (S.C. Ct. App. 1996)). 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, 586, 243 S.E.2d 460, 460 (S.C. 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 *n*th degree. . . .” *Worrell v. S.C. Power Co.*, 186 S.C. 306, 313, 195 S.E. 638, 641 (S.C. 1938).

“Unlike a motion for directed verdict, the trial judge weighs the evidence under the thirteenth juror doctrine and need not view the evidence in the light most favorable to the opposing party.” *McEntire v. Mooregard Exterminating Servs., Inc.*, 353 S.C. 629, 633, 578 S.E.2d 746, 748 (S.C. Ct. App. 2003); *see also Parker v. Evening Post Publ’g Co.*, 317 S.C. 236, 247, 452 S.E.2d 640, 646 (S.C. Ct. App. 1994) (stating the trial court may take its own view of the evidence). Furthermore, the decision of whether to grant a new trial upon the facts is one addressed to the sound discretion of the trial judge. *S.C. State Highway Dep’t v. Clarkson*, 267 S.C. 121, 126, 226 S.E.2d 696, 697 (S.C. 1976).

“South Carolina’s thirteenth juror doctrine is so named because it entitles the trial judge to sit, in essence, as the thirteenth juror when he finds ‘the evidence does not justify the verdict,’ and then to grant a new trial based solely ‘upon the facts.’” *Norton v. Norfolk S. Ry. Co.*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (S.C. 2002) (quoting *Folkens*, 300 S.C. at 254, 387 S.E.2d at 267). By

sitting “[a]s the ‘thirteenth juror,’ the trial judge can hang the jury by refusing to agree to the jury’s otherwise unanimous verdict.” *Id.* at 478, 567 S.E.2d at 854. As stated by the South Carolina Supreme Court in *Folkens*,

The effect is the same as if the jury failed to reach a verdict. . . . When a jury fails to reach a verdict, a new trial is ordered. Neither judge nor the jury is required to give reasons for this outcome. Similarly, because the result of the “thirteenth juror” vote by the judge is a new trial rather than an adjustment to the verdict, no purpose would be served by requiring the trial judge to make factual findings.

300 S.C. at 254, 387 S.E.2d at 267.

In the present case, the jury returned a verdict finding that Defendants deviated from the standard of care, while simultaneously making an inconsistent finding that the deviation was not the proximate cause of Plaintiff’s injuries. This result is contrary to the preponderance of the evidence, if not all of the evidence and clearly indicates confusion of the jury as to proximate cause. Plaintiff presented evidence that because Defendants breached the standard of care, Plaintiff’s blood flow was compromised which led to necrosis of her tissue and an infection, and required her to seek extensive additional treatment and ultimately reconstructive surgery. Indeed, it was undisputed that the surgery was the cause of Plaintiff’s injuries and damages; the dispute was whether Defendants’ surgical approach violated the standard of care. Upon weighing the evidence in this case, the Court, acting in its capacity as the thirteenth juror, should rule that the verdict is against the preponderance of the evidence and grant a new trial so that justice may prevail.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that this Court grant Plaintiff’s Motion for a New Trial as to Proximate Cause and Damages Only, or in the alternative for Judgment Notwithstanding the Verdict. Alternatively, Plaintiff requests a New Trial Absolute as

well as any and all other such relief to which she may be entitled. Plaintiff respectfully requests that she be allowed to file a supplemental memorandum upon receipt of the rough trial transcript as the Court orders.

Respectfully submitted,

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ATTORNEYS FOR PLAINTIFF

November 28, 2022

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C.A. No.: 2018-CP-10-02109
	)	
Rebecca Turisk,	)	
	)	
Plaintiff,	)	DEFENDANTS' RESPONSE IN
	)	OPPOSITION TO PLAINTIFF'S
vs.	)	MOTION FOR A NEW TRIAL AS TO
	)	PROXIMATE CAUSE AND DAMAGES
	)	ONLY, OR, IN THE ALTERNATIVE,
	)	FOR JUDGMENT
Dennis K. Schimpf, M.D. and Sweetgrass	)	NOTWITHSTANDING THE VERDICT,
Plastic Surgery, LLC,	)	OR, ALTERNATIVELY, FOR A NEW
	)	TRIAL ABSOLUTE
Defendants.	)	
	)	

Defendants Dennis K. Schimpf, M.D. and Sweetgrass Plastic Surgery, LLC (collectively, "Defendants"), by and through undersigned counsel, hereby submit the following Response in Opposition to Plaintiff's Motion for a New Trial as to Proximate Cause and Damages Only, or, in the alternative, for Judgment Notwithstanding the Verdict, or, also in the alternative, a New Trial Absolute. As detailed further below, neither a new trial nor judgment withstanding the verdict (JNOV) in favor of Plaintiff is warranted because the jury's verdict was not inconsistent and the weight of the evidence supported a verdict in favor of the Defendants.

I. STANDARDS OF REVIEW

a. NEW TRIAL

Whether to grant a new trial is a matter within the discretion of the trial judge, and the decision will not be disturbed on appeal unless it is unsupported by the evidence or is controlled by an error of law. *Daves v. Cleary*, 355 S.C. 216, 231, 584 S.E.2d 423, 430 (Ct. App. 2003) (citing *Stevens v. Allen*, 336 S.C. 439, 446, 520 S.E.2d 625, 628-29 (Ct. App. 1999)). Stated another way, a jury's verdict is entitled to "substantial deference." *Mills v. S.C. State Ports Auth.*, 435 S.C. 213, 227, 865 S.E.2d 910, 917 (Ct. App. 2021). "A new trial absolute should be granted only if the

verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive.” *Id.* at 226 (internal citation omitted). A so-called inconsistent verdict is not an automatic ground for a new trial. *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 49-50, 691 S.E.2d 135, 149 (2010) (internal citation omitted). To the contrary, where there is a logical reason for reconciling an inconsistent verdict, it is the duty of the court to sustain it. *Id.*; *see also Longshore v. Saber Sec. Servs.*, 365 S.C. 554, 561, 619 S.E.2d 5, 9 (Ct. App. 2005) (affirming the trial court’s decision to not overturn a jury verdict in favor of the defendants on an assault and battery claim where the jury found liability for negligent hiring because the verdict could be “harmonized.”); *Johnson v. Hoechst Celanese Corp.*, 317 S.C. 415, 422, 453 S.E.2d 908, 912 (Ct. App. 1995) (affirming denial of plaintiffs’ motion for new trial where the jury returned a verdict for two other plaintiffs because the moving plaintiffs did not prove each element of their causes of action).

Equally important to medical malpractice cases like this one, the plaintiff must show, through expert testimony that, “in their professional opinion, the injuries complained of most probably resulted from the defendant’s negligence . . . [and] when it is the only evidence of proximate cause relied upon, it must provide a significant causal link between the alleged negligence and the plaintiff’s injuries, rather than a tenuous and hypothetical connection.” *Daves*, 355 S.C. at 230, 584 S.E.2d at 430 (*quoting James v. Lister*, 331 S.C. 277, 286, 500 S.E.2d 198, 203 (Ct. App. 1998)). In other words, the plaintiff has the burden of proving both a deviation from the standard of care and proximate cause through expert testimony. *Id.*; *see also Richardson's Rests. v. Nat'l Bank of S.C.*, 304 S.C. 289, 295, 403 S.E.2d 669, 672 (Ct. App. 1991) (internal citation omitted) (“In order to prevail on a claim of negligence, the plaintiff must show (1) a duty

of care owed by the defendant to the plaintiff; (2) a breach of that duty by a negligent act or omission; and (3) damage proximately resulting from the breach. If he fails to establish any one of these elements, his cause of action fails.”). Where a jury finds that she did not do so and it is supported by the evidence, the decision of the jury should not be disturbed through a new trial. *See Stevens*, 342 S.C. at 53, 536 S.E.2d at 666 (“[I]f a jury finds the plaintiff has failed to prove damages proximately caused by the defendant’s negligence, then its verdict should be for the defendant.”); *Dropkin v. Beachwalk Villas Condo. Ass’n*, 373 S.C. 360, 365, 644 S.E.2d 808, 810 (Ct. App. 2007) (affirming denial of the plaintiff’s motion for a new trial in a traditional negligence case where plaintiff did not prove proximate cause).

b. JUDGMENT NOTWITHSTANDING THE VERDICT (JNOV)

In reviewing the denial of motions for directed verdict and JNOV, the evidence and the reasonable inferences that can be drawn therefrom must be viewed in the light most favorable to the non-moving party, which, at this juncture, is Defendants. *Daves*, 355 S.C. at 229, 584 S.E.2d at 429 (citing *Brady Dev. Co. v. Town of Hilton Head Island*, 312 S.C. 73, 78, 439 S.E.2d 266, 269 (1993)). The motion should not be granted where the “evidence yields more than one inference[,] or its inference is in doubt.” *Id.* (internal citation omitted). As with considering a motion for a new trial, a jury’s verdict should be given substantial deference when contemplating a JNOV. *See Mills*, 435 S.C. at 227, 865 S.E.2d at 917.

II. ARGUMENT

a. THE COURT SHOULD DENY PLAINTIFF’S MOTION BECAUSE THE VERDICT IS NOT INCONSISTENT

As an initial matter, the jury’s verdict in this case was not “inconsistent” as Plaintiff now argues. *See e.g., Stevens*, 342 S.C. at 51, 53, 536 S.E.2d at 661, 666 (holding a verdict that found the defendant liable for *proximately causing* the plaintiff’s injuries yet awarding zero dollars in

damages was facially inconsistent); *Herring v. Home Depot, Inc.*, 350 S.C. 373, 381, n.16, 565 S.E.2d 773, 777, n.16 (Ct. App. 2002) (internal citation omitted) (illustrating that a verdict in favor of a plaintiff for both revocation of acceptance and breach of warranty would be inconsistent due to their contradictory elements). Instead, it was a verdict indicative that Plaintiff failed to prove at least one of the required elements of her medical malpractice cause of action: proximate cause.¹ This kind of verdict is entirely permissible and appropriate under South Carolina law. *See Dropkin*, 373 S.C. at 365, 644 S.E.2d at 810 (cited above); *see also Vinson v. Hartley*, 324 S.C. 389, 411-12, 477 S.E.2d 715, 727 (Ct. App. 1996) (denying the plaintiff's motion for a new trial where the jury found for the defendant on proximate cause although the defendant admitted negligence). Otherwise, a plaintiff would be relieved of its burden to prove each and every element of its cause of action.

Regardless and even assuming *arguendo*, the verdict was somehow “inconsistent”, it was not irreconcilably inconsistent as is required by our jurisprudence and, therefore, this assertion cannot be a basis for granting a new trial. *Austin*, 387 S.C. at 49, 691 S.E.2d at 149 (internal citation omitted) (holding that verdicts must be irreconcilably inconsistent to warrant a new trial). First, contrary to Plaintiff's contention in her Motion, Plaintiff did not pursue a single theory of liability. At trial, Plaintiff argued that both Defendants' choice of surgical technique and their post-operative violated the standard of care. Therefore, it stands to reason that the jury could have found that Defendants' post-operative care breached the standard of care, but the choice of surgical technique did not – undermining completely Plaintiff's assertion that “the surgery itself, at least, proximately caused some damages to Plaintiff[,]” which, as discussed below, is not supported by the record anyway. Alternatively, the jury could also have concluded that another surgical option was

¹ The jury did not need to reach the element of damages because it found the Plaintiff failed to meet her burden of proof as to proximate cause which is sufficient in and of itself to reach the result they did.

appropriate, but also concluded that the choice of technique was not to blame for Plaintiff's complications or claimed damages. Finally, as detailed above, unlike the verdict in *Stevens*, the verdict reflects that Plaintiff **did not prove** her damages were proximately caused by Defendants' breach. Thus, an award of zero damages is entirely consistent with South Carolina law and does merit a new trial as to any issue or JNOV.

Further, the mere fact that the jury did not find proximate cause does not mean that the jury was somehow "confused" on the issue. Indeed, the record supports that the opposite was true. The jury was verbally instructed on Plaintiff's burden of proof as to all of the required elements, and specifically on the issue of proximate cause and was also provided with a hard copy of the jury instructions. Additionally, at Plaintiff's request, the jury was polled after the verdict was read and each juror confidently affirmed that the verdict was, in fact, the one that they had reached. Accordingly, any concerns that the jury was somehow confused as to proximate cause is completely without support and likewise does not justify a new trial of any kind or JNOV.

b. THE COURT SHOULD DENY PLAINTIFF'S MOTION IN ITS ENTIRETY BECAUSE THE JURY'S VERDICT IS NOT CONTRARY TO THE WEIGHT OF THE EVIDENCE, BUT RATHER IS AMPLY SUPPORTED BY THE PREPONDERANCE OF THE EVIDENCE.

The jury's verdict is amply supported by the overwhelming weight of the evidence, so there is likewise no basis for the application of South Carolina's thirteenth juror doctrine. Plaintiff's Motion mischaracterizes the testimony of Defendants' experts and Dr. Schimpf, as well as Dr. Herrera. Neither Defendants' experts, Dr. Lefkowitz or Dr. Joseph, Dr. Schimpf, nor Dr. Herrera testified that any of Plaintiff's alleged damages were *proximately caused* by any negligent act of Defendants. In fact, Dr. Herrera explicitly declined to testify that Defendants even breached the standard of care. Instead, they testified that despite Defendants' use of the gold-standard surgical technique, Plaintiff unfortunately suffered a known complication from her surgery – not due to any negligence, and that Defendants appropriately responded to them.

Notably, Plaintiff's sole expert, Dr. Hultman, also acknowledged that Plaintiff's complications were known to her particular surgery and occur even when the procedure is performed according to the standard of care as it was in this case. Dr. Hultman specifically agreed that Dr. Schimpf met the standard of care in the manner in which he performed the inferior pedicle approach. He likewise readily admitted that Dr. Schimpf appropriately warned Plaintiff about the inherent risks during the informed consent process and that Defendants' technique is not only the gold standard, but one that he uses himself. Contrary to Plaintiff's assertion, neither the jury nor the Court was required to accept Dr. Hultman's isolated criticism that he would have used a different approach for Plaintiff's surgery. *McCourt by & Through McCourt v. Abernathy*, 318 S.C. 301, 307, 457 S.E.2d 603, 607 (1995) (holding that the jury was properly instructed that "[t]he mere fact that the plaintiff's expert may use a different approach is not considered a deviation from the recognized standard of medical care."); *see also McGrady v. United States*, 650 F. Supp. 379, 381 (D.S.C. 1986) ("The mere fact that a plaintiff's expert witness is of the opinion that he would have chosen a different approach or method in the diagnosis or treatment of a patient is not dispositive of determining the liability issue in a medical malpractice suit.").

Plaintiff's Motion also relies exclusively on evidence of Plaintiff's post-surgical complications. However, South Carolina law is clear that evidence of complication alone is not sufficient to prove liability. *McCourt*, 318 S.C. at 308, 457 S.E.2d at 607 (also holding that jury was properly instructed that negligence may not be inferred from a bad result). Therefore, there is simply no basis in law or fact for the Court to disrupt the jury's verdict under the thirteenth jury doctrine either.

Moreover, as referenced above, Defendants' experts testified that Defendants appropriately informed Plaintiff of the risks inherent to her surgery prior to Plaintiff's election of surgery.

Plaintiff's expert confirmed this by acknowledging that he did not have any criticisms of Defendants' informed consent process. Plaintiff similarly acknowledged that Defendants properly informed her of the risks of her surgery and testified that she was aware that infection, nipple loss, and the need for additional surgeries were potential complications of her surgery. This goes directly to the application of assumption of the risk, which also supports the jury's verdict of no liability. Simply put, the evidence more than supports the jury's ultimate verdict and there is no basis for the judicial intervention Plaintiff now seeks.

III. CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court deny Plaintiff's Motion in its entirety.

Respectfully submitted,

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December 1, 2022
Charleston, South Carolina

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

(Jury Selection was held but not transcribed herein.)

MATTER(S) OF LAW - PRETRIAL MOTIONS

THE COURT: Counsel, ready to proceed with the motions in limine?

ATTORNEY O'NEAL: We're ready, Your Honor.

THE COURT: All right. Plaintiff, y'all go first.

ATTORNEY O'NEAL: May it please the Court. My name is Misty O'Neal with Rogers, Patrick, Westbrook & Brickman, representing plaintiff, Rebecca Turisk. Before, this morning's -- or this afternoon's -- arguments of parties -- and I'll let defense counsel confirm this -- the parties agreed on issues of Mary Ackerman's testimony regarding prior surgeries performed by Dr. Schimpf, that those will be admissible.

The parties have also agreed -- do you agree, Todd? Is that a fair and appropriate recitation?

ATTORNEY SMYTH: Yes, Your Honor. So this is a lay witness who had surgery with Dr. Schimpf independent of the plaintiffs. She's the one that referred the plaintiff to Dr. Schimpf.

The only concern we have potentially is that there is some opinion testimony in her deposition with regard to how or what the cleanliness level was of the surgery center, something to that effect, and whether that had some play on the patient getting an infection. I don't think she would be qualified to offer any testimony to that issue because she's not a medical

1 expert.

2 So that would be the one caveat, she would not be able to
3 introduce any testimony regarding the source of infection.

4 ATTORNEY O'NEAL: Plaintiff agrees.

5 THE COURT: All right. We're on the same page on that one.

6 ATTORNEY O'NEAL: Okay. And then the second item on
7 plaintiff's motion in limine, testimony regarding plaintiff's
8 comments on social media posts expressing dissatisfaction with
9 medical providers other than defendants, the parties have agreed,
10 as well, that those will not be admissible.

11 THE COURT: Is that correct, counsel?

12 ATTORNEY SMYTH: Yes, Your Honor.

13 THE COURT: All right.

14 ATTORNEY O'NEAL: That moves us to the third item in our
15 motion in limine, which is plaintiff's status as disabled. Just
16 for a little background information for the benefit of the Court,
17 plaintiff was deemed disabled as of, I believe, 2010 -- 2012,
18 sorry. Her disability revolves around chronic back pain. The
19 allegations in the present case do not allege any exacerbation of
20 the back pain due to her surgery complication.

21 There was a caveat to our motion in limine that we were
22 planning to introduce evidence of a burnout, a generator burnout,
23 of her spinal cord stimulator. We have withdrawn that. We'll no
24 longer introduce evidence on that front. And we will withdraw
25 the claims for damages relating to the neuro stimulator revision

1 surgery as well.

2 That being said, the status of plaintiff as disabled is not
3 relevant to the facts and issues in the case. It's our position
4 that her status as disabled is very likely to prejudice the jury.
5 Unfortunately, a lot of jurors see someone who is disabled as
6 milking the system or taking advantage of the system, and given
7 the fact that it has very little probative value, we feel that
8 any benefit at trial is exceeded by the potential for unfair
9 prejudice to plaintiff.

10 Moreover, there is no loss of earning capacity. I think
11 that defense counsel mentions a lost wages claim. That has been
12 withdrawn for several years, and I believe defense counsel and I
13 are on the same page as far as that goes. There's no loss of
14 earning capacity. There's no lost wages claim, as well, another
15 reason that we feel that disability is not relevant to the
16 present matter.

17 THE COURT: Counsel.

18 ATTORNEY SMYTH: Yes, Your Honor. I believe this is
19 directly relevant because the plaintiff is claiming loss of
20 enjoyment of life, and I think when you look at her ability to
21 participate in activities of daily living, she's definitely been
22 affected by that because of her disability. And it's hard to
23 parse those things out. And I think it provides the proper
24 context for the jury to understand if she was unable to do a lot
25 of these things beforehand, this incident didn't really

1 contribute, or exacerbate, that issue. So I think it is highly
2 relevant in terms of the claim for noneconomic injuries.

3 THE COURT: I agree. I think if she's claiming loss of
4 enjoyment of life, that is relevant.

5 ATTORNEY O'NEAL: Understood. The next item of plaintiff's
6 motion in limine are with reference to her pain medications;
7 narcotics and opioid use.

8 With regards to the disability for back pain that we just
9 discussed, Ms. Turisk suffered serious injuries to her back,
10 requiring extensive surgery in 2008 and 2009. Over the years she
11 has worked with her providers to manage the pain resulting from
12 those injuries, sometimes including narcotic pain medicine such
13 as morphine, as needed; sometimes including other opioids.

14 And we feel that the use of these medications and
15 introducing them into evidence is not related to her breast
16 surgery, especially with regard to the medication usage prior to
17 the 11/1/2016 surgery performed by Dr. Schimpf. The pain for
18 her -- her back pain is unrelated to her breast pain. Those are
19 two separate issues. I understand the defense's position that
20 that does bring into her loss-of-enjoyment-of-life issue.

21 However, Dr. Schimpf was aware of the medications that she
22 was using at that time, including opioids and pain medicine at
23 the time of his surgery, and it is our position that the
24 probative value is outweighed by the risk of unfair prejudice to
25 the plaintiff in light of, particularly, the current opioid

1 epidemic, the fact that the national media attention is on opioid
2 litigation today. It's our position that we run the risk of that
3 evidence unfairly prejudicing the plaintiff.

4 THE COURT: Counsel.

5 ATTORNEY SMYTH: Thank you, Your Honor. Very briefly, our
6 argument is basically the same as the one I made on the preceding
7 motion. Plaintiff has made a claim for pain and suffering, and I
8 think, again, this one, as well as the next motion which deals
9 with her fibromyalgia condition, all relate to those noneconomic
10 damages claims. They provide the proper context.

11 She's been under the care of pain management specialists
12 since, I think, 2008, and so she's had, unfortunately, a lot of
13 issues with chronic pain. And I think that needs to be something
14 that a jury would consider when they're faced with a
15 pain-and-suffering/loss-of-enjoyment-of-life type claim.

16 THE COURT: I would anticipate, she also, by reviewing the
17 briefs, of the types of medications she was on and the fact that
18 it was considered by Dr. Schimpf in the type of approach he took
19 for surgery or whatever he's doing, he would have to know what
20 she's currently taking. Is that part of any of the arguments
21 here?

22 ATTORNEY SMYTH: Not directly. No, Your Honor. I don't
23 think that her pain medication had anything do with the surgical
24 outcome, I'm sure.

25 THE COURT: Right. But as far as, there was something in

1 there about the steroids and that she wasn't taking. Maybe
2 that's getting into the next motion.

3 ATTORNEY SMYTH: Perhaps.

4 ATTORNEY O'NEAL: Right. With regard to steroid use, I
5 think we do point out that Dr. Schimpf was aware of her steroid
6 use at the time of the surgery.

7 THE COURT: As far as the pain medication and her being on
8 for pain management in the past, she had before, that's certainly
9 something as far as her loss of enjoyment of life and pain and
10 suffering.

11 I would certainly limit and caution defense counsel to not
12 categorize it as anything negative. Obviously it's prescribed
13 medication. There's certainly nothing wrong about taking
14 prescribed medication. There's no allegation that I'm aware of
15 that she was misusing prescribed medication. And certainly any
16 negative connotations as far as opioids, particularly with
17 illegal use or overuse of the opioid substances or matters that
18 were not prescribed. So as long as there's no connotation that
19 she was using it not as prescribed, or abusing it, I think it's
20 certainly relevant.

21 ATTORNEY O'NEAL: The next point in plaintiff's motion in
22 limine, as defense counsel alluded to, is plaintiff's
23 fibromyalgia. And it's our position, Your Honor, that
24 plaintiff's fibromyalgia diagnosis and treatment status of being
25 a fibromyalgia patient is wholly unrelated and irrelevant to the

1 issues at case.

2 She was diagnosed several years before surgery. She
3 testified at her deposition that her fibromyalgia was under
4 control with a regimen that worked for her. In fact, her
5 rheumatologist, Dr. Fink, said that he recognized no increased
6 risk of infection associated with fibromyalgia. It's irrelevant,
7 but not only is it irrelevant, it's very likely to confuse and
8 mislead the jury.

9 In the testimony of Dr. Fink, who is patient's
10 rheumatologist, defense counsel was attempting to elicit
11 testimony -- or maybe not attempting, but elicit testimony --
12 that her status as having fibromyalgia somehow made her more
13 prone to complications. That is unsupported in the evidence.
14 There's no expert. There's no treating provider that has said
15 that on the record.

16 THE COURT: Counsel.

17 ATTORNEY SMYTH: Very briefly again, Your Honor, plaintiff's
18 fibromyalgia is a chronic pain condition that, again, goes to the
19 loss of enjoyment of life/pain and suffering. We do anticipate
20 calling Dr. Fink as a witness, and he did say that, in his
21 experience, patients with fibromyalgia tend to do worse from
22 surgeries in general.

23 I'm certainly not arguing that the fibromyalgia caused an
24 infection, but I do think that is relevant. He's got annotations
25 in his record that indicate that the patient had a hard time

1 getting up in the morning; he said four to six hours of
2 stiffness; pain and suffering, those kind of things. I think
3 that's all relevant, again, to quality-of-life-type issues and
4 noneconomic damage claims that are being made.

5 THE COURT: Certainly I think that the jury's able to
6 determine the difference between, or extinguish between, a pain
7 and infection. Certainly, the pain and suffering, she may take
8 medication. I saw an excerpt from his deposition that patients
9 with fibromyalgia tend to have a very low pain threshold, in his
10 experience.

11 However, that is certainly distinguishable from having an
12 infection and that she had no contraindication of having this
13 with implant removal or breast-reduction surgery. So certainly
14 the expert can clarify those two distinctions in which the jury
15 would be able to make that distinguishable factor.

16 ATTORNEY O'NEAL: Understood, Your Honor. Next issue that
17 plaintiffs raise in our motion in limine is testimony or evidence
18 suggesting that plaintiff was immunocompromised. Throughout the
19 course of the underlying depositions leading up to this trial,
20 counsel for defendant have attempted to elicit testimony from
21 various providers that plaintiff was, quote, prone to infection.
22 That's language used in Dr. Herrera's trial preservation
23 deposition.

24 Her status of prone to infection is not supported in the
25 medical records. As I mentioned earlier, Dr. Fink had already

1 testified that fibromyalgia did not put her at greater risk of
2 having postoperative complications related to infection; it did
3 not put her at a greater risker of having infection. He also
4 testified that he was unaware of any prior history of infection.

5 Plaintiff has adrenal fatigue, or adrenal insufficiency,
6 also known as Addison's Disease. What that is, is essentially
7 her adrenal glands do not produce enough cortisol or other
8 steroids and hormones, so she occasionally, as needed, takes
9 steroids to manage that.

10 Defendants have made several insinuations that as a result
11 of her steroid use she is immunocompromised, and has elicited
12 testimony from various providers to that effect. The problem
13 with that is steroid use for adrenal fatigue, or adrenal
14 insufficiency, is basically bringing plaintiff back up to a
15 normal range of cortisol hormone levels. It does not have the
16 same effect as what you would expect with the typical patient
17 taking corticosteroid, or a cortical steroid. Our expert,
18 Dr. Hultman, is prepared to testify to that fact.

19 It's our position that this is likely to mislead and confuse
20 the jury by leaving them to think that she was at a higher risk
21 of developing an infection and having poor wound healing despite
22 what Dr. Schimpf did or did not do at the surgery.

23 As I mentioned before, Dr. Schimpf was aware of her steroid
24 use. He made no recommendations for her to lower her steroid
25 use. In fact, several treating physicians and experts for

1 defendants opined that there was -- there was nothing that they
2 saw that the plaintiff did or did not do that increased her risk
3 of these postoperative complications.

4 THE COURT: Counsel.

5 ATTORNEY SMYTH: I'm sorry. I didn't want to interrupt, but
6 I think our position is that we never did plan to call the
7 plaintiff as immunocompromised and don't plan to pursue that, so
8 I don't think there's an issue there. I just couldn't find an
9 opportunity to jump in. I'm sorry.

10 THE COURT: All right. Well, that takes care of that one.

11 ATTORNEY O'NEAL: Okay. The next item in plaintiff's motion
12 in limine is evidence or testimony that the bacterial source of
13 plaintiff's breast infections included enterococcus faecalis. We
14 think those should be excluded from the evidence.

15 First of all, the wound culture that was performed on
16 plaintiff during the time that she was being treated for her
17 postoperative infections, there were three types of bacteria
18 cultures, not just the faecalis bacteria.

19 It's our position that there's no dispute that there was an
20 infection and that there was postoperative infection. The type
21 of infection is highly irrelevant, particularly in light of the
22 fact that there were three different strands of bacteria
23 cultured.

24 One of defendant's experts actually testified that bacteria
25 growth is unavoidable once blood flow has been compromised, which

1 is one of the primary complaints that plaintiff is alleging as
2 part of this action, is that the blood flow itself was
3 compromised because of the technique used by the surgeon.
4 Essentially he interrupted the vascularity and the blood flow was
5 not allowed to return to those vessels.

6 We think that this testimony and evidence being brought in
7 is not only irrelevant but that it's highly misleading for the
8 jury and unfairly prejudicial.

9 Essentially what defense counsel is attempting to insinuate
10 is that either plaintiff or her caregivers, post surgery, had
11 poor hygiene and did not wash their hands properly and that they
12 were the source of introducing the bacteria. It's done
13 indirectly and directly at Dr. Herrera's trial preservation
14 deposition. In fact, we think that that should be excluded for
15 those reasons.

16 THE COURT: Counsel.

17 ATTORNEY SMYTH: Yes, Your Honor. One of the allegations
18 that the Court's already observed is the plaintiffs are critical
19 of the postoperative care that was provided in this instance. I
20 think the medical records indicate that the first time that
21 Ms. Turisk was diagnosed with an infection was about 30 days
22 after the surgery. She had been seen in follow-up at multiple
23 times and not found to have an infection.

24 It's our position that this was a secondary infection that
25 developed later and unrelated to what Dr. Schimpf did initially.

1 In other words, she didn't get the infection from his surgery --
2 surgical center. But one of the things that she has alleged is
3 that she didn't think the surgical center was clean and that she
4 thinks she might have gotten bacteria in that form.

5 The other point that I would make is that we do have an
6 infectious disease expert who's coming to talk about that, and
7 Dr. Schimpf is going to talk about that. This particular strand
8 of bacteria is only found in the gut, and there's no real way for
9 it to get into an open flesh wound other than hygiene-type
10 issues.

11 So to the extent that we're getting accused of causing this
12 lady an infection, I think it's highly relevant to know what kind
13 of bacteria it is. It also speaks to what kind of treatment was
14 necessary, because you don't treat every bacteria the same, and
15 so we should be able to talk about what treatment was prescribed
16 in response to the infection as well.

17 ATTORNEY BURKE: Your Honor, if I may. Ms. O'Neal is doing
18 fine, but let me try to clean this up a little bit. Plaintiff is
19 not going to testify in court that she thought the surgery center
20 was duty. I am aware that she testified to that at her
21 deposition, but she's not going to give that testimony in court.

22 Again, our expert's theory of the case is not that she was
23 exposed to bacteria in the surgical center. He did not testify
24 to that at his deposition. Our expert explains the process of
25 the tissue in the breast dying, and the environment of the

1 necrotic tissue in the breast then becomes highly susceptible to
2 bacterial infection.

3 And, you know, there were bacteria in there, but just when
4 anyone hears the "F" enterococcus, the fecal bacteria, their
5 brain just goes a lot of different places and it goes nowhere
6 good. And I think you'll hear testimony from the doctors in the
7 case, both from the plaintiff's side and the defense side, that
8 that particular bacteria is so prevalent in the environment that
9 it's probably in the courtroom right now.

10 And it's just so prejudicial to suggest that she lost
11 100 percent of her breast tissue on the right and half of it on
12 the left because her caregivers didn't wash their hands. And
13 that's a gross oversimplification of what plaintiff is claiming
14 in the case as a whole.

15 THE COURT: Certainly, obviously the case is about a
16 bacterial infection, and the type of bacteria is certainly
17 relevant. As to how it got there, I believe that's really a
18 question of fact for the jury to determine. I understand that
19 she's going to testify, and her caregivers will testify, as to
20 the precautions they took, and the jury can certainly make that
21 determination.

22 Like you said, it's everywhere, so certainly we can't
23 speculate as to what the jury would think. We can only present
24 this testimony through the witnesses that were there and the
25 precautions that they took.

1 ATTORNEY BURKE: And I just want to be clear that it's not a
2 chicken-and-egg thing. The cutting off of the blood supply by
3 the surgical technique that Dr. Schimpf used is what prepared the
4 environment for the bacteria. I don't know if that -- and that's
5 why we think the actual kind of bacteria that's in there is not
6 relevant as to how the process happened of the necrosis and the
7 infection.

8 THE COURT: I understand that. Though it's still bacteria,
9 and the status of how she was will be presented by y'all. And
10 they can certainly rebut that, and you can rebut it by your
11 testimony and your experts as to how it affected her. So your
12 motion is denied.

13 ATTORNEY BURKE: Thank you.

14 ATTORNEY O'NEAL: Moving to the plaintiff's last item for
15 our motion in limine, it's our position that any evidence and
16 testimony related to the informed consent of the risks that were
17 explained to plaintiff, that she signed off on in her records,
18 should be excluded, the reason for that being that plaintiff is
19 not making a claim for lack of informed consent.

20 The courts have recognized that there's separate causes of
21 action for lack of informed consent as opposed to medical
22 negligence. It's irrelevant to the facts in issue at case. It
23 doesn't have any tendency to make any material fact more or less
24 probable, and it's more likely to confuse and mislead the jury.

25 Essentially Mr. Turisk -- the inference will be, when this

1 evidence is introduced to the jury, that suggests Ms. Turisk
2 consented to all the risks and complications that may arise from
3 the implant removal and reduction mammoplasty even if defendant's
4 negligence caused those complications.

5 Moreover, she did not -- she was not informed of, she did
6 not consent to, the inaccurate surgical approach that Dr. Schimpf
7 chose to use. A sister court, the Virginia Supreme Court, held
8 in *Wright v. Kaye* that evidence of information conveyed to the
9 plaintiff in that case concerning the risk of surgery in
10 obtaining her consent is neither relevant, nor material, to the
11 issue of the standard of care.

12 It's our position that that issue has no relevance to the
13 causation, no relevance to the deviation from the standard of
14 care and, moreover, it is very likely to mislead and confuse the
15 jury who will interpret that, those signatures and initialing of
16 the informed consent form, as her essentially assuming the risk
17 of any complications that would arise therefrom.

18 THE COURT: Response.

19 ATTORNEY SMYTH: Yes, Your Honor. First of all, we have
20 pled this as an affirmative defense in the case in our answer,
21 and it does go directly to the heart of the defense in this
22 matter. Plaintiffs allege a breach of standard of care. Part of
23 the standard of care in talking to your patients about surgery is
24 going over the risks associated with that. That is probably the
25 most relevant point in this case, and so our defense is built on

1 it.

2 I would also point the Court's attention to the *Faile v.*
3 *Bycura* case. That's a Supreme Court decision in South Carolina
4 in 1986, and the reference on that would be 289 South Carolina
5 398. And that very issue was considered by our Supreme Court,
6 and it was determined that the evidence of informed consent is
7 relevant, especially when an assumption-of-risk defense has been
8 pled.

9 THE COURT: Do you happen to have a copy of that case?

10 ATTORNEY SMYTH: Yes, I do. It's a short one.

11 ATTORNEY O'NEAL: Very quickly, Your Honor, I would just
12 like to respond, if I may. I understand that defense pled the
13 affirmative defense of informed consent. However, plaintiff did
14 not allege that claim. I just want to make that clear. That's
15 not part of the cause of action.

16 THE COURT: In looking at this case, counsel, it talks about
17 assumption of the risk to apply, and that's not what we have
18 here. Basically her informed consent talks about the risks of
19 surgery, and it's not relevant, nor material, to the standard of
20 care, which would be the causation of the breach of the standard
21 of care and the proximate cause of her injuries. So your motion
22 on that is granted.

23 ATTORNEY O'NEAL: Thank you, Your Honor.

24 ATTORNEY SMYTH: Your Honor, could I respond to that
25 briefly?

1 THE COURT: Certainly.

2 ATTORNEY SMYTH: I don't mean to belabor the point, but that
3 is the central tenet of our defense in this case, is that these
4 risks that she -- the complications that she ended up suffering
5 were things that were made known to her at the beginning, before
6 the surgery even happened. And to not let us introduce evidence
7 of that would mislead the jury, because they're going to say this
8 poor lady went through his surgery and she had no idea what the
9 risks were that were associated with this procedure. It's a very
10 different story than the reality.

11 The reality is each one of these risks and complications
12 that she's experienced were discussed with her, and she signed
13 off as having known that. You can't come into the courtroom and
14 then say, You can't use that information on me. That's the whole
15 reason it's there.

16 THE COURT: Response to that?

17 ATTORNEY O'NEAL: Plaintiff is not disagreeing that she
18 signed the informed consent. First of all, those informed
19 consent forms were required before she was able to undergo
20 surgery with Dr. Schimpf.

21 Secondly, our position is that the probative value of such
22 form and the conversations around the informed consent do not go
23 to the relevance of the cause of action at play. As Your Honor
24 just spoke, the question in front of the jury is whether or not
25 there was a breach of standard of care in performing the surgery.

1 Informed consent does not go to that.

2 And more than just it's irrelevant, it's going to be highly
3 misleading for a jury who is unfamiliar with, likely unfamiliar
4 with, this level of surgery; also unfamiliar with the legal ins
5 and outs of our arguments and deliberations today. They are
6 going to interpret that as she signed off; these were all the
7 risks that were shown to her; and she signed off on having those
8 risks performed; she signed off on any possible complication,
9 including death.

10 I just think it's highly prejudicial and it's highly
11 misleading and confusing for the jury. And she did not consent
12 to that negligence, as Dr. Herrera has testified in his trial
13 preservation deposition.

14 THE COURT: Anything further?

15 ATTORNEY SMYTH: Your Honor, just, in that *Faile* case, the
16 very last paragraph I think is the point that I was trying to
17 make. And it says that, In light of Faile's testimony that the
18 risks of the surgery were explained to her, we agree the issue of
19 assumption of risk should have been submitted to the jury.

20 And that's a defense that we're pleading in this case. We
21 have a right to be able to put up evidence to support our defense
22 in that matter. And it's up to the jury to decide whether that
23 is the basis for their decision or not, but we certainly should
24 not be prohibited from talking about the central issue in the
25 case, which is, Did you know this could happen?

1 THE COURT: Any other South Carolina case law that y'all
2 found on this?

3 ATTORNEY O'NEAL: I'm sorry, Your Honor?

4 THE COURT: Do you have any South Carolina case law that
5 you're relying on?

6 ATTORNEY O'NEAL: No, Your Honor. Unfortunately, I was
7 unable to find any case law specifically on point, as I believe
8 the case cited by the defense is not on point.

9 As you made the distinction, it's regarding the assumption
10 of the risk, and there is no cause of action that should not be
11 allowed in because if there's no cause of action defendant's
12 affirmative defense is irrelevant.

13 THE COURT: Well, it looks like the Supreme Court has told
14 us differently, so I think since they pled it as an affirmative
15 defense, the jury will be given a jury instruction regarding the
16 two different standards. Obviously assumption of risk is not an
17 assumption of consenting to deviation from the standard of care,
18 so the jury will have the opportunity to make that distinction.
19 But based upon the *Faile* case, I think it is appropriate.

20 ATTORNEY O'NEAL: Understood, Your Honor. And I would just
21 ask counsel if they could point to the provision in their
22 affirmative defenses, their answer, where they make the
23 allegation, or the affirmative defense, of assumption of risk,
24 just for my benefit.

25 ATTORNEY SMYTH: It's no. 3 in our answer. And I'm happy to

1 read it into the court, if you would like.

2 THE COURT: That would be good. Thank you.

3 ATTORNEY SMYTH: Sure. The defense reads as follows: The
4 plaintiff was properly informed about the potential risks,
5 benefits, and complications associated with the procedure at
6 issue, and voluntarily accepted those risks and consented to
7 undergo with this knowledge. Therefore, plaintiff is barred from
8 recovery against defendant.

9 ATTORNEY O'NEAL: One qualifying request, Your Honor. Would
10 you be amendable to excluding evidence of the exact informed
11 consent form where she signed given the likelihood that that may
12 be interpreted differently by the jury than just a general --
13 general testimony regarding the discussions that were had with
14 Ms. Turisk about the risks and complications of the surgery?

15 THE COURT: No, ma'am. If she signed a form, she's held to
16 have read it and understood it before she signed it. So, no.

17 ATTORNEY O'NEAL: Understood.

18 THE COURT: Any other motions?

19 ATTORNEY O'NEAL: None from us.

20 ATTORNEY MAPLES: Your Honor, we have three brief motions on
21 behalf of defendants. Our first motion concerns plaintiff's
22 speculative damages. Particularly, we have moved to exclude
23 speculative damages that are not supported by expert testimony in
24 this case. And we have identified very specific damages,
25 particularly a bill from SMC for \$16,163, which the parties

1 attempted to negotiate in good faith for its exclusion; however,
2 was unable to come to an agreement. We move to exclude that
3 particular bill because we do not have expert testimony to
4 support that it is medically necessary, which is required under
5 South Carolina law.

6 Particularly, this bill was incurred when the plaintiff
7 presented to Trident Health Systems. It's also based as
8 Turisk-SMC-00398. She presented in February of 2017, and at
9 first blush she complains of breast pain. However, she also
10 complained of fatigue, body aches, congestion, and later she was
11 worked up for abdominal pain, and diarrhea, and also anxiety.

12 She was not provided any treatment related to her breasts.
13 In fact, her breasts are noted to be healing well in this
14 appointment. So it's our contention that this particular bill
15 should be excluded.

16 Additionally, we have moved to exclude evidence in her bills
17 relating to her fat-grafting procedures which occurred in March
18 of 2018. So we would move to exclude all of those procedures
19 from March 2018 forward as not being supported as medically
20 necessary.

21 Plaintiff's own expert, Dr. Herrera, at his video trial
22 deposition, which will be played for the Court, was unable to
23 testify that these particular procedures were, in fact, medically
24 necessary. Specifically when asked, the question: In other
25 words, a medically necessary procedure is something that you

1 would need to improve your function or ability? Answer:
2 Certainly. Question: Participate in activities of daily living.
3 And that's not what we're talking about, is it? Answer: No, I
4 don't believe so. So we also move to exclude the bills related
5 to her fat grafting on that basis.

6 And finally, the last set in which we'll discuss is her
7 psychological assessments. There are five bills from MUSC
8 pertaining to psychological assessments in September and October
9 of 2017. The plaintiffs have not proffered and have not produced
10 any psychological expert who can speak to her mental health and
11 relate those bills to the treatment by the defendant, so we move
12 to exclude those.

13 And in our motion we also made reference to the spinal
14 stimulator bills. However, since plaintiff has presented that
15 they do not intend to pursue those, that won't be an issue.

16 So those three are the basis for our motion, because they
17 are not supported by expert testimony as medically necessary.

18 ATTORNEY BURKE: And, Your Honor, we can eliminate the
19 psychiatric assessments from MUSC from the bills. We are
20 claiming garden variety: Mental anguish, emotional distress. No
21 exacerbation of prior depression or anxiety, so those, they can
22 come out. We agree to that.

23 THE COURT: Any response as to the Trident bills and the fat
24 grafting?

25 ATTORNEY BURKE: My colleague, Ms. O'Neal, is going to

1 handle those.

2 THE COURT: Okay.

3 ATTORNEY O'NEAL: So, Your Honor, thank you very much. The
4 visit, as referenced by defense counsel, at Summerville Medical
5 Center from 12/08 to 12/12 that appear at -- beginning, one of
6 the initial notes is from Summerville Medical Center,
7 Turisk-SMC-398, her chief complaint at this visit was congestion
8 and breast pain.

9 It's noted in the record that she was discharged from the
10 hospital two days prior for stomach sepsis. She presents having
11 symptoms that she believes were signs of infection; a fever,
12 feeling run down, very fatigued. She was obviously very
13 concerned that the sepsis was ongoing and, given her severe
14 complications thus far, it was more than reasonable for her to
15 seek medical care and intervention.

16 During that time at Summerville Medical Center, although the
17 primary impression given at discharge was abdominal pain, the
18 secondary impressions listed were breast wound, along with
19 diarrhea, panic attack, and viral syndrome.

20 She was worked up with a wound assessment during this visit
21 as well. I believe her dressings were changed. She was given a
22 full workup for her breast postoperative infections. And it's
23 our position that those items are relevant to the underlying
24 claim. I just want -- go ahead.

25 ATTORNEY BURKE: I just need to be clear, Judge Murphy. She

1 was hospitalized with sepsis related to the breast infection, and
2 it did not come from the stomach.

3 ATTORNEY O'NEAL: And just to be clear, defendants allege
4 that the claim related to the fat grafting that Ms. Turisk
5 underwent are speculative, not medically necessary. First of
6 all, speculative is quite the word, because typically that's
7 referring to anticipated future damages.

8 We have concrete medical records and supporting bills that
9 the parties have gone back and forth and agreed that these are
10 the records that we are talking about. We are talking you about
11 concrete numbers.

12 And all of plaintiff's medical bills claimed are documented,
13 and the amounts have been verified and reviewed prior to today,
14 obviously. We are not claiming any future damages, so there's no
15 speculation along with these damages.

16 The reconstructive surgeries were discussed at length, as
17 mentioned by defense counsel, at Dr. Herrera's trial preservation
18 deposition. Defendants tried to equate necessary, was medically
19 necessary. In his trial preservation deposition, he does relate
20 his treatment of Ms. Turisk, and he does not qualify that to her
21 postoperative complication.

22 If we look -- and I'm happy to give Your Honor a copy of the
23 transcript if you would like it, but I can also read it into the
24 record -- at 82, beginning at line 5, the question is: Okay.
25 So, Dr. Herrera, I'm going to ask you, in your opinion, were each

1 of the surgeries that you performed on Rebecca related to her
2 postoperative complications and infection following her prior
3 breast implant surgery with Dr. Schimpf on November 1st, 2016?
4 There's some objections, and there's a little colloquy. Witness
5 answers at line 18: No. It clearly says she had a previous
6 surgery by Dr. Schimpf. That's really all I can comment on.
7 Obviously this is a complication, but I don't have anything other
8 than the surgery performed by him, you know, from that
9 standpoint. And here's the follow-up question at line 25 of page
10 82: And I appreciate that answer. And my question is, is your
11 care and treatment related to the complication? That's my
12 question. Answer: I believe it is.

13 No qualification about which care he provided was related to
14 the complication.

15 As far as whether or not the treatment was necessary, I
16 don't think there's any dispute about whether the procedures
17 leading up to and including the double mastectomy were medically
18 necessary. The distinction that defense is trying to make is
19 that these postoperative reconstructive surgeries that
20 Dr. Herrera performed are not medically necessary.

21 However, as stated in *Mali v. Odom*, which is a case cited by
22 defendants in their motion in limine, Expert testimony is usually
23 required unless the subject matter is of common knowledge to
24 laypersons. And again, that case sites the appellate case which
25 says, Expert evidence is required in a medical malpractice case

1 except where no special learning is needed to evaluate the
2 defendant's conduct.

3 This is a cosmetic surgery case. There's no requisite for
4 expert testimony, as to the reconstructive surgery, whether or
5 not the reconstructive surgeries were necessary. A layperson can
6 see the necessity of the reconstructive surgeries to restore
7 Ms. Turisk's breasts to where they were. Excuse me, Your Honor.

8 ATTORNEY BURKE: And, Judge Murphy, if I may. Dr. Herrera
9 is Rebecca's surgeon at MUSC, and plaintiff will play his trial
10 preservation deposition this afternoon. And he performed a total
11 of six surgeries on Rebecca: The first being the complete
12 mastectomy on the right and the partial mastectomy on the right;
13 and then he performed five reconstructive surgeries.

14 And I believe that the five reconstructions following
15 mastectomies are what defense is trying to claim is not related,
16 or -- well, not medically necessary.

17 And these fat-grafting procedures and these reconstructive
18 surgeries were not purely cosmetic. Dr. Herrera also testified
19 that he did scar revision; that the scarring was painful, and the
20 scar revisions were done to alleviate that pain. He removed
21 painful fat necrosis that were solidified in her breasts. So
22 there was more to it than just reconstruction.

23 But I was a little blown away by this motion, and I'm kind
24 of sitting here thinking, What can I compare this to? I mean,
25 this is a medical negligence claim. The breach of the standard

1 of care in performing the removal of the implants and the breast
2 reduction led to this cascade of events of the necrosis of the
3 tissue from her breasts, and there's no other way to make the
4 plaintiff whole than to try to recreate the breasts that were
5 taken away from her.

6 If this were a dog-bite case, I don't think we would stop at
7 stitching up the dog bite and then not allow the plaintiff to
8 recover for the cosmetic surgery to fix the scar. It really
9 doesn't even make sense to me. I can't see it, but this is my
10 client so that may be my problem. But I just wanted to clarify,
11 actually, everything that went into the fat-grafting surgery --
12 and just -- thank you.

13 THE COURT: Counsel, anything further?

14 ATTORNEY MAPLES: Yes, Your Honor. First of all, all of
15 these bills have to be supported by expert testimony.
16 Plaintiff's perception alone is insufficient, because the South
17 Carolina case law is very clear on this point. Experts are not
18 required when it's within the realm of a layperson's common
19 knowledge. However, we're dealing in medical negligence and
20 really niche topics within the cosmetic procedure, breast
21 reconstruction, and then later mastectomies, and fat-grafting.

22 So the plaintiff alone cannot establish, through her
23 testimony, whether she believes something is related or
24 proximately caused. We're going to have to have expert testimony
25 on this point, and the plaintiff simply does not have that.

1 Their own expert, Dr. Herrera, cannot say and testified that he
2 will not say that the fat-grafting procedure, specifically --
3 we're not contesting the initial mastectomies, as plaintiff's
4 counsel correctly pointed out -- he does not say that the
5 grafting procedures, those subsequent five, were medically
6 necessary, and he does not link them to any conduct on behalf of
7 the defendants, which is the pivotal issue here.

8 And back to the -- I don't mean to jump back in time, but
9 going back to the SMC bill that we initially brought up, that
10 \$16,000 bill, Your Honor, again, they are also only relying on
11 the plaintiff's perception that that was caused by her breast
12 pain, but then her subsequent workup had nothing do with her
13 breast pain. She had a CT of her abdomen and pelvis. She was
14 being treated for diarrhea and abdominal pain. And they don't
15 have an expert to testify that that particular bill was
16 proximately caused by the conduct of the defendant, just like
17 they can't link up that same for the fat-grafting procedures.

18 And merely the fact that they occurred in temporal
19 proximity, so they occurred after her initial reconstruction
20 surgery with Dr. Herrera, is not enough. These subsequent
21 cosmetic procedures, their expert cannot link up to the conduct
22 of the defendant. And because they lack that expert testimony,
23 any testimony about them and the presentation of these bills
24 would require the jury to speculate.

25 And so for those reasons, we believe that the fat grafting,

1 as well as that SMC bill, should be excluded as speculative,
2 because they don't have the expert testimony that is required
3 under South Carolina law.

4 THE COURT: Thank you, counsel. I disagree for the reasons
5 as stated by plaintiff's counsel. They will be admissible. They
6 are relevant as being conjecture to the alleged breach of the
7 standard of care.

8 And as far as the fat-grafting procedure, obviously subject
9 to the proper foundation as established by Dr. Herrera, but
10 certainly common knowledge would dictate that if the breast
11 surgery has gone wrong, that somebody's going to reconstruct it
12 to make it be where it should have been to start with. So I do
13 find that that is within the commonly knowledge of a layperson to
14 restore her but for the alleged breach of the standard of care.

15 ATTORNEY MAPLES: Yes, Your Honor. Just to clarify, are you
16 also admitting the SMC bill, that \$16,000 bill that we discussed?

17 THE COURT: Yes.

18 ATTORNEY MAPLES: Then I'll move on to our second motion,
19 which would be to exclude evidence, testimony and presentation,
20 about medical treatment and surgeries that have not been proven
21 by expert testimony as medically necessary. And again, we cited
22 those fat-grafting procedures that we just discussed, that SMC
23 visit, and then also included in that was the spinal cord
24 stimulator surgeries. And so with that, Your Honor, we would
25 move to exclude testimony for the same reasons that we just

1 discussed.

2 THE COURT: The same rulings I made. I already excluded the
3 generator.

4 ATTORNEY MAPLES: Yes, Your Honor. And then finally, our
5 last motion is to exclude cumulative photos of plaintiff's
6 breasts. Prior to coming to court today, the plaintiff
7 designated -- excuse me -- the plaintiff designated 27 photos of
8 her breasts, your Honor. And these photos, they graphically
9 depict the condition of her breasts between November of 2016 and
10 as recent as two days ago. And many of these photos are
11 duplicative in that they do not show significant changes in
12 conditions because they were taken in such short proximity of one
13 another.

14 And, Your Honor, 27 is simply too much to demonstrate the
15 point which we understand they are going to demonstrate, which is
16 what her condition was at a particular time.

17 But the fact that there are 27 photos, Your Honor, that
18 would by far cumulative and it's needless to establish the point
19 that they're going to make and, at a certain point, Your Honor,
20 would only be offered to inflame the passions of the jury.

21 And we have South Carolina case law on point for that that
22 says that photographs that are just shown to the jury to elicit
23 an emotional response must not be permitted.

24 And so we would ask that the Court strike, or limit, some of
25 plaintiff's photos of her breasts, as they are cumulative.

1 Oh, and sorry. Before I sit down, I want to highlight one
2 particular photo. And that is, there is a photo -- I believe
3 it's No. 12 that they have premarked -- which is an overview shot
4 that shows both plaintiff's breasts, as well as her abdominal
5 site. And as we indicated, both parties indicated in their
6 pretrial briefs, the abdominoplasty is not at issue here. But in
7 that particular photo, you can see significant bruising along her
8 flanks and her abdominal incision scar.

9 And so we would ask to exclude that particular photo, in
10 addition to limiting the number of photos that plaintiff --

11 ATTORNEY BURKE: Four?

12 ATTORNEY MAPLES: Four. Sorry, premarked as 4.

13 ATTORNEY BURKE: And, Your Honor, when we plan to publish
14 that particular photo to the jury, we do intend to redact the
15 bottom portion. So I actually agree with them on that one. We
16 don't want to show the whole torso. But Ms. O'Neal has the
17 photos, if you would like to flip through them.

18 I'm sorry, Allie, I don't mean to interrupt you.

19 ATTORNEY MAPLES: That's okay. Well, in that case, we would
20 ask that only the top portion be disclosed to the jury. And we
21 still remain steadfast in our position that 27 is too many to
22 disclose to the jury.

23 ATTORNEY O'NEAL: May I approach the bench?

24 THE COURT: Yes, ma'am.

25 ATTORNEY BURKE: And while she approaches, I'll be happy to

1 give you a little argument on the --

2 THE COURT: Sure.

3 ATTORNEY BURKE: So the breast surgery with Dr. Schimpf took
4 place over six years ago. And we pulled these photographs down
5 from over 130. And, as you know now, she's had six surgeries,
6 mastectomies plus five reconstructions. And those 27 photographs
7 were very carefully pulled from the whole group to document the
8 post surgical time period, the initial necrosis of the tissue,
9 and then her injuries, the debridement, the wound VAC, the
10 hospitalization for sepsis. And then we show the jury
11 progression with each be fat-grafting procedure as the scarring
12 improved and the fullness in her breasts improved. And, of
13 course, we provided one recently so they know where Ms. Turisk is
14 now without -- I mean, she's not going to have any further
15 reconstruction.

16 So take a look. And then certainly, your Honor, if it's too
17 much, we'll go back.

18 THE COURT: So 4 is the one we talked about you can take off
19 the bottom?

20 ATTORNEY BURKE: Yes, ma'am.

21 THE COURT: But what's the significant difference, say,
22 between 3 and 5? And 4?

23 ATTORNEY BURKE: So 3 depicts her right breast, and 5
24 depicts her left breast on the 6th, as well as her drain tube.
25 And the ones that we picked, we selected them so that they, as

1 closely as possible, lined up with her appointments with
2 Dr. Schimpf, as well, in the immediate postoperative period.

3 THE COURT: So unless I'm getting my left and my right
4 confused, it looks like 3 and 5 are pretty much the same other
5 than the drain tube.

6 ATTORNEY BURKE: So you would like us to pick --

7 THE COURT: Pick one of those two.

8 ATTORNEY BURKE: Between 3 and 5?

9 THE COURT: Correct.

10 ATTORNEY BURKE: Well, 3 and 5 are on different dates. Five
11 is on the 12th, and 3 is on the 6th. So if you'd like for us to
12 pick, we can pick -- we can pick between one of the ones on the
13 6th.

14 THE COURT: Okay. Pick one of those.

15 ATTORNEY BURKE: Okay.

16 THE COURT: And it looks like the two on the 28th.

17 ATTORNEY BURKE: I'm sorry, which one?

18 THE COURT: The three. Three pictures on 11/28.

19 ATTORNEY BURKE: Those are all in Dr. Schimpf's record, but
20 we can cut those back if that ...

21 THE COURT: They all look about the same, so you can just
22 pick one of those three.

23 ATTORNEY BURKE: Okay.

24 ATTORNEY MAPLES: Your Honor, if I may, just briefly. Just
25 for context, we wanted to highlight that there are photographs

1 that are already admitted into evidence. Well, they will be
2 admitted once the deposition is played through Dr. Herrera.
3 There's a stack of photos that also depict her surgical
4 condition. I know there are six sets, and each set has multiple
5 photos in it.

6 ATTORNEY O'NEAL: And just to be clear, we're not publishing
7 those, Exhibits 2 through 6, and not every single sub page of
8 Exhibit 6 because were multiple subparts of each photograph
9 record. Those will not be published except during the course of
10 playing Dr. Herrera's deposition. They were admitted into
11 evidence with no objection at the time of his deposition.

12 And so for the benefit of the jury, to be able to see what
13 it is he's looking at as he's testifying, those will flash up on
14 the screen, but they are not being used and published at trial.

15 THE COURT: So the ones we're actually talking about is this
16 stack right here?

17 ATTORNEY O'NEAL: Yes, ma'am.

18 ATTORNEY BURKE: Yes.

19 THE COURT: Just take out those ones that we talked about
20 that were on the same date. And the rest of them look like they
21 depict different stages of her condition on different days
22 throughout the whole process, and they're different.

23 ATTORNEY BURKE: We will pull out one photo from the 6th,
24 and we'll pick one from the 28th.

25 THE COURT: Perfect.

1 ATTORNEY BURKE: Thank you.

2 ATTORNEY O'NEAL: Thank you, Your Honor.

3 THE COURT: Anything further?

4 ATTORNEY O'NEAL: No, Your Honor. That concludes the
5 defendant's motions.

6 (Off-the-record discussion.)

7 (The Court left the bench momentarily and returned.)

8 THE COURT: Counsel, we do have a note from one of the
9 jurors. During jury selection, she did indicate she had knee
10 surgery and she needs to be able to sit, or she can stand,
11 frequently. I'll just read it to you: Dislocated knee. Injured
12 last week. Patella subluxation. Pain and discomfort. Cannot
13 sit for long periods of time.

14 I told her we can sit her in the back row where she can
15 stand up and down. Her leg is swelling, cannot bend. Will need
16 additional pain medication for prolonged periods.

17 Obviously I still have to ask her if that's any type of
18 medication that would cause her any kind of impairment in her
19 ability to -- do y'all just want me to bring her out real quick
20 and ask her that?

21 ATTORNEY BURKE: That would be great. And when y'all had
22 that conversation, I think you were in the big jury room so I was
23 not privy to the extent of her injuries. I mean, I saw her come
24 up, but I didn't know what was going on with her. And if I had
25 known that, I might not have seated her.

1 THE COURT: Really, I didn't think it was -- obviously I
2 said we would provide transportation to her, and I told her she
3 could stand up and down, but she didn't indicate something about
4 taking more pain medication.

5 Y'all want to take a quick break, and then I'll bring her
6 out before I bring the rest of the jury?

7 ATTORNEY BURKE: Sure.

8 (Court recessed at 2:30 p.m. and reconvened at 2:40 p.m.,
9 without the jury present.)

10 THE COURT: Ms. Burke, do you want to wait for co-counsel
11 before we bring out the juror?

12 ATTORNEY BURKE: No, ma'am. We can proceed. Thank you.

13 THE COURT: Could we please have juror no. 135, please.

14 (Juror No. 135 enters the courtroom.)

15 THE COURT: Good afternoon, Ms. Jervey. You can have a seat
16 right there, if you'd like.

17 JUROR NO. 135: Right here?

18 THE COURT: Yes, ma'am. And, Ms. Jervey, I'm just going to
19 place you under oath very briefly.

20 CHRISTINA F. JERVEY, JUROR NO. 135, SWORN IN

21 THE COURT: So, Ms. Jervey, during jury selection you
22 informed me that you had recently had the knee problem and you
23 had problems standing and sitting, which I'm happy to
24 accommodate. We can put you in that very last row so if you need
25 to stand up at any point, you're certainly more than welcome to.

1 I'm concerned, though, as far as your pain and discomfort.
2 Are you experiencing further pain and discomfort now?

3 JUROR NO. 135: Well, so I dislocated my knee. So sitting
4 for prolonged periods causes swelling, and that is where the pain
5 comes from. So as long as there's breaks and I can elevate, you
6 know. I was able to sit in the juror room for the last two hours
7 and elevate, and I'm fine.

8 THE COURT: Okay.

9 JUROR NO. 135: I just don't know how many hours we're
10 sitting.

11 THE COURT: We'll be sitting for a while but, like I said,
12 if you want to sit in the back row, you can certainly stand up.
13 If we can provide something for you to put your foot on, we are
14 happy to do that as well.

15 JUROR NO. 135: So will I be sitting for hours at a time
16 without being able to ice and elevate?

17 THE COURT: You can ice, and we can provide a box or
18 something for you to put your foot on. And if you need to stand
19 up during that time, you can.

20 JUROR NO. 135: Okay. And walk around?

21 THE COURT: I don't know as far as, like, walking around too
22 much. You don't want to be disruptive of the testimony.
23 Obviously you need to pay attention. So, you can certainly
24 stand. We will take breaks every, you know, couple hours just to
25 use the restroom, get a snack, or whatever, and you can stand up.

1 And you're sitting, you can certainly ice and elevate. Would
2 that work okay for you?

3 JUROR NO. 135: I mean, I'll do my best. I don't really
4 know what to anticipate. All I know is the last two days I
5 haven't moved hardly, you know, so this is extremely taxing to
6 come in here for three hours and not be able to ice. But I feel
7 better now that I was able to. So I really don't know. I'm just
8 telling you how I feel, you know, and to do my best duty, I feel
9 like I shouldn't be in pain and discomfort here.

10 THE COURT: Well, no. We certainly don't want you to be.
11 We want to be as accommodating as best we possibly can.

12 JUROR NO. 135: Okay.

13 THE COURT: Let me ask you this, though. As far as -- you
14 also put in here that you need additional pain medication for
15 prolonged periods. Tell me about that.

16 JUROR NO. 135: Well, again, if I'm going to be sitting here
17 all day, I just feel like I'm going to have to do something for
18 the inflammation and for the pain.

19 THE COURT: Can you tell me what you're taking? Is it
20 something narcotic, or is it more like Tylenol?

21 JUROR NO. 135: No, I'm not, not yet. Hopefully I don't get
22 to that point. So I have a brace on, and when it swells it just
23 gets extremely tight. So, you know, I think I'll be fine. I
24 just have no idea how long I sit here. I've never done this
25 before. You know.

1 THE COURT: I'll be honest with you. It will be a long
2 week, so there will be times when you come in and will sit for a
3 while. But like I said, we'll put you in the back row, and we'll
4 provide something you can put your foot on, and an ice pack, if
5 you need to. As I said, if, at some point, you get to the point
6 where you need to take a break, if you would raise your hand and
7 let me know --

8 JUROR NO. 135: You'll excuse me to go out and take a rest?

9 THE COURT: Well, we'll have everybody. You can't just one
10 person can't go out. Everyone has to be present during the
11 testimony. So if you feel that you're okay going forward with us
12 making those accommodations for you --

13 JUROR NO. 135: I would prefer to do this at a different
14 time when I felt well, but I don't feel like it's a choice. So
15 that's how I feel. I wouldn't have shown up today and I would
16 have gone to my doctor's appointment, but that wasn't a choice,
17 so.

18 THE COURT: All right. Well, let me just discuss this
19 briefly with the attorneys. If you would go back to your jury
20 room, we'll be right back with you.

21 JUROR NO. 135: Okay.

22 (Juror No. 135 leaves the courtroom.)

23 THE COURT: All right. Any statements from either the
24 plaintiff's counsel or defense counsel as to their position as to
25 juror no. 135?

1 ATTORNEY BURKE: Your Honor, I would be in favor of excusing
2 the juror. I mean, she's obviously distressed. She said she
3 didn't go to her doctor's appointment today so that she could
4 show up for jury service. She seems a little caught offguard
5 that she was selected. The level of discomfort is concerning. I
6 worry about her disruption of the trial, and to concentrate. I
7 think it would be in the best interest of all parties to have her
8 be excused.

9 THE COURT: Defense counsel?

10 ATTORNEY SMYTH: Your Honor, I agree.

11 ATTORNEY BURKE: Good job.

12 ATTORNEY SMYTH: I do have some of the same concerns. It's
13 a long -- a lot of it deals with pain and suffering, too, which
14 could cloud the way that she perceives the evidence if she's not
15 feeling well, so I think it's probably safest to excuse her.

16 THE COURT: Looks like we're all three on the same page
17 then. I agree with your assertion. Do you mind letting Ms.
18 Jervey -- any objection to just letting the bailiff know that
19 she's excused?

20 ATTORNEY BURKE: No, Your Honor.

21 ATTORNEY SMYTH: No objection.

22 THE COURT: Will you please let juror no. 135 know that
23 she's excused. We'll just transfer her to another term of court.
24 Maybe give her, like, four months or so. Thank you, sir.

25 ATTORNEY BURKE: Tell her we hope she feels better soon.

1 I'm very sympathetic.

2 (Off-the-record discussion held.)

3 THE COURT: Madam Court Reporter, we'll mark this as a court
4 exhibit.

5 (Court's Exhibit 1 is marked for identification.)

6 THE COURT: Can we have our jury? I'm sorry. I thought I
7 asked for that. I apologize.

8 (Jury seated in the courtroom at 2:55 p.m.)

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

10 THE COURT: Thank you. Madam Clerk, if you'd please swear
11 in the jury.

12 CLERK OF COURT: Ladies and gentlemen of the jury, if you'll
13 please stand and raise your right hand to be sworn.

14 (Clerk of Court administers oath to jurors.)

15 CLERK OF COURT: If you accepted this oath, please be
16 seated. Let the record reflect all jurors are seated.

17 OPENING REMARKS TO THE JURY

18 THE COURT: Thank you. Welcome back, ladies and gentlemen
19 of the jury. Thank you for accepting the important oath of
20 responsibility for jury service and for your contribution today
21 to our system of justice.

22 What I will now say to you is meant to serve as an
23 introduction to the trial of this case. These remarks are not a
24 charge on the law in this case. I will instruct you on the law
25 of this case at the end of the trial before you retire to decide

1 the case. Before the trial begins, I want to explain to you the
2 procedure that we will follow so that you can better understand
3 what is happening during the trial of this case.

4 You have been selected as fair and impartial jurors whose
5 purpose is to find and determine the facts. You are the sole
6 judges of the facts. If, at any time, I make any comment
7 regarding the facts, you must disregard that.

8 You are to determine the facts from the testimony that you
9 hear and any other evidence that is presented. You should not be
10 influenced by any opinions or statements you may have heard
11 outside of this courtroom.

12 It is especially important that you perform your duty in
13 determining the facts diligently and conscientiously because
14 ordinarily there is no way to correct an erroneous determination
15 of the facts by a jury. When you comply with your oath to
16 impartially determine the facts of this case, you will have
17 fulfilled your duty as juries and no one will have the right to
18 criticize your verdict.

19 On the other hand and with equal emphasis, the same law that
20 makes you the judges of the facts makes me the judge of the law.
21 The law, as given by the Court, is the only law that you may
22 consider. You must accept it and follow it even though you may
23 disagree with it. I cannot tell you what the facts are, and you
24 cannot disagree with me about what the law is or should be. Your
25 job is to take the law as I give it to you and apply it to the

1 facts as you find them from the testimony from the witnesses,
2 and, any other evidence that is introduced or presented during
3 the trial. After doing that, you will render your verdict under
4 the solemn oath that you just took as jurors.

5 Until I advise you to begin your deliberations, you must not
6 discuss this case with anyone, including your fellow jurors, your
7 family members, your friends, and anyone involved in this case.
8 This includes any discussions which are face-to-face, anything by
9 telephone, email, texts, blogs, or any other method of
10 communication. You may not use a computer, a cellphone, or any
11 other electronic device with communication capabilities at any
12 time while you are in the courtroom or during your deliberations.

13 During your breaks for meals or overnight, if necessary, of
14 course you may use these devices; however, you may not, at any
15 time, use these devices to get or send information about this
16 case. This includes any information about a party, a witness, an
17 attorney, a court officer, any news accounts about the case, any
18 research on any topics that may be raised, or any topics you may
19 think may be helpful in deciding the case, or any testimony that
20 is presented by any of the parties.

21 During the trial, do not read, listen to, or watch any
22 potential news reports about this case. This would include
23 anything that may be in the newspaper, on the internet, radio, or
24 television. You must not consider anything you may have read or
25 heard about this case outside of this courtroom, whether before

1 or during the trial of this case.

2 After the case is submitted to you, you must discuss it only
3 in your jury room with your fellow jurors.

4 The attorneys and the parties in this case have been advised
5 they're not to talk to you at all, so if you see them coming in
6 and out of the courthouse and they don't speak to you, they're
7 not being unfriendly; they're just following the Court's
8 instructions.

9 It is important for you to keep an open mind and not decide
10 any issue in this case until all of the evidence has been
11 presented, the parties have made their closing arguments, and I
12 have instructed you on the law in this case.

13 Now in just a moment the attorney for the plaintiff will
14 make what is called an opening statement. The attorney will
15 explain to you what the issues in the case are, at least what the
16 attorney thinks the issues in the case are. The attorney for the
17 defendant will also make an opening statement. What the
18 attorneys tell you during their opening statements is not
19 evidence in this case; it is only their contention as to what
20 those issues are.

21 The evidence in this case will be presented to you by the
22 testimony of sworn witnesses from the witness stand and any
23 exhibits that are properly introduced during the trial of this
24 case.

25 From time to time during the trial you may hear one of the

1 lawyers say something like, We have a matter of law; May we
2 approach the bench?, or sometimes myself, I might find it
3 necessary to excuse you from the courtroom for a short while so
4 that attorneys and I can discuss a matter of law. The reason for
5 this is because you are the judges of the facts in this case, and
6 sometimes when I'm discussing matters of law with the attorneys
7 it may be necessary for me to make some comment as to the facts
8 in connection with ruling as to whether or not a particular law
9 applies. I am not supposed to tell you what I think the facts
10 are, so I will excuse you from the courtroom for a short while
11 these discussions take place so that you, in no way, will be
12 influenced by anything I might say or do in connection with the
13 facts of this case.

14 In determining what the true facts are in this case, you
15 must decide whether or not the testimony of the witness is
16 believable. It will be my responsibility to rule, as a matter of
17 law, as to whether certain testimony is admissible at all or not,
18 but once the testimony is admitted, whether or not you believe it
19 is solely for you to determine.

20 In deciding whether to believe a witness, you have the right
21 to consider whether the witness has an interest in the result of
22 the trial, whether the witness is prejudiced towards either the
23 plaintiff or the defendant, the opportunity for the witness to
24 have seen the matters and the things about which the witness may
25 testify, and the way that the witness acts on the witness stand.

1 You have the right to consider anything that is in the
2 record that will help you evaluate the testimony of the
3 witnesses. That means it is your duty to pay close attention to
4 these witnesses, to observe the witnesses, to listen to the
5 witnesses, and to pay close attention to the attorneys and to the
6 Court. Don't let your thoughts wander but pay strict attention
7 to the testimony so at the end of the trial you will be able to
8 determine what the true facts are and apply the law to those
9 facts and render a verdict under the solemn oath that you just
10 took as jurors.

11 Are there any exceptions or objections to the opening
12 remarks from either the plaintiff or the defense?

13 ATTORNEY BURKE: No objections, Your Honor.

14 ATTORNEY SMYTH: None from the defense, Your Honor. Thank
15 you.

16 THE COURT: Counsel.

17 ATTORNEY BURKE: May it please the Court.

18 THE COURT: Yes, ma'am.

19 OPENING STATEMENT ON BEHALF OF PLAINTIFF

20 ATTORNEY BURKE: Good afternoon, ladies and gentlemen of the
21 jury. And finally at 3:00 on a Monday we begin. I'm Beth Burke.
22 I know I introduced myself to you earlier. And, I represent
23 Rebecca Turisk. I just want to tell you all that I appreciate
24 you all being here so much. I know that you have you put your
25 lives on hold, your jobs, your families, your housework, your

1 dogs, your cats, your plants. Everything you have going on has
2 been suspended to come here and help us with a very important
3 case. And, we do appreciate it. Thank you very much.

4 On November 1st of 2016, Dr. Schimpf performed a surgery on
5 Rebecca. He performed a surgery to remove breast implants that
6 Rebecca had in place when she was about 25 years old, and to
7 reduce her breasts, and to give her a breast lift. Rebecca had
8 just turned 50 years old, and she wanted to do something for her
9 health; she wanted to do something to mark the milestone; a gift
10 to herself, so to speak.

11 Rebecca suffers from neck and back pain, and so her goal
12 with the surgery was literally to get some weight off of her
13 chest, hopefully relieve some of those problems. So she planned
14 for the surgery, and she thought she had selected the right guy
15 to do the job.

16 On November 1st she was driven to Dr. Schimpf's surgery
17 center by a friend; she was prepped for surgery; she was put
18 under anesthesia; and Dr. Schimpf performed the breast implant
19 removal, and the breast reduction, and the breast lift.

20 Unfortunately, Dr. Schimpf didn't perform the surgery
21 properly. Dr. Schimpf selected an improper surgical technique to
22 execute the removal of the implant and the breast lift.

23 When a physician -- you heard Judge Murphy earlier this
24 morning mention that we have alleged that Dr. Schimpf has
25 violated the standard of care and breached the standard of care,

1 so I want to take just a minute to talk about what that means.

2 Doctors owe their patients the duty of care. And when
3 doctors fail to provide care that a reasonable, prudent physician
4 would provide under the same or similar circumstances, they
5 breach their duty of care to their client/to their patient.
6 Dr. Schimpf's breach was the improper surgical technique.

7 So what happened as a result of that breach of the standard
8 of care? The evidence in the case will show that by performing
9 the wrong approach to the surgery the vascular structures of
10 Rebecca's breasts were basically cut off. The blood supply to
11 her right and left breast were damaged, worse on the right than
12 the left.

13 When you cut off the blood supply to tissue, that tissue
14 dies, it becomes necrotic, and that's what happened to Rebecca's
15 breasts. The tissue in her right breast and her left breast
16 became necrotic, and she lost her nipple, her entire
17 nipple-areolar complex, on the right side.

18 Over the course of the next few weeks Rebecca followed up
19 with Dr. Schimpf, as she was instructed to do. She went to her
20 postoperative visits.

21 But, over that time, things started happening with Rebecca's
22 healing that indicated a problem to her. She called Dr. Schimpf.
23 And finally, on November 30th is when the right nipple was
24 debrided off of her breast. At that point Rebecca lost
25 confidence in Dr. Schimpf.

1 On that evening, on November the 30th, she went to the
2 emergency room at the Medical University of South Carolina. She
3 was not admitted that night, but she was admitted a couple of
4 days later on December 3rd, and was hospitalized for four days.
5 She was given IV antibiotics. Debridement were performed on her
6 breasts. A debridement is where dead tissue is cut away from
7 live tissue in order to help the live tissue heal and grow. It's
8 a very painful procedure.

9 When she was discharged from the Medical University of South
10 Carolina around the 7th of December, at that point she became the
11 patient of a plastic surgeon at MUSC named Dr. Herrera. Rebecca
12 followed up with Dr. Herrera. He cared for her wounds. He
13 debrided her wounds. He referred her to a wound care center in
14 Summerville close to Rebecca's home so that she could get wound
15 care close to home. And by Dr. Herrera's effort and wound-care
16 efforts -- the process of the necrosis that had started couldn't
17 be stopped, and it all goes back to the cutting off of the blood
18 supply that happened in Dr. Schimpf's surgery because he
19 performed an improper technique, which was a violation of the
20 standard of care.

21 Over time, the necrosis got worse and worse. Rebecca was
22 even hospitalized for sepsis. The necrotic breasts became
23 infected, and she developed a systemwide infection. She required
24 emergency surgery at that admission to do a surgical debridement
25 of her breasts. The bedside debridements were not working for

1 her.

2 Not too long after that, Dr. Herrera took Rebecca into an
3 operating room at MUSC and performed a double mastectomy. One
4 hundred percent of breast tissue that remained on the right was
5 removed, and the majority of the breast tissue on the left.

6 In doing those mastectomies -- and you're going to hear
7 testimony from Dr. Herrera. In doing those mastectomies, he will
8 tell you that those were necessary to remove the necrotic tissue
9 from her body and close those wounds.

10 Rebecca took some time after that to heal. She went back to
11 see Dr. Herrera about 10 months later, and at this point Rebecca
12 and Dr. Herrera were ready to embark on reconstruction. And as a
13 part of that reconstruction, Dr. Herrera was also going to
14 relieve some of the pain Rebecca was feeling in her breast after
15 of mastectomy.

16 For the next couple of years, Dr. Herrera performed five
17 different surgeries to reconstruct Rebecca's breasts, a little
18 more on the right than the left. As you remember, she lost the
19 nipple on her right and had a 100 percent mastectomy.

20 Dr. Herrera performed fat-grafting procedures. And you'll
21 learn a little more about that. He carved the fat from different
22 places in Rebecca's body, and then transplanted it into her
23 breasts in order to recreate the breast mound that Rebecca lost.

24 In conjunction with those surgeries, he also removed
25 hardened, necrotic fat that was still left. He removed scar

1 tissue. And you'll see photos of all this. And you'll see a
2 photo of how Rebecca looks today.

3 So we're here because of Dr. Schimpf's violation of standard
4 of care, and we're here because of Rebecca's injuries and damages
5 as a result of that breach.

6 Rebecca has about half-a-million dollars in medical bills.
7 Rebecca has suffered pain, and emotional distress, loss of
8 enjoyment of life, and even though Dr. Herrera did his best,
9 Rebecca still has disfigurement in her breast, one of the most
10 eminent parts of your body, and one of the defining
11 characteristics of the female body.

12 The defense in this case is going to want to try to distract
13 your attention from what happened in Dr. Schimpf's operating
14 room. They're going to want you to focus on Rebecca, and they're
15 going to try to get you to blame Rebecca's horrible surgical
16 outcome on Rebecca.

17 They're going to talk to you about Rebecca's preexisting
18 chronic pain that she had in her neck and her back. They're
19 going to talk to you about Rebecca's fibromyalgia. They're going
20 to talk to you about the fact that Rebecca had adrenal fatigue.
21 They're going to talk to you about the medications that Rebecca
22 was using, as prescribed by her physician, to manage her chronic
23 medical condition.

24 But as you hear those facts about Rebecca's life -- and
25 those are the facts. Rebecca does not have a perfect life -- I

1 just want you to think, What does Rebecca's chronic pain have to
2 do with Dr. Schimpf's surgical technique? What does her
3 fibromyalgia have to do with her surgical technique? What does
4 her adrenal fatigue have to do with the surgical technique? And
5 how does any of that diminish, how do any of those preexisting
6 conditions that she had diminish, what she went through and what
7 she's going to live with? And the answer is that it doesn't.

8 The evidence in this case is going to show that none of
9 those preexisting conditions impacted her outcome. We believe
10 that we will prove that the outcome that Rebecca Turisk
11 experienced following that surgery with Dr. Schimpf was dictated
12 by the first cut he made in her skin. Thank you.

13 THE COURT: Counsel.

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

15 THE COURT: Yes, sir.

16 OPENING STATEMENT ON BEHALF OF DEFENDANT

17 ATTORNEY SMYTH: Good afternoon, ladies and gentlemen. My
18 name's Todd Smyth. I introduced myself briefly beforehand, but
19 I'm going to reintroduce my team who's sitting with me today.
20 Allie Maples is one of the attorneys in our office. She's going
21 to be helping me try the case. And next to her is Dr. Schimpf.
22 And Katie Rhodes is our paralegal, and she's hopefully going to
23 be keeping us straight this week.

24 I want to start off by just talking to very bluntly, very
25 plainly, because I think some mischaracterizations have already

1 been made in this case. And I want everybody in this jury box to
2 understand that just because we are on the opposite side of a
3 lawsuit does not anyone in this courtroom bears Rebecca Turisk
4 any ill will. By all accounts, she's a fine lady. She's been
5 through a lot of difficult and painful things in her life.

6 We are forced this week to talk about her breasts, her body.
7 That's a very sensitive subject, and we understand that, and I
8 want you to know that nothing that is said in this courtroom by
9 me or by any of our team is never meant to humiliate her, to
10 embarrass her, to demean her in any way.

11 We're here because we have a lawsuit to defend. Plaintiffs
12 have made some very serious allegations, allegations that we do
13 not believe have any merit. They've made allegations of medical
14 malpractice.

15 You heard a little bit about some of the terms that we're
16 going to talk about this week. Standard of care. That's defined
17 as what a reasonable physician would do in the same or similar
18 circumstances. It's the tried-and-true techniques that people in
19 the same specialty of medicine use over and over and over again.
20 That's the standard of care. That's what Dr. Schimpf has been
21 accused of violating. We're here to defend that case.

22 One of the other points that I want to make for you early,
23 and I believe Judge Murphy will probably echo this to you on a
24 daily basis, is this: Every lawsuit has two sides. It's like a
25 coin. So far you've heard the plaintiff's version of the case,

1 but you haven't seen the other side of the coin. And in our
2 system of justice, the plaintiff gets to go first. They get to
3 call their witnesses; they get to put up their evidence; they get
4 to show you pictures. It may be very tempting and very-much
5 human nature to start to think, I have permission to make my
6 decision about this case, but you would not have seen the other
7 side of the coin. And we're here this week to show you the other
8 side of the coin, because we believe, very firmly, that
9 Dr. Schimpf met the standard of care.

10 We're going to call a number of witnesses, the first of
11 which is going to be Dr. Schimpf, who was obviously her
12 physician. He cared for her and he treated her. He spent a lot
13 of time with Rebecca before this surgery started, and he talked
14 to her about some important things. Those of us that have
15 undergone surgery ourselves or ever had a close family member or
16 friend undergo surgery understand that when it comes to an
17 operation there is no free lunch. There are risks with every
18 single surgery that's performed. And being a good doctor,
19 Dr. Schimpf spent time with Ms. Turisk, and he talked to her
20 specifically about the risks that are associated with
21 breast-reduction surgery.

22 We're going to show you the form that she signed where she
23 understood those risks. Those risks including very serious
24 things, very difficult complications; tissue loss, nipple loss,
25 asymmetry, meaning your one breast is a different size or shape

1 from the other. These are all things that can happen. The need
2 for revisional surgery when they do happen. These are all things
3 that can happen even when the surgery is done by the book using
4 those same tried-and-true techniques that surgeons have performed
5 hundreds and thousands of times. So we're going to call
6 witnesses who will talk about that.

7 And Dr. Schimpf's going to be the first one. He's got a
8 unique story. He went to college on a basketball scholarship.
9 And after college, his mother had been diagnosed with cancer when
10 he was younger. He started working in the emergency room, and he
11 was drawn to medicine because he wanted to help people, so he
12 spent time training, learning to become one of the best plastic
13 surgeons he could be. He trains.

14 And then he began his practice here in Charleston. He
15 worked at an academic hospital, and then he opened his own
16 private practice called Sweetgrass Plastic Surgery. And he's
17 been there for about 10 years.

18 In that time period, Dr. Schimpf will tell you that he's
19 literally done thousands of these surgeries. This was not his
20 first rodeo. He knew what he was doing. He knows the
21 appropriate techniques that can be used when performing
22 breast-reduction surgery.

23 He used the technique, and he'll tell you, something called
24 an inferior pedicle. You're going to get some very complicated
25 medical terms this week, so you're going to learn a lot, so I

1 think most juries really enjoy understanding that process. But
2 the technique that Dr. Schimpf used, you will hear from multiple
3 witnesses, is the go-to technique for the surgery. This is not
4 something that he made up. This is not something that he chose
5 randomly. He chose it based on the physical history that he took
6 from Ms. Turisk, the findings in that physical history, and his
7 experience and skill as a surgeon. He chose the technique that
8 he felt would work the best.

9 There's been some suggestion that he completely disrupted
10 the blood supply to the nipple. We're going to bring you
11 evidence to show that that's not the case; that was not the cause
12 of this problem.

13 We're going to bring -- in medicine, another term that
14 you'll hear used a lot this week is something called a known
15 complication. These are some of those risks that I talked about
16 earlier that can happen even when everything is done correctly.

17 Dr. Schimpf is going to talk to you about how he performed
18 surgery, what he does during the surgery to make sure that all of
19 the structures within the breast are getting the proper blood
20 supply that they need, and that there were no complications,
21 there was no issue with blood supply to her breasts when he
22 finished that surgery.

23 He's also going to talk to you about her aftercare. Any
24 good physician wants to take care of their patient after surgery.
25 Dr. Schimpf is no different. Anytime Ms. Turisk picked up the

1 phone to call, he answered. He gave her his personal cellphone.
2 He was responsive. He called her back. If she needed to be
3 seen, he made an appointment to see her.

4 She, unfortunately, did develop an infection in her breast
5 about a month after surgery. And we're going to bring you
6 experts to talk about why that is. We've got an infectious
7 disease expert, Dr. Patrick Joseph from California, who's going
8 to talk about this process of fat necrosis, how it happens, why
9 it happens, and why it can be so devastating, why it's so
10 difficult to treat.

11 We're also going to bring you another expert, another
12 plastic surgeon, board-certified plastic surgeon just like
13 Dr. Schimpf who's been doing those surgeries for years, who knows
14 what he's doing, who's done there procedure regularly throughout
15 the course of his career. His name is Dr. Todd Lefkowitz. He
16 practices right off of I-26 in Lexington, South Carolina. He's
17 going to come here and tell you what his opinions are in the
18 case. He's reviewed the medical records, he's reviewed the
19 deposition testimony of all the witnesses, and we've asked him to
20 come in and share his opinions with you.

21 And I believe what you're going to hear from Dr. Lefkowitz
22 is not only did Dr. Schimpf use the standard of care, he used the
23 gold standard, the go-to technique, the one that's used most
24 often throughout this country when this surgery is performed, and
25 he did it correctly.

1 That's one thing you're not going to hear from the
2 plaintiff's side of the table, is that any aspect of the surgery
3 that Dr. Schimpf performed was incorrect. Nobody's going to come
4 in here and accuse him of making a mistake in the execution of
5 the surgery.

6 We talked a little bit about expert witnesses and, as Judge
7 Murphy will tell you, you are the sole judges of their
8 credibility. You get to ask yourselves, Who do I believe?, Who
9 do I trust?, Who do I think has done this procedure the most out
10 of the expert witnesses, either somebody who has done it
11 recently, or somebody that hasn't done it in years, or somebody
12 that spent more time, perhaps, in a courtroom as an expert
13 witness than they do in the operating room? These are all things
14 that you will get to assess as you listen to the expert
15 witnesses.

16 We believe that the experts that we provided are going to be
17 very helpful to you, and we hope that's the case, and will help
18 you understand some of the science.

19 One other thing that I would be remiss if I didn't address
20 is photographs. I talked early on about how these are difficult
21 complications that Ms. Turisk suffered. Nobody's disputing that.

22 You're going to see a lot of photographs in this case. Some
23 of them may be very disturbing to you because it's something
24 you're not used to seeing. Plaintiffs are going to tell you,
25 Well, that depicts her condition, but at some point, when you see

1 these same photographers over and over and over and over again,
2 you might start asking yourself, Why? I've seen those; I
3 understand what it looks like; I know it's a surgical thing. Why
4 are we seeing them repeatedly? And you might ask yourself, Is
5 there something more in play?, Is there another motive, perhaps,
6 to engender some sympathy?

7 And that's one thing that I think Judge Murphy is going to
8 tell you at the end of this case when she's charging you on the
9 law, is that even though we're all human, even though we all
10 empathize with somebody who's had a difficult time like Ms.
11 Turisk undoubtedly has, sympathy has no place in this courtroom.
12 Your verdict has to be based on facts and the evidence, and
13 that's it. And that's the oath we're counting on you having
14 taken, and hope that you'll follow through with it.

15 We believe that once you listen to all the evidence, once
16 you've seen both sides of the coin, we're going to ask you for a
17 verdict that says Dr. Schimpf met the standard of care in using
18 the gold standard technique. Ms. Turisk, unfortunately,
19 experienced a complication, but it wasn't because of medical
20 negligence.

21 Thank you for your time and attention.

22 THE COURT: You may call your first witness.

23 ATTORNEY TANENBAUM: Plaintiff calls Mary Ackerman.
24
25

1 MARY ACKERMAN,
2 having first been duly sworn, was examined and testified as
3 follows:

4 CLERK OF COURT: Please be seated. I'm going to have you
5 state your full name, spelling your last name, and speak loudly
6 into the microphone.

7 THE WITNESS: Mary Ackerman.

8 ATTORNEY TANENBAUM: This lady's taking down your testimony,
9 so ...

10 THE WITNESS: Okay.

11 ATTORNEY SMYTH: Your Honor, may we move the podium? We
12 cannot see the witness from where we are.

13 THE COURT: Yes, sir.

14 ATTORNEY TANENBAUM: Oh, I'm sorry.

15 THE WITNESS: Mary Ackerman, A-c-k-e-r-m-a-n.

16 THE COURT: Your witness.

17 ATTORNEY TANENBAUM: Thank you, Your Honor.

18 **DIRECT EXAMINATION**

19 BY ATTORNEY TANENBAUM:

20 Q Good afternoon.

21 A Good afternoon.

22 Q I think we met once before. Nice to see you again. I'm
23 Mark.

24 A Mark.

25 Q So, Mary, tell me, where were you born and raised?

1 A I was born in Berkeley, California, after the war, and I was
2 raised in northern Minnesota.

3 Q Could you pull that microphone -- it may be my hearing, but
4 if you could pull that microphone a little closer, I'd appreciate
5 it. Thank you very much.

6 A Okay. Is that better?

7 Q It is. Thank you. And give us the benefit of your
8 background please. Where were you educated, and what have you
9 done for a living?

10 A Okay. As I said, I was born in California, raised in
11 Minnesota. And I left Minnesota and went back to California when
12 I was 17. I got married and had a child. I lived in San Diego
13 and went to work for the federal government fairly young after I
14 got the kids a little bit grown, and I worked for the -- I went
15 to work as a GS-2, which is just like a clerical position.

16 I worked for the federal government for 27 years, and during
17 that time I was promoted on a regular basis. I took courses
18 through the Defense Acquisition University in government
19 contracting, which was the field that I ended up in.

20 I worked for a number agencies. I worked for the Department
21 of Defense for Navy in San Diego. I worked for Coast Guard. I
22 then worked for Transportation. And finally, the State
23 Department, the U.S. Department of State. I was a procurement
24 analyst in positions out in Washington, D.C. I was an auditor.
25 I went into other agencies looking at their contracting

1 operations to see if they did it properly, and then we would
2 issue a report on what we found in those reviews.

3 When I retired from the state department, I was a GS-15,
4 which is as high as you can go in the general service area. I
5 was a director of the office and in charge of policy for the
6 Department of State's acquisition arena. I had a very successful
7 career.

8 When I retired, I went to work for private sector for
9 another eight years up in D.C. I really loved the government
10 contracting work. It's not an exciting field for most people,
11 but I liked it, so ...

12 Q Well, congratulations to you. I know I made it to an E-4 in
13 the Army, but that's about as far as I went, unfortunately.

14 So in terms of coming to Charleston, when did you come here
15 and how did you meet Rebecca?

16 A I moved to Charleston when I retired for good. I moved down
17 here the 1st of February of 2011, and I moved into Crowfield
18 Plantation up in Goose Creek, and Rebecca lived in my
19 neighborhood.

20 I think the first time I met Rebecca, I was walking my
21 mother around. She would come and stay with me part of the year.
22 And mom had a walker. And I think Rebecca's little dog came
23 running cross the street. And that's how we met the first time.

24 Q And did you and Rebecca develop a relationship?

25 A We did. She called me one night, frantic that her dog had

1 found a kitten in the back yard. And I'm a cat person, and so
2 she brought the kitten over to me, and I fostered the kitten
3 until I found a home for it. So we started a friendship at that
4 time.

5 And then we had a -- we had a like of photography, and so I
6 was able to learn some things from her and William Long.

7 Q I'm going to Costco at the end of the week.

8 A Yes, I think you need to.

9 Q So, thank you. So y'all developed a friendship. And are
10 you still friends?

11 A Yes.

12 Q And how would you describe your friendship?

13 A Well, Rebecca's kind of like my daughter. She calls me mom.
14 I take her to appointments a lot of times. We're just friends.

15 Q So you've been there for her, so to speak?

16 A Yeah.

17 Q And do you know Dr. Schimpf?

18 A Yes.

19 Q How do you know Dr. Schimpf?

20 A I had surgery with Dr. Schimpf.

21 Q Was it similar to the -- and forgive me for asking, but was
22 it similar to the surgery that Rebecca had?

23 A There was some difference. I had a standard breast
24 reduction. Rebecca had im -- what do you call it?

25 Q Implant removal.

1 A Implants that had to be removed from her breasts, and then I
2 think they did a lift on that. So there were some differences.

3 Q And did you discuss with Rebecca what plastic surgeon to use
4 when she was going to have her breast reduction and implant
5 removal?

6 A Yes.

7 Q And did you recommend Dr. Schimpf?

8 A I did.

9 Q And you were happy with your result?

10 A In general, yes. The work that he did for me was fine.

11 Q And so were you familiar with what it looks like, so to
12 speak, as you're postsurgical and as you're beginning to recover
13 from that surgery? Were you familiar with it? Had you been
14 through that?

15 A I knew what mine looked like.

16 Q Okay. And now today you know what Rebecca's looked like?

17 A Yes.

18 Q So tell me, please, did you have anything to do with Rebecca
19 getting to Dr. Schimpf's and then coming home?

20 A Yes.

21 Q Tell us about that.

22 A I picked her back up in the morning, and I took her over and
23 I dropped her off.

24 Q May I open that for you?

25 A Yes, please.

1 Q Are you a little nervous up here?

2 A Yes.

3 Q I spilled coffee this morning, so don't do what I did. And
4 you took her there?

5 A I took her there, and then I went home. And they called me
6 when she was ready to be picked up.

7 Q And where did she go from that surgery? Where did you take
8 her?

9 A She came to my home.

10 Q And how long did she stay with you?

11 A She stayed in my home while I left and went on a trip to as
12 Australia. I had to look that up. And so I think I was gone for
13 four or five weeks, and her and William stayed in my home.

14 Q Do you recall the date that you left?

15 A I left on the, I believe it's the, 15th of November.

16 Q So she would be in your home together for two weeks?

17 A Right.

18 Q Did you have an opportunity to help Rebecca with her wound
19 and with her dressings?

20 A Yes. I think it was about the third day, maybe, I went in
21 and started changing the bandages. And that was the first time I
22 saw -- well, first of all, the gauze was stuck to her nipples,
23 and so I had to get a pan of water and soak the dressing to take
24 it off. And that was the first time I saw that things weren't
25 looking quite right. It didn't look like mine.

1 Q Did you talk to Rebecca about that then?

2 A I'm sure I did.

3 Q And were you in communication with Dr. Schimpf's office
4 about that?

5 A It was either me or William contacted his office. I believe
6 we sent pictures of the nipples. I -- go ahead.

7 Q Well, tell us who William was.

8 A William Long was a friend of Rebecca's. And William was my
9 friend, too. He stayed and really took care of Rebecca after I
10 left, and he would --

11 Q Was William Rebecca's significant other?

12 A Yes. Yes, he was her significant other.

13 Q And tell us about William a little bit.

14 A Okay. William was a gentle giant, so William must have been
15 six-foot-three tall, but he was about that thin, too. He was a
16 very thin guy. But he was a gifted musician, for one thing. He
17 was a very meticulous person. I think you might have referred to
18 him as a germophobe in many ways.

19 ATTORNEY TANENBAUM: And I didn't ask to get set up for
20 this, but one of the things I want to show -- we have a print of
21 November 6. And, counsel, I want to be able to show this,
22 publish this to the jury. I can't show it until it's admitted
23 into evidence. I apologize.

24 ATTORNEY BURKE: The Court's indulgence.

25

1 BY ATTORNEY TANENBAUM:

2 Q So let me show you this for identification purposes.

3 THE COURT: Counsel, would you show it to defense counsel
4 first, please.

5 ATTORNEY TANENBAUM: I'm sorry.

6 THE WITNESS: Yeah.

7 BY ATTORNEY TANENBAUM:

8 Q And do you recognize that?

9 A Yes. That's Rebecca's breast.

10 Q And did you see that on November the 6th, the day it was
11 taken?

12 A Yes.

13 ATTORNEY TANENBAUM: I'd move this into evidence, Your
14 Honor.

15 THE COURT: Any objection?

16 ATTORNEY MAPLES: No objection, Your Honor.

17 THE COURT: All right. It's in.

18 ATTORNEY TANENBAUM: This will be Plaintiff's 1.

19 (Plaintiff's Exhibit 1 is marked for identification.)

20 (Plaintiff's Exhibit 1 is received in the record.)

21 ATTORNEY TANENBAUM: I'd like to publish this to the jury,
22 if I could, Your Honor.

23 THE COURT: Yes, sir.

24 BY ATTORNEY TANENBAUM:

25 Q Now, you said it wasn't -- didn't look like your breasts did

1 after the surgery. Was that, what I'm going to call, the
2 nipple-areolar complex?

3 A Yes. Yes. Mine didn't look like that.

4 ATTORNEY TANENBAUM: And we've got another photograph that
5 we couldn't -- It's not quite prepared, Your Honor, but I'd like
6 to get the witness to identify it, and then we can finish
7 cropping it, if I could, before we publish it. But she can
8 identify it. I'm not going to publish it. I'm not going to move
9 it into evidence, Your Honor. Your Honor?

10 THE COURT: Yes, sir, subject to the previous Court's
11 ruling.

12 (Plaintiff's Exhibit 2 is marked for identification.)

13 BY ATTORNEY TANENBAUM:

14 Q And can you identify this photograph which has been marked
15 previously, also, as 11/6/2016? And that would be photo 2 -- 3,
16 down at the bottom left. Four, photograph 4.

17 A Yes.

18 Q And I'm not going to publish that to the jury yet, but does
19 that show a -- what did you see? Is that something that you saw,
20 also, on November the 6th when you began to dress the left side
21 of her breast?

22 A I saw both sides.

23 Q All right. And is this a true and accurate representation
24 of what you saw that day?

25 THE COURT: Counsel, you need to put that picture down,

1 please. Just be mindful in not showing the picture to the jury.

2 ATTORNEY TANENBAUM: No, I'm not showing it to the jury.
3 I've got the back of it to the jury.

4 THE COURT: Thank you.

5 ATTORNEY TANENBAUM: I've got that. Okay. And I'll leave
6 that here for now, Your Honor.

7 THE COURT: Yes, sir.

8 BY ATTORNEY TANENBAUM:

9 Q Rebecca [sic] -- excuse me. Did you spend any time with
10 Rebecca since you returned from Australia?

11 A Yes.

12 Q And did she go through any operative procedures after you
13 returned?

14 A She did go through operative procedures to try to rebuild
15 some of the breast tissue.

16 Q And how was she during those periods of time?

17 A Rebecca used to go out and do a lot of photography. She's a
18 wonderful photographer. And after the surgery she wasn't able to
19 carry the lenses that she used to be able to carry. She had some
20 really big lenses. And so she really kind've quit doing it. And
21 that was such a source of joy for her.

22 And we see each other, you know, two - three times a month
23 now. Go to dinner. She seems to be getting a bit better, but
24 she went through a lot of depression from this procedure and all
25 of the things that happened beyond.

1 Q How long had you known Rebecca until -- when did you first
2 meet her? How long ago was that?

3 A Say what?

4 Q If this surgery was in 2016, when did you meet Rebecca for
5 the first time?

6 A I think it was about 2013.

7 Q Okay. So during that three-year period, compared to the way
8 she is now, can you give us some idea?

9 A When I first met Rebecca, she was very active. She had some
10 physical issues. I knew she had pain in her back and her neck,
11 but she still was able to enjoy life a lot. We went to -- we
12 went just shooting pictures, the three us, Rebecca, William, and
13 me. William was also a gifted photographer. And so I was
14 getting the benefit of their knowledge, going with them.

15 That stopped after this surgery because she simply couldn't
16 lift the equipment anymore, plus her -- I mean, she just didn't
17 have that joy going on.

18 Q And today she's getting somewhat better?

19 A She's getting better. Yeah. I think she's getting better,
20 but that's a long time.

21 Q Thank you. That's all the questions I have. And I'm sure
22 Mr. Smyth will have some questions for you.

23 THE COURT: Cross-examination.

24 ATTORNEY MAPLES: Yes, Your Honor.

25 ATTORNEY SMYTH: May I bring the podium back up?

1 THE COURT: Yes, sir.

2 ATTORNEY MAPLES: May it please the Court.

3 THE COURT: Yes, ma'am. Your witness.

4 **CROSS-EXAMINATION**

5 BY ATTORNEY MAPLES:

6 Q Good afternoon, Mrs. Ackerman. My name's Allie Maples, and
7 I'm an attorney that represents the defendants in this case,
8 Dr. Schimpf and his practice, Sweetgrass Plastic Surgery. It's
9 nice to meet you.

10 A Nice to meet you.

11 Q I want to talk about your relationship with Mrs. Turisk in
12 greater detail, but before I do that I want to walk back and make
13 something very clear to the members of the jury. Now, you're not
14 a medical doctor, correct?

15 A No, I'm not.

16 Q You've never worked in healthcare?

17 A No.

18 Q You've never reviewed any of Mrs. Turisk's medical records?

19 A No.

20 Q You haven't looked at any of her postoperative medical
21 records?

22 A No.

23 Q You didn't attend any of her postoperative appointments with
24 her?

25 A No.

1 Q You can't tell this jury one way or another whether anything
2 Dr. Schimpf did caused any of the current conditions that Mrs.
3 Turisk experienced? Is experiencing. Excuse me.

4 A No.

5 Q And you told us that your breasts didn't look like
6 Mrs. Turisk's in the photos that you just reviewed with counsel,
7 correct?

8 A Correct.

9 Q But again, by your own admission, you had a different
10 surgery, right?

11 A Yes.

12 Q You described it as a standard breast reduction, correct?

13 A Yes.

14 Q You didn't have implants removed, correct?

15 A Correct.

16 Q Now I'd like to talk about your relationship with
17 Mrs. Turisk, like I said, in greater detail. You told us that
18 you've been friends with Mrs. Turisk almost 10 years, right?

19 A Uh-huh. Correct.

20 Q And you're not just friends, right? Sometimes you're
21 coworkers?

22 A We have been.

23 Q You've worked at Mrs. Turisk's business, haven't you?

24 A For a short time, yes, I did, when she was short.

25 Q You were a paid employee of Mrs. Turisk?

1 A Correct.

2 Q She's also performed some favors for you over the years?

3 A For instance?

4 Q She housesits for you?

5 A She has done housesitting for me when I've gone on long
6 trips; that is correct.

7 Q She's taken care of your cats?

8 A She has.

9 Q Now, through your friendship with Mrs. Turisk you've become
10 familiar with her health history, right?

11 A Yes.

12 Q You knew about her health history before she had the surgery
13 with Dr. Schimpf?

14 A I knew she had back pain, yes.

15 Q You knew about her health history before you recommended
16 Mrs. Turisk to Dr. Schimpf, correct?

17 A Yes.

18 Q And like you said, you knew that she had back pain, right?

19 A Yes.

20 Q You're aware that she had a permanent spinal cord stimulator
21 implanted in her back --

22 A Yes.

23 Q -- due to that pain?

24 A Yes.

25 Q And you're aware that that caused her to be limited long

1 before she had the surgery with Dr. Schimpf?

2 A Yes.

3 Q Now, we talked about the fact that you recommended
4 Mrs. Turisk undergo surgery with Dr. Schimpf. Now, you also told
5 us that you actually drove Mrs. Turisk to her surgical
6 appointment, correct?

7 A I did.

8 Q And you picked her up?

9 A I did.

10 Q And after the appointment you actually met with
11 representatives from Dr. Schimpf's office about her aftercare,
12 right?

13 A Yes. I was given the postoperative sheet and signed for it.

14 Q They gave you discharge instructions?

15 A Uh-huh.

16 Q And you would recognize those discharge instructions if I
17 showed them to you today?

18 A Yes.

19 ATTORNEY MAPLES: Your Honor, let the record reflect I'm
20 approaching the witness with Turisk 12. This will be Defense
21 Exhibit 1. May I approach the witness?

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

23 THE COURT: Yes, ma'am.

24 BY ATTORNEY MAPLES:

25 Q Mrs. Ackerman, this is the discharge instructions that you

1 received from Dr. Schimpf's office after Mrs. Turisk's procedure,
2 correct?

3 A Correct.

4 Q That's your signature at the bottom of that page?

5 A Correct.

6 Q And these, again, were provided to you by Dr. Schimpf's
7 office after Mrs. Turisk's procedure?

8 A Correct.

9 Q These don't appear to be changed or altered in any way?

10 A No.

11 ATTORNEY MAPLES: Your Honor, at this time we move into
12 evidence Defense Exhibit 1.

13 THE COURT: Any objection?

14 ATTORNEY TANENBAUM: No objection, Your Honor.

15 THE COURT: All right. It's in.

16 (Defendant's Exhibit 1 is received in the record.)

17 ATTORNEY MAPLES: May I publish to the jury?

18 THE COURT: Yes, ma'am.

19 BY ATTORNEY MAPLES:

20 Q Mrs. Ackerman, can you confirm for the jury that what
21 they're seeing on the screen is the same document that you signed
22 after Mrs. Turisk's procedure?

23 A Yes, it is.

24 Q At the top of this document it provides some information for
25 Mrs. Turisk after her procedure, correct?

1 A Correct.

2 Q In fact, it says, Do not stay alone, right?

3 A Correct.

4 Q Says, You may feel sleepy, light-headed, or dizzy at times?

5 A Correct.

6 Q If you look further down the line -- if I can pull it up
7 here -- it provides that, If you should experience any of the
8 following, please call your physician's office during office
9 hours, correct?

10 A Correct.

11 Q And it provides a phone number?

12 A Uh-huh. Yes.

13 Q To your knowledge, that was the phone number to
14 Dr. Schimpf's office?

15 A Yes.

16 Q And underneath it says, Dr. Schimpf's on his cellphone after
17 hours and during the weekend, correct?

18 A Correct.

19 Q And again, it provides another number?

20 A Uh-huh. Yes.

21 Q And to your knowledge, that's Dr. Schimpf's personal
22 cellphone number?

23 A Yes.

24 Q So after Mrs. Turisk's procedure, Dr. Schimpf actually
25 provided you and Mrs. Turisk with two phone numbers to reach him?

1 A Yes.

2 Q And you knew that you could do that, right?

3 A Yes.

4 Q Now, this document also provides that you are to call
5 Dr. Schimpf if Mrs. Turisk experiences any of the following:
6 Difficulty breathing?

7 A Yes.

8 Q Bleeding that you feel is excessive?

9 A Yes.

10 Q Pain that is greater than explained to me in the teaching?

11 A Yes.

12 Q Increased redness, warmth, swelling, hardness around the
13 operative area?

14 A Yes.

15 Q Increasing and progressive drainage from the surgical area?

16 A Yes.

17 Q Am I correct that you actually had some of these concerns
18 after Mrs. Turisk's procedure?

19 A Yes.

20 Q So you called Dr. Schimpf, right?

21 A Yes.

22 Q And he answered?

23 A Yes.

24 Q You actually called him the day of her procedure, right --

25 A Yes.

1 Q -- because you had some concerns that Mrs. Turisk was
2 feeling lightheaded and dizzy?

3 A Correct.

4 Q And he provided you with some aftercare instructions for
5 Mrs. Turisk?

6 A Yes, he did.

7 Q And as a result you felt you were able to properly rehydrate
8 Mrs. Turisk after that complication?

9 A Yes.

10 Q You called Dr. Schimpf several other times after that day,
11 right --

12 A Yes.

13 Q -- with additional concerns?

14 A Uh-huh.

15 Q And each and every time he answered your call?

16 A I can't say specifically that he answered the call every
17 time I called.

18 Q But you spoke to him on --

19 A But I did speak to him.

20 Q On more than one occasion?

21 A Yes.

22 Q And you told us a moment ago that you worked with William
23 Long on her aftercare?

24 A Yes.

25 Q And you observed him make additional phone calls to

1 Dr. Schimpf as well?

2 A Yes.

3 Q And Dr. Schimpf was responsive to those calls?

4 A To my knowledge.

5 Q In the days following Mrs. Turisk's procedure, after you
6 called Dr. Schimpf several times, I'm correct that you never took
7 her to the emergency room, right?

8 A I did not.

9 Q You never decided to take her to Dr. Schimpf's office to be
10 seen?

11 A I did not.

12 Q In spite your concerns, you never called 911, right?

13 A No, I didn't.

14 Q In fact, you were comfortable enough leaving Mrs. Turisk at
15 your home after her procedure, right?

16 A When I went on my trip.

17 Q You left Mrs. Turisk at your home to housesit for you after
18 her procedure?

19 A I left Ms. Turisk in my home with Mr. Long to housesit while
20 I was gone.

21 Q And to also care for your cats?

22 A Mr. Long took care of my cats.

23 Q But Mrs. Turisk was present as well?

24 A She was in my bedroom.

25 Q And at no point after that trip did you ever take

1 Mrs. Turisk to the emergency room?

2 A No.

3 Q You never took her to Dr. Schimpf's office again?

4 A No.

5 Q And you never took her to another physician?

6 A No.

7 Q Thank you. I have no further questions.

8 A Okay.

9 THE COURT: Any redirect?

10 ATTORNEY TANENBAUM: Just a couple of things.

11 **REDIRECT EXAMINATION**

12 BY ATTORNEY TANENBAUM:

13 Q I forgot to ask you, where is William Long today?

14 A William Long is deceased.

15 Q I know you were asked questions about not taking Rebecca to
16 the emergency room, or wherever. That photograph that was taken
17 11/6, is that when the bruises appeared for the first time?

18 A Pardon me?

19 Q Is that when the breast looked like that for the first time,
20 November the 6th?

21 A I think it looked like that when I changed the dressings on
22 -- it was about the 3rd or 4th.

23 Q And did you speak to Dr. Schimpf's office about that?

24 A I did.

25 Q What were you told?

1 A I was told that it was normal; that it would slough off.

2 Q And her follow-up appointment, if that photograph was taken
3 on November the 6th, was two days later, on November the 8th; is
4 that correct?

5 A Correct.

6 Q Do you recall calling his office between 8th and the 15th
7 before you left town?

8 A I believe I called him at least once on the 10th.

9 Q I'm sorry?

10 A I believe I called him at least once on the 10th, but I
11 don't recall what we discussed.

12 Q And her next follow-up appointment was on the 15th, and she
13 went in then, correct?

14 ATTORNEY MAPLES: Objection, Your Honor.

15 THE COURT: Please don't lead the witness.

16 BY ATTORNEY TANENBAUM:

17 Q Did she go to her next follow-up appointment before you --
18 the day you left town?

19 A I don't know.

20 Q And you were gone for six or eight weeks; is that correct?

21 A It was six to eight weeks that I went on that trip. Yes.

22 Q And, of course, she was already under the care of MUSC --

23 ATTORNEY MAPLES: Objection, Your Honor.

24 BY ATTORNEY TANENBAUM:

25 Q Was she already under the care of MUSC when you returned?

1 A She was under the care of Dr. Herrera.

2 ATTORNEY TANENBAUM: Thank you.

3 THE COURT: You may step down, Ms. Ackerman. Thank you.
4 You may call your next witness.

5 ATTORNEY BURKE: Your Honor, our next witness will be
6 Dr. Fernando Herrera, and he will be presented by his videotape
7 trial preservation deposition.

8 THE COURT: Ma'am, you may proceed.

9 ATTORNEY BURKE: Thank you. May I approach while he's
10 setting that up?

11 THE COURT: Yes, ma'am.

12 (Sidebar discussion held off the record.)

13 THE COURT: Ladies and gentlemen of the jury, the next
14 deposition testimony is about an hour and a half, so we're going
15 to take a brief break, about five minutes, so that will allow to
16 everybody to set up, and then we'll resume with the trial of the
17 case. That way you'll have a brief recess before we get started.
18 Please go to the jury room.

19 Again, please remember not to discuss this case amongst
20 yourselves. We'll be right back with you.

21 (Jury escorted out of the courtroom at 3:57 p.m.)

22 (Court recessed at 3:57 p.m. and reconvened at 4:06 p.m.,
23 without the jury present.)

24 MATTER(S) OF LAW

25 ATTORNEY TANENBAUM: Your Honor, I'm sorry. Counsel stepped

1 out for a second.

2 THE COURT: That's fine.

3 ATTORNEY TANENBAUM: While she's out, we're going to -- we
4 have this photograph 6. I know Your Honor said only one from the
5 6th. And, I apologize, but this one wasn't ready, no. 4, and so
6 we used no. 6. And I was using it to illustrate the difference
7 between the right and the left.

8 THE COURT: Correct. I thought y'all had taken out the
9 other one on the 6th that was the same.

10 ATTORNEY TANENBAUM: The only two -- there might be a third
11 one, but I think there were only two on the 6th.

12 THE COURT: Right. The one with the tube, which was no. 5.
13 That one was different because that includes both breasts.

14 ATTORNEY TANENBAUM: Okay.

15 THE COURT: We had just discussed cropping it so --

16 ATTORNEY TANENBAUM: Thank you, Your Honor.

17 ATTORNEY SMYTH: The second one was just marked for ID right
18 now, correct?

19 THE COURT: Correct.

20 ATTORNEY TANENBAUM: Just for ID right now.

21 THE COURT: Parties ready for the jury?

22 ATTORNEY BURKE: Not quite, Your Honor. I need to speak
23 with opposing counsel, and then I need to speak with you about
24 the photos that will be shown.

25 (Jury seated in the courtroom at 4:14 p.m.)

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

2 THE COURT: Thank you. Welcome back, ladies and gentlemen
3 of the jury. Testimony is now going to be presented to you by a
4 deposition. A deposition contains sworn testimony given by a
5 witness outside of the court in the presence of the attorneys
6 who, for each party, asks questions of the witness.

7 This testimony is entitled to the same consideration, and is
8 to be judged by credibility and weight by you, the same way as if
9 the witness were present and gave the testimony which is going to
10 be presented to you from the witness stand. It is then for you
11 to determine the effect, value, weight, and the truth of the
12 testimony given in the deposition.

13 You may proceed.

14 ATTORNEY BURKE: Thank you, Your Honor. The plaintiff calls
15 Dr. Fernando Herrera.

16 FERNANDO HERRERA,
17 having first been duly sworn, was examined and testified by
18 videotaped deposition.

19 (Videotaped deposition played for the jury.)

20 THE COURT: Ladies and gentlemen, that will conclude the
21 testimony for this morning. If you would be back in the jury
22 room, say, around 9:15 or so, as soon as we have everyone
23 together, we will resume with the trial in the case.

24 Again, please remember my previous instruction not to
25 discuss the case amongst yourselves or with anyone else. We will

1 see you in the morning. Have a nice evening.

2 (Jury dismissed for the day at 5:37 p.m.)

3 THE COURT: Counsel, anything before we recess?

4 ATTORNEY BURKE: Nothing from the plaintiff, Your Honor.

5 ATTORNEY SMYTH: Nothing, Your Honor.

6 THE COURT: See everyone in the morning.

7 MATTER(S) OF LAW

8 ATTORNEY BURKE: Your Honor, I'm sorry. We do have an
9 issue. Mark, if you want to?

10 ATTORNEY TANENBAUM: Sure. Your Honor, we have -- there are
11 hundreds of pages of bills -- and I think I discussed this in my
12 pretrial brief --

13 THE COURT: Yes, sir.

14 ATTORNEY TANENBAUM: -- that relate to the care that
15 Dr. Herrera just discussed. We've also prepared a summary sheet,
16 a one-page spreadsheet. It's got some comments on it that we
17 used so that Todd could understand what each procedure was and
18 what those bills related to without having to go back and get
19 into the doctor-client privilege.

20 I would like to use the summary sheet and not send the
21 hundreds of pages back to the jury room with a calculator. I
22 think it's certainly a compilation that's allowed by the rules,
23 if Your Honor agrees, if Your Honor will so rule. But it's
24 traditionally what we've always done, rather than sending those
25 records back, or those bills back. And so that's the issue.

1 I think Todd has an objection to it, and I thought we ought
2 to at least be prepared for that tomorrow when Rebecca takes the
3 witness stand. So I just thought I'd mention that to you.

4 THE COURT: Yes, sir. Mr. Smyth, the nature of your
5 objection? I'm sorry.

6 ATTORNEY SMYTH: That's okay. It happens all the time. We
7 came from the side of the family that couldn't afford the extra
8 "e" on the end. Your Honor, our position is that the bills are
9 the proper evidence. And I'm not in a position to be able to
10 allow a summary to go back when we contest the relationship, the
11 proximal cause, of a lot of those bills as to whether or not
12 they're corrected.

13 And so our concern is that this is a mass of bills from a
14 bunch of facilities, and none of it's really been tied to any
15 negligence, and so I don't think that being able to send back a
16 summary that makes it a nice and easy thing where the jury can
17 assume there's some connection without having proven it in the
18 record is proper. So that's my biggest concern, Your Honor.

19 I think there are a number of bills in there that deal with
20 other procedures that she was having. We sorted most of that
21 out, but there is still a big gap of proof that puts me in a spot
22 that I'm not able to agree to send a summary back without some
23 nexus.

24 THE COURT: Yes, sir?

25 ATTORNEY TANENBAUM: We can send the bills back if that's

1 what will solve the problem, but the summary sheet ought to go on
2 top, without any of the comments that we've made, for their
3 review.

4 We've been discussing this. I thought we had this agreed to
5 but for two, I think, issues since last week, and it was just
6 early this morning, I believe, or late last week, yesterday, that
7 we discovered that we didn't have an agreement. I thought we
8 did.

9 THE COURT: So subject to the accuracy of the summary, of
10 course, that must be established through the testimony, and then
11 if it's very voluminous, I don't see a problem with a summary.
12 But you're asking for all the bills to be attached and a summary
13 on top?

14 ATTORNEY SMYTH: I'm not asking for that, Your Honor. I'm
15 just asking for the bills. And my concern is that there's not
16 going to be a witness who can link all of that stuff. And so
17 we're a little bit cart-before-the-horse, I think, in addressing
18 this, but until there's been some level of proof connecting these
19 damages by expert testimony, which is what's required, then I
20 don't think they're ever going back. But we're not there yet, I
21 don't think.

22 THE COURT: So this may be a bit premature then. So your
23 client's going to testify to the bills that she received, is
24 that --

25 ATTORNEY TANENBAUM: That's correct.

1 THE COURT: That certainly is admissible.

2 ATTORNEY TANENBAUM: And that's what we propose to do, is
3 hand her the stack of bills, ask her to look through them, put on
4 the spreadsheet, and, Are these all bills you received from each
5 facility, and the date?

6 I do have prepared a cheat sheet because, as Your Honor has
7 heard, there's been multiple admissions, and I don't know if
8 anybody's memory is good enough to recall exactly what was done
9 at a particular facility.

10 But Dr. Herrera himself testified to the things at MUSC, the
11 emergency room at MUSC, the wound care center, and some testimony
12 that will come in later about various emergency room visits that
13 were made and Dr. Schimpf was notified about. So I really think
14 that everything is tied together.

15 We won't send the comments back, but we've got the bills
16 tied into every visit, and we've got them in that spread summary
17 form.

18 THE COURT: Well, certainly it would depend upon her
19 testimony as far as the admissibility is concerned.

20 ATTORNEY TANENBAUM: I've got to go to Costco tonight.

21 THE COURT: I'm sorry. It would depend upon the
22 admissibility of each bill, based upon her testimony, as we go
23 through the process. Obviously we're talking volumes and
24 volumes, where it will be easier just to submit a summary. That
25 would be preferable.

However, if the defense objects to that, we'll certainly have to take it up as the testimony goes along.

ATTORNEY TANENBAUM: All right. Thank you.

THE COURT: Anything further? All right. We'll see everyone in the morning.

(Court recessed for the day at 5:43 p.m.)

(End of Transcript of Record, Volume I of IV.)

CERTIFICATE OF REPORTER

I, Cathy J. Provost, Official Court Reporter for the Fourteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial/proceedings of the captioned case in the Court of Common Pleas for Charleston County, South Carolina, on the 14th day of November, 2022.

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

Date: January 7, 2023

/s/ Cathy J. Provost
Cathy J. Provost, RMR
Official Circuit Reporter

STATE OF SOUTH CAROLINA	)	COMMON PLEAS COURT OF THE
	)	
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
REBECCA TURISK	)	NO. 2018-CP-10-02109
VS.	)	
DENNIS K. SCHIMPF, M.D.	)	TRANSCRIPT OF RECORD
	)	Jury Trial - Volume II of IV
	)	(Pages 95 - 256)

B E F O R E:

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

DATE: Tuesday, November 15, 2022
9:19 a.m.

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

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

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

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

4 THE COURT: Received a note from one of our jurors, juror
5 no. 160, Ms. Kemeshia Linen. Apparently her daughter is in the
6 emergency room. She was going to send us fax verification from
7 the emergency room that she was there, so obviously -- I can't
8 foresee an objection from anybody, but looks like we are down to
9 12 jurors. Anything from the plaintiff?

10 ATTORNEY BURKE: No objection, Your Honor.

11 ATTORNEY SMYTH: No, Your Honor. I think just as a matter
12 of housekeeping, I don't know that we put anything on the record
13 yesterday about the other juror being excused and the first
14 alternate being substituted. And I don't know how you want to
15 handle that, but just so it's clear. I know you handled the
16 excused part, but I don't think you formally said that the first
17 alternate was now on.

18 THE COURT: Right. So the first one would be Cortney
19 Franklin, would be the first alternate. And then the second
20 alternate was Gary McClellan. So I'll let them know when they
21 come in.

22 (Court's Exhibit 2 is marked for identification.)

23 THE COURT: Anything else?

24 MATTER(S) OF LAW

25 ATTORNEY BURKE: Your Honor, the plaintiff would just like

1 to make sure that we're clear on your position on the plaintiff
2 being allowed to testify to her billing charges that she believes
3 are related to her injuries that she incurred in this case. That
4 was our position. I believe that was Your Honor's position
5 yesterday, but before I begin my direct examination of my client,
6 I just would like clarification on that before I proceed.

7 THE COURT: Yes, ma'am. That would be my position. She can
8 certainly testify that those were the bills that she received and
9 in her view. Certainly it will be up to the jury to determine
10 whether they're reasonably and medically necessary pursuant to
11 what she is claiming.

12 ATTORNEY SMYTH: Your Honor, just one issue on that.
13 Plaintiffs have provided a summary of the bills, and in that
14 summary is a commentary about what the bills relate to. Again,
15 that summary was done by the attorneys and not by Ms. Turisk.
16 And I think their plan, as they relayed to me, was they wanted
17 her to be able to read all of that, and I don't think that's
18 proper. I think that's hearsay, and it's not her testimony,
19 number one; and that it's not proper use of how to refresh a
20 witness with a recollection.

21 THE COURT: My understanding was that we were going to
22 redact the commentary; is that correct?

23 ATTORNEY SMYTH: That was my understanding, as well, but in
24 talking with plaintiff's counsel, they may have a different
25 position on that.

1 ATTORNEY TANENBAUM: I apologize, Your Honor. May I address
2 that?

3 THE COURT: Go ahead. I'm listening.

4 ATTORNEY TANENBAUM: In any case, Your Honor, I believe it
5 depends on the cross-examination. If it's, Hey, can you tell us
6 what this bill is for?, she's going to say no, okay. But --
7 close your ears -- I anticipate her testimony being that she has
8 reviewed this with the lawyers, that she's looked at the various
9 records and the bills, and that this is an accurate statement
10 with her thoughts as to what occurred at each appointment.

11 And if the defense intends to raise any issue about the
12 veracity of those bills and their relationship and necessity for
13 it, in her mind, then -- and failure to prove that -- then I
14 think she's got a right to submit that to -- you've got a right
15 to submit that, we've got to, to the jury. There are at least, I
16 estimate -- I apologize, I don't know how many lines that is.

17 So she can either testify from those notes on the witness
18 stand, or she can say, Yes, each of these entries is correct, and
19 not submit those, that commentary, to the jury. But it really
20 depends on what the defense is going to argue. That's how we
21 will tie each of those bills in and prove them.

22 THE COURT: Mr. Smyth, correct me if I'm wrong, it sounds
23 like his concern is that the commentary is hearsay based upon
24 your notations as to what happened, not what she recalls
25 experiencing during those visits.

1 ATTORNEY TANENBAUM: I'm sure her testimony will be those
2 are accurate; that's an accurate representation of her thoughts.

3 THE COURT: Of what she went through --

4 ATTORNEY TANENBAUM: Yes.

5 THE COURT: -- and what she recalls?

6 ATTORNEY TANENBAUM: Yes. We did type it, but --

7 THE COURT: Based upon what she told you?

8 ATTORNEY TANENBAUM: Absolutely based on what she told us.

9 THE COURT: Okay. Does that clarify?

10 ATTORNEY SMYTH: Not really. I mean, you know, I think it's
11 an improper use of information they're trying to provide the
12 witness that she might not already have, and you're supposed to
13 testify from your own knowledge, and you're not allowed to have
14 notes to do that. And I think it's just an improper way to get
15 past the evidentiary burden it is that they have.

16 She has to be able to testify not only that these are the
17 bills that she received, but that she knows what's in them,
18 right, in order to lay that foundation, and I don't know that
19 she's able to do that without the notes. And, that's the
20 problem.

21 THE COURT: Well, he can ask her, Did we review the notes
22 that you received, the bills that you received, and we talked
23 about what happened, and this is what you told me what happened
24 on this visit, and does this accurately reflect what you told me,
25 as what we discussed?

1 ATTORNEY SMYTH: As long as that commentary's not going back
2 to the jury and she's not dependent on it for her testimony, I
3 don't have a problem with that.

4 THE COURT: Okay.

5 ATTORNEY SMYTH: But those are the two problems that I have,
6 if she's going to be reading from something else that's not going
7 into evidence.

8 ATTORNEY TANENBAUM: May it please the Court. She's
9 absolutely entitled to testify from her notes if she wishes to,
10 and then place those into evidence. Otherwise, a witness often
11 couldn't keep up with the timeline. And that's what this is.

12 THE COURT: I agree.

13 ATTORNEY TANENBAUM: Thank you, Your Honor.

14 ATTORNEY BURKE: Your Honor, we need maybe one or two
15 minutes. We're culling together the photo exhibits that I'll be
16 using in my direct and admitting into evidence, and I need to
17 prepare a set for defense counsel. And if you'd like, I can hand
18 those up to you as well.

19 THE COURT: Yes, please.

20 ATTORNEY BURKE: And so we're culling and clipping together.
21 So if we could just have a couple more minutes.

22 THE COURT: Sure.

23 ATTORNEY BURKE: Maybe five minutes.

24 THE COURT: That's fine.

25 ATTORNEY BURKE: Thank you.

1 ATTORNEY TANENBAUM: Thank you very much, Your Honor.

2 ATTORNEY SMYTH: Your Honor, just so I'm clear on what the
3 Court has ruled in terms of the summary, the summary with the
4 comments is not going into evidence?

5 THE COURT: That's correct.

6 ATTORNEY SMYTH: Okay.

7 THE COURT: The comments on her notations. She's going
8 to -- basically that's how you're going to get her -- discuss
9 with her what she recalls as far as the notations.

10 ATTORNEY TANENBAUM: That's what the comments are.

11 THE COURT: Summary just needs to be an accurate reflection
12 of the bills that add up to the summarized notes.

13 I understand what you're saying as far as commentary is
14 concerned. Certainly that would explain, just a short
15 explanation of, what she went to the visit for. I think that's
16 perfect.

17 ATTORNEY TANENBAUM: Thank you, Your Honor.

18 THE COURT: Once she establishes that that's what she went
19 for and that's what she discussed, and that was the date, if she
20 can add up -- if the numbers add up to the bills and it's an
21 accurate reflection of her testimony, it certainly summarizes it
22 to help the jury understand.

23 ATTORNEY SMYTH: And my concern is twofold. I think, under
24 Rule 612, only an adverse party can move that into evidence when
25 it's used for refreshing your recollection.

1 THE COURT: This is not to refresh her recollection. This
2 is shown as a summary of the bills, which is proper as far as an
3 accurate summary of the bills. It basically helps the jury
4 understand the voluminous documents, and it leads as support
5 interpretation of that. So if she can add up the bills and this
6 is what she received and it's a summary of what she received, I
7 think it's appropriate.

8 ATTORNEY SMYTH: I understand that part, as well, but my
9 concern, too, is that the commentary might lead the jury to
10 believe that this is all corrected, and that doesn't suffice the
11 burden of proof on --

12 THE COURT: You can cross-examine her on the commentary.
13 And basically if that's what she told -- that that was the
14 reason, in her mind, for the visit, and that's the commentary, I
15 went, on 11/28 for this reason and that was the visit, that this
16 bill was received, then you can cross-examine her on it.

17 ATTORNEY TANENBAUM: Thank you very much, Your Honor. Does
18 Your Honor want to keep that?

19 THE COURT: If it's okay.

20 ATTORNEY TANENBAUM: Absolutely.

21 THE COURT: Thank you. Are there any objections to the
22 jurors being able to take notes?

23 ATTORNEY TANENBAUM: I'm sorry?

24 ATTORNEY BURKE: The question was, Is there any objection to
25 the jurors taking notes?

1 ATTORNEY TANENBAUM: To the jurors taking notes. No. I'm
2 sorry. I am going to Costco on Saturday.

3 ATTORNEY SMYTH: No objection from the defense.

4 THE COURT: All right. Thank you.

5 ATTORNEY TANENBAUM: May it please the Court.

6 THE COURT: Yes, sir.

7 ATTORNEY TANENBAUM: We also prepared the stack of bills
8 that have redacted insurance information on them which you
9 haven't seen yet.

10 ATTORNEY SMYTH: No.

11 ATTORNEY TANENBAUM: I'm sorry. We will hand those to him
12 this morning. And we may ask the Court to allow us to send those
13 back with that compilation, as well, in case anybody has any
14 question about -- in case anybody raises a question about the
15 accuracy of the preparation.

16 ATTORNEY SMYTH: I think it's one or the other. I don't
17 think you get the summary and the bills. The bills plus the
18 summary, that's cumulative, for sure.

19 ATTORNEY TANENBAUM: If you can find a way to add all this
20 up, knowing what number on the bills actually reflects the total
21 charge for that visit. But you've got to do this for a living to
22 know how to read those bills, as Your Honor probably has
23 experienced.

24 THE COURT: Well, I think Mr. Smyth is right. As far as
25 that's concerned, the purpose of the summary is so that they

1 don't have to look at all the bills.

2 ATTORNEY TANENBAUM: Very good.

3 THE COURT: If her testimony says that it accurately
4 reflects all the bills together and this is what she received,
5 then that's fine.

6 ATTORNEY TANENBAUM: Thank you very much, Your Honor. I
7 understand.

8 THE COURT: Thank you.

9 (Off-the-record discussion.)

10 ATTORNEY BURKE: Your Honor, just a follow-up on your
11 earlier ruling regarding your concern about duplicative photos.
12 You had specifically asked me to remove two photos for the date
13 of November 6. I will go ahead and advise the Court that these
14 two photos are in here, but I hope the Court would give me some
15 leeway on that because that's a very critical time period in the
16 case. She is still under the care of Dr. Schimpf. And I have
17 pulled out later photos.

18 So overall, the number of photos that the jury's going to
19 see has decreased. And two of those in here are already in
20 evidence, one from Dr. Herrera and one from Mary Ackerman, if you
21 would like me to show the two photos.

22 THE COURT: Right. So you're saying that you kept one in
23 that we talked about removing?

24 ATTORNEY BURKE: You originally asked me to remove one of
25 the photos because they're of the same date. Mary Ackerman

1 testified to the three yesterday when she was talking about
2 removing the bandages.

3 THE COURT: Right.

4 ATTORNEY BURKE: And I'd like photo 4 to go back, as well,
5 because it does show the left and right breast, as well as the
6 drain tube.

7 THE COURT: And that was a totally different picture.

8 ATTORNEY BURKE: Just wanted to make sure. I didn't want to
9 be in violation. Thank you.

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

11 (Jury seated in the courtroom at 9:38 a.m.)

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

13 THE COURT: Thank you. Good morning, ladies and gentlemen
14 of the jury. Welcome back. As to the two alternates who are
15 sitting in the back, due to some unfortunate circumstances, you
16 are now members of the jury. So, Ms. Franklin and Mr. McClellan,
17 I mean, you're welcome to stay right there if you'd like but next
18 time if you want to sit with the remainder of the jury, you may
19 do so.

20 Also, I received a note regarding note-taking, which we have
21 provided notepads for you to take notes. You may take notes
22 during the trial in this case. However, please remember that
23 some people are better note-takers than other people. Jurors'
24 notes should not be given any greater weight than the
25 recollection of other jurors, and the recollection of individual

1 jurors should be considered as reliable as notes taken by other
2 jurors.

3 Also, please be mindful of the fact that if you're taking
4 notes you may not be paying as close attention to body language
5 or things of that nature with witnesses. So please be mindful
6 that you may take notes to help you recollect dates and things of
7 that nature, but please also be mindful to use them appropriately
8 and not to doodle and draw and things of that nature, which
9 sometimes we may tend to do.

10 With that, we will continue with the trial of the case. You
11 may call your next witness.

12 (Court's Exhibit 3 is marked for identification.)

13 ATTORNEY BURKE: Thank you, Your Honor. The plaintiff will
14 call Rebecca Turisk, please.

15 REBECCA TURISK,

16 having first been duly sworn, was examined and testified as
17 follows:

18 CLERK OF COURT: Be seated. Have you state your full name,
19 spelling your last name, and speak clearly into the microphone.

20 THE WITNESS: Okay. Good morning.

21 **DIRECT EXAMINATION**

22 BY ATTORNEY BURKE:

23 Q Good morning, Rebecca. We're going to start at the
24 beginning. Where were you born?

25 A Kingsville, Texas.

1 Q And when did you move to South Carolina?

2 A 1998.

3 Q Do you have children?

4 A I do.

5 Q Do you have any grandchildren?

6 A I do.

7 Q And what can you tell us about your grandchildren?

8 A I have one grandchild. He's ten years old. He speaks two
9 languages. He's good at martial arts. He's -- at ten years old,
10 he's a brown belt, which is a little below black belt. Plays
11 chess. Loves chess. Beats me every time. And loves board
12 games. Pretty sure he cheats. He beats me every time.

13 Q Are you married?

14 A No, I'm not.

15 Q Have you worked in the past?

16 A I have.

17 Q What have you done?

18 A I've always been interested in business. I mean, since age,
19 like, 20 up, I've just had different businesses.

20 Q Do you currently work?

21 A I do.

22 Q Where do you work now?

23 A Work at a landscaping supply business that I built in, I
24 think it was, 2011.

25 Q Do you have any degrees or certifications?

1 A I do. I'm a master gardener.

2 Q And what is a master gardener?

3 A Master gardener, you pretty much know all the native plants
4 in our zone, how they grow, where they grow, which ones are
5 poisonous, you know, which ones you're going to put in when. And
6 it's just kind of a fancy name for know-it-all, I guess.

7 But I also, you know, know how to do sprinkler systems and
8 how to do the weed and feed, and especially with your sod and
9 grass.

10 Q So Rebecca, how often do you work at the landscape supply
11 company?

12 A It's seasonal. Oh, during the busy time, 20 hours a week.
13 Right now, you know, 10 to 20 hours a week. It depends what's
14 going on. And if we're shorthanded, then I obviously have to
15 step in.

16 Q Is there a reason why you only work 20 hours a week compared
17 to 40?

18 A Well, thanks to modern technology, I can do a lot of things
19 at home because I have the cameras, so I have a POS system, I
20 mean, that I can see what's going on from home. And I'm just to
21 the age to where, you know, it's just trying on me. And
22 everything that I've been through, it's -- I kind of lost the
23 desire to be there.

24 Q Do you have any hobbies, Rebecca?

25 A I do.

1 Q What are your hobbies?

2 A Enjoy photography. I do landscaping photography, you know,
3 nature. And I also do dance photography. I photograph a lot of
4 the dance events in the Lowcountry, you know, spring recitals, to
5 the little ones, up to the more advanced dancers. And I
6 photograph quite a bit at Charleston Music Hall, the Sotille,
7 just different theaters around town.

8 Q At some point did you decide that you wanted a breast
9 reduction?

10 A I did.

11 Q Why did you want a breast reduction?

12 A Fifty years old, kind of a milestone. Over the years
13 they've just become heavier. My breasts were elongated. They
14 were pulling my shoulders forward. I had two previous back
15 surgeries, so I knew that the large breasts were making me
16 uncomfortable, and I felt like if I had a breast reduction, that
17 it would alleviate at least some of that pain, if not all, and I
18 would have more enjoyment in life.

19 Q Do you recall your first meeting with Dr. Schimpf?

20 A I do.

21 Q Do you know approximately when that meeting occurred?

22 A It was in July of 2016.

23 Q What do you recall?

24 A We talked about the procedure of taking out the implants
25 that I had since I was 25 years old, and a breast lift and

1 reduction, along with a tummy tuck.

2 And we also did talk about things, you know, that can go --
3 the risks of surgery, you know, what you see. You know, there's
4 always risks, I understand that, you know, so infection and
5 fever; maybe not liking the outcome; you know, maybe the symmetry
6 might be off; may have to do more surgery on down the line.

7 Q Rebecca, do you recall if you and Dr. Schimpf discussed
8 anything about your prior breast implant surgery, where you had
9 your implants placed?

10 A Yes. He asked me, Are your implants under the muscle or
11 over the muscle? Well, this was 25 years ago, and I don't
12 remember. And he said, That's okay. When we get in the
13 operating room, I'll find out then.

14 Q Did you see Dr. Schimpf again after that July 2016 visit?

15 A I did.

16 Q Do you recall the next visit?

17 A It was toward the end of October.

18 Q What did you do at that visit at Sweetgrass Plastic Surgery?

19 A Had an appointment with Dr. Schimpf. Wanted to go in and
20 proceed with everything we had talked about beforehand.
21 Wanted -- you know, I was ready.

22 Q Did you ultimately schedule surgery with Dr. Schimpf to
23 remove your breast implants, have the breast reduction, the
24 breast lift, and tummy tuck?

25 A I did.

1 Q And before we go any further, are you bringing any claims
2 against Dr. Schimpf for the tummy tuck?

3 A No.

4 Q And why not?

5 A Satisfied with it.

6 Q What do you recall about the day of surgery?

7 A I was very excited. I've been waiting for this moment for
8 quite some time. Nervous, obviously.

9 Q Were any photographs taken that day?

10 A Yes. There was a photograph taken before the surgery. A
11 before-picture, I guess you would say.

12 Q Rebecca, you have in front of you --

13 ATTORNEY BURKE: Your Honor, the Court's indulgence for one
14 moment.

15 BY ATTORNEY BURKE:

16 Q Rebecca, just for your reference, I believe you have some
17 documents with you on the witness stand that we're going to be
18 talking about today. And is there a document there with a no. 1
19 on it? Do you have it?

20 A The document --

21 ATTORNEY BURKE: May I approach, Your Honor?

22 THE COURT: Yes, ma'am.

23 THE WITNESS: Okay. I understand.

24 BY ATTORNEY BURKE:

25 Q All right. Thank you.

1 A Yes. Excuse me.

2 Q No problem at all. Rebecca, what is document no. 1 that you
3 have in front of you?

4 A What is documented here is the --

5 Q We've got to get it in evidence first.

6 A Okay.

7 Q Do you recognize document no. 1?

8 A I do.

9 Q And what does it depict?

10 A This is the picture of my breasts before the surgery.

11 Q And what was the date of this photo?

12 A November 1st, 2016.

13 Q And do you know who took this photo?

14 A The nurse.

15 Q And is this a fair and accurate representation of the
16 appearance of your breasts on the 1st of November, 2016?

17 A It is.

18 Q I hand this to the clerk to be marked.

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

20 ATTORNEY BURKE: I'd like to publish Exhibit 3 to the jury,
21 please.

22 THE COURT: Have you moved it in?

23 ATTORNEY BURKE: Oh, I'm sorry. Thank you, Your Honor. At
24 this time I'd move Exhibit 3 into evidence.

25 THE COURT: Any objection?

1 ATTORNEY SMYTH: No, Your Honor.

2 THE COURT: Okay. It's in.

3 (Plaintiffs Exhibit 3 is received in the record.)

4 ATTORNEY BURKE: Permission to publish, Judge?

5 THE COURT: You may.

6 BY ATTORNEY BURKE:

7 Q Rebecca, could you step down from the witness stand. I'm
8 going to ask you a couple questions about Exhibit 3.

9 ATTORNEY BURKE: Your Honor, this is a blowup of Exhibit 3,
10 for demonstrative purposes only.

11 BY ATTORNEY BURKE:

12 Q Did you have scars from your prior implant surgery?

13 A Yes, I did.

14 Q Are you able to see the scars on that picture?

15 A I can see them.

16 Q Okay. Could you draw the scars on that picture for the
17 jury, please.

18 A The previous -- the implants that I had were surgically
19 placed in through the bottom, through the areolae, and the only
20 incisions made on the areolae was at the bottom. It's from here
21 to here, and on each side --

22 ATTORNEY SMYTH: May I approach, Your Honor?

23 THE COURT: That's fine.

24 THE WITNESS: -- an incision at the bottom of the areolae.

25

1 BY ATTORNEY BURKE:

2 Q All right. Thank you very much. You can have a seat.

3 ATTORNEY BURKE: Mark, do you want to take that picture
4 away.

5 BY ATTORNEY BURKE:

6 Q You can go back to the witness stand, Rebecca.

7 Rebecca, did you have any postoperative complications from
8 your breast implant surgery 25 years ago?

9 A No.

10 Q Where did you have the surgery that you had with Dr. Schimpf
11 on November 1st of 2016?

12 A At his office.

13 Q And once the surgery was over, did you go home that day?

14 A I went to a friend's house to recover.

15 Q Okay. And who was that friend?

16 A Mary Ackerman.

17 Q Okay. Were you given any wound-care instructions at
18 discharge?

19 A Yes.

20 Q Do you recall what any of those instructions were?

21 A I do not recall, because my caretakers had them, but I know
22 that they followed the instructions because next to the bed there
23 was a bedside table with the instructions laying there, and
24 gloves, and anything, bandage, wound care, whatever we needed.

25 Q And who were your caregivers?

1 A Mary Ackerman and William Long.

2 Q Rebecca, I'm going to bring out this demonstrative again and
3 just ask you a couple questions about it. Do you recognize the
4 photo on the picture?

5 A I do.

6 Q And what is the photo a depiction of?

7 A This is a picture of me before the breast reduction. You
8 can see my breasts were long, pendulous. I don't know if you can
9 see it from there, but you can see indentions in the shoulder,
10 you know, from wearing a bra that had carried the breasts.

11 Q Rebecca, do you remember the date this photograph was taken?

12 A I do.

13 Q And what was the date?

14 A November 1st --

15 Q And --

16 A -- excuse me -- 2016.

17 Q Is this an accurate depiction of your breasts as they looked
18 on November 1st of 2016?

19 A It is.

20 Q And are the markings that you added to this photograph an
21 accurate representation of the location of your scars from your
22 prior implant surgery?

23 A It is.

24 ATTORNEY BURKE: At this time, Your Honor, I'd like to move
25 this into evidence.

1 THE COURT: Any objection?

2 ATTORNEY SMYTH: No, Your Honor. I think that photo's
3 already in evidence. It seems duplicative.

4 ATTORNEY BURKE: This one is different because it has her
5 drawing on it.

6 THE COURT: I'll allow it.

7 ATTORNEY BURKE: Thank you, Your Honor.

8 THE COURT: That would be No. 4?

9 ATTORNEY BURKE: Yes, ma'am.

10 (Plaintiff's Exhibit 4 is marked for identification.)

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

12 (Plaintiff's Exhibit 5 is marked for identification.)

13 BY ATTORNEY BURKE:

14 Q Rebecca, I'm going to hand you document 3 for
15 identification, please. Rebecca, can you identify what document
16 3 is?

17 A Yes. It's a picture I took.

18 Q And what is the date of that photo?

19 A This is November 6th.

20 Q And why was this photo taken on November 6?

21 A First of all, being a photographer, you photograph
22 everything. Also, I wanted to photograph my journey.

23 Q Rebecca, let's back up. Is this photograph, taken on
24 November 6th of 2016, a fair and accurate representation of your
25 breasts on that date?

1 A It is.

2 ATTORNEY BURKE: Okay. Your Honor, at this time I'd like
3 to -- I'd like to admit ...

4 THE COURT: No. 5?

5 ATTORNEY BURKE: No. 5 into evidence. Once we get going,
6 I'll get them.

7 THE COURT: Any objection, Mr. Smyth?

8 ATTORNEY SMYTH: No, Your Honor.

9 THE COURT: All right. It's in.

10 (Plaintiff's Exhibit 5 is received in the record.)

11 BY ATTORNEY BURKE:

12 Q Okay, Rebecca. I'm going to hand you what's been marked
13 Exhibit 5 in evidence. Rebecca, would you tell the jury what
14 Exhibit 5 depicts.

15 A This picture was taken during one of my bandage changes.

16 Q And who took that photograph?

17 A I did.

18 Q Okay. Okay.

19 A I had this -- the Steri-Strips, I thought -- first of all, I
20 want to say, is that the black thing over my breast, I didn't
21 know what it was, so I just called it the black thing, for lack
22 of better words. I honestly thought it was a blood-soaked
23 bandage that had dried, and underneath it was my nipple.

24 Q All right, Rebecca. I'm handing you another document to
25 review. Rebecca, you have in front of you a document. Can you

1 identify what that document is?

2 A Yes. This is a picture of my breasts that I took after
3 surgery.

4 Q Do you know the date of the document in front of you?

5 A Yes. It was November 6.

6 Q And is that a fair and accurate representation of your
7 breasts on November 6th?

8 A It is.

9 ATTORNEY BURKE: At this time, Your Honor, I'd like to move
10 that photograph into evidence as Exhibit 6.

11 THE COURT: Any objection?

12 ATTORNEY SMYTH: No, Your Honor.

13 THE COURT: All right. It's in.

14 (Plaintiff's Exhibit 6 is marked for identification.)

15 (Plaintiff's Exhibit 6 is received in the record.)

16 ATTORNEY BURKE: Your Honor, may we publish Exhibit 6 to the
17 jury?

18 THE COURT: Yes, ma'am.

19 ATTORNEY BURKE: Thank you.

20 BY ATTORNEY BURKE:

21 Q All right, Rebecca. Why did you take the photograph that's
22 been marked as Exhibit 6?

23 A Again, I took many pictures during the course to document
24 what I thought was going to be my journey of healing, and I took
25 this picture during one of the bandage changes.

1 Q Do you recall your next visit with Sweetgrass Plastic
2 Surgery?

3 A I do.

4 Q Do you know approximately when that visit occurred?

5 A It was two days after I took this picture. It was
6 November 8th.

7 Q Okay. What do you recall about that visit?

8 A I remember meeting with Rebecca Johnson, who kept commenting
9 about how bruised the breasts were, especially the right side,
10 and I talked to her about the odor that was beginning to come
11 from the breast, and just how I felt.

12 During this time she removed the drainage tubes from the
13 breasts. When she kept commenting about the bruising on the
14 breasts, she says, Let me go get Dr. Schimpf.

15 Dr. Schimpf walked into the room, looks at my right breast,
16 and goes -- doesn't say anything to me at the time but, on his
17 way out, he turns back around and points at my right breast and
18 says, We can tattoo that later. That was it.

19 Q Rebecca, do you recognize the document in front of you?

20 A I do.

21 Q And what is the document in front of you?

22 A This is the image that I took of my right breast.

23 Q And what was the date?

24 A November 12.

25 Q And is this an accurate picture of the appearance of your

1 breast on November 12th of 2016?

2 A It is.

3 ATTORNEY BURKE: Your Honor, I move that Exhibit 7 be moved
4 into evidence.

5 THE COURT: Any objection?

6 ATTORNEY SMYTH: None, Your Honor. Thank you.

7 (Plaintiff's Exhibit 7 is marked for identification.)

8 (Plaintiff's Exhibit 7 is received in the record.)

9 ATTORNEY BURKE: Your Honor, may I publish to the jury?

10 THE COURT: You may.

11 BY ATTORNEY BURKE:

12 Q Rebecca, can you tell the jury what Exhibit 7 depicts.

13 A Again, this is a picture of the right breast. And I noticed
14 down below, where they call it the "T" zone, that the incision
15 was beginning to open up and I was having a discharge from there,
16 a foul discharge. And I know that we had to keep changing the
17 bandages often, like every two hours, because it would just soak
18 the bandage.

19 And again, I thought the black thing over the right breast
20 was a blood-soaked bandage that had dried, and underneath it was
21 my nipple, and I left the Steri-Strips alone, because I was
22 hoping to let them fall off naturally.

23 Q Rebecca, I have to ask, why are you wearing a Bud Light
24 lanyard?

25 A I was given that from one of the nurses who had a box of

1 them. She said that when you have these, when you have the
2 drainage tubes come from your breasts and they dangle off to the
3 side, they'll get wrapped around furniture, you know, get caught
4 on -- you know, just get caught on things, and then they would
5 tug at your breasts.

6 So with this, you'd wear it around your neck, and you can
7 clip up the tubes so you have more, you know -- you know, they're
8 stable, they're in front of you and not dangling to the sides.

9 Q Do you recall on November 12th if your drain tubes for your
10 abdominal procedure were still in place?

11 A Yes, they were.

12 Q And, Rebecca, down at the bottom of this exhibit there's
13 like a white. Can you identify what the white thing is at the
14 bottom of the photograph.

15 A Okay. Down at the bottom of the photograph, that was like a
16 draping of surgical material. I know that during the different
17 wound changes William would always lay -- I called him
18 Dr. Long -- he would always lay sanitary paper out. And when he
19 would clean the breasts, you know, instead of putting anything
20 dirty on the bed or whatever, he'd put it on the paper.

21 Q Thank you, Rebecca. I'm going to hand you the next
22 document. All right, Rebecca. Do you recognize the document
23 that you've just been handed?

24 A I do.

25 Q And what is this document?

1 A This is a picture of my right breast.

2 Q And when was that photo taken?

3 A November 14.

4 Q And who took that photograph?

5 A I did.

6 Q And is this photograph an accurate representation of the
7 appearance of your breast on November 14th, 2016?

8 A It is.

9 ATTORNEY BURKE: All right. At this time I move Exhibit 8
10 into evidence.

11 THE COURT: Any objection?

12 ATTORNEY SMYTH: No, Your Honor.

13 THE COURT: It's in.

14 (Plaintiff's Exhibit 8 is marked for identification.)

15 (Plaintiff's Exhibit 8 is received in the record.)

16 ATTORNEY BURKE: Your Honor, may we publish to the jury?

17 THE COURT: Yes, ma'am.

18 BY ATTORNEY BURKE:

19 Q All right. Rebecca, why did you take that photograph that's
20 been marked as Exhibit 8?

21 A Well, first of all, that's what I did. And, second of all,
22 I wanted to take a picture of close because I noticed that the
23 black thing on my breast, that the breast -- around it was
24 becoming red, inflamed, and was beginning to separate. And also,
25 I was having a discharge from the lower part of the breast. And

1 then down at the "T" zone, it was beginning to separate even
2 more, and I was having drainage from there as well. And also, I
3 was just having a foul order. It was just coming from my breast,
4 and it was becoming even stronger.

5 Q So Rebecca, you talked about how they looked and how they
6 smelled. How were your breasts feeling on November 11th of 2016?

7 A Felt feverish, achy, they felt angry. My breasts -- felt
8 like a storm going on within my breasts down here. It's just
9 difficult to describe.

10 Q Rebecca, do you recall your next -- did you see Dr. Schimpf
11 again?

12 A I did.

13 Q And do you recall approximately when that was?

14 A It was November 18.

15 Q Or thereabouts?

16 A Yes.

17 Q Okay.

18 A Excuse me. November 15, I believe.

19 Q Okay. What do you recall about that visit?

20 A At this point, I was so sick that I really do not remember
21 much about it.

22 Q When you say sick, in what way were you sick?

23 A I don't remember if I had a fever, but I know I felt
24 feverish. I was sick, tired. You know, I wasn't sleeping at all
25 at nighttime. Confused.

1 Q Do you remember who you saw at that November 15, 2016,
2 visit?

3 A I believe it was Rebecca Johnson.

4 Q Okay. Do you recall what treatment you were given that day,
5 if any?

6 A I think I remember this day I saw the nurse assistant,
7 Jordan, I think. I think this was the day that I was ...

8 Q Do you know, or are you guessing? Because we don't want you
9 to guess.

10 A On this day I saw Jordan, and I told her about the foul odor
11 coming from the breast. This is when she took the drainage tubes
12 from the tummy tuck area.

13 Q Okay.

14 A And she says, Well, I don't think you have an infection but,
15 just in case, let's put you on a round of antibiotics.

16 ATTORNEY BURKE: All right. The Court's indulgence, please.

17 THE COURT: Yes, ma'am.

18 BY ATTORNEY BURKE:

19 Q Rebecca, if Dr. Schimpf's chart reflects that you saw
20 Rebecca Johnson on November 15th rather than Jordan Harper, does
21 that refresh your recollection?

22 A Yes, it does. I remember seeing Rebecca the first time and
23 the second time.

24 Q Okay.

25 A And I believe this was my second visit.

1 Q Okay.

2 A This was six years ago.

3 (Plaintiff's Exhibit 9 is marked for identification.)

4 BY ATTORNEY BURKE:

5 Q All right. I'm going to hand you the next document to
6 review. All right, Rebecca. Can you identify the photo as
7 Exhibit 9?

8 A I can.

9 Q When was it taken?

10 A This picture was taken on November 15.

11 Q And who took that photo?

12 A I did.

13 Q And is this an accurate representation of the appearance of
14 your breast on November 15th of 2016?

15 A Yes, it is.

16 Q All right.

17 ATTORNEY BURKE: Your Honor, at this time I would move
18 Exhibit 9 into evidence.

19 THE COURT: Any objection?

20 ATTORNEY SMYTH: No, Your Honor.

21 THE COURT: It's in.

22 (Plaintiff's Exhibit 9 is received in the record.)

23 ATTORNEY BURKE: May we publish?

24 THE COURT: Yes, ma'am.

25

1 BY ATTORNEY BURKE:

2 Q All right, Rebecca. What does Exhibit 9 depict?

3 A This is a picture of the left breast. It shows that -- this
4 is during one of the bandage changes, because everything's always
5 covered up and I had a bandage on it. So I always took an
6 opportunity, when the bandage came off in between cleaning, to
7 take a picture -- and noticed on the left breast that the nipple
8 around it started turning black. Around the edge it was red, it
9 was feverish, and down at the bottom of the "T" area it now was
10 beginning to open up and it was beginning to drain, had a foul
11 odor. Just all kinds of stuff was draining from down at the "T"
12 area, as well as the breast area, to the point to where the
13 bandages had to be changed, like, every two hours.

14 Q What is the black spot laying beside your left breast?

15 A During the wound care, William would take hydrogen peroxide
16 and just pour it right on the breast. Well, before the towel it
17 would just kind of drip down and it would be underneath my back,
18 so he would place a towel underneath my arm to catch whatever
19 hydrogen peroxide was pouring down to the side.

20 Q All right, Rebecca. Do you remember when you next visited
21 Sweetgrass Plastic Surgery?

22 A Yes. It was November 18.

23 Q Actually, I'm going to show you ...

24 A I showed -- This is the day that I saw Dr. Schimpf.

25 Q Hang on. Just hang on. You've got to wait for a question.

1 A Okay.

2 Q All right, Rebecca. Take a look at that photo. What is the
3 date of that photo?

4 A This is November 28.

5 Q And who took that photo?

6 A The nurse at Sweetgrass Plastic Surgery.

7 Q And is this photo an accurate depiction of your breast, your
8 right breast, on November 28th of 2016?

9 A It is.

10 ATTORNEY BURKE: Your Honor, at this time I'd like to move
11 Exhibit 10 into evidence.

12 THE COURT: Any objection?

13 ATTORNEY SMYTH: None, Your Honor.

14 THE COURT: All right. It's in.

15 (Plaintiff's Exhibit 10 is marked for identification.)

16 (Plaintiff's Exhibit 10 is received in the record.)

17 ATTORNEY BURKE: And request to publish?

18 THE COURT: Yes, ma'am.

19 BY ATTORNEY BURKE:

20 Q All right, Rebecca. Does Exhibit 10 refresh your
21 recollection that your next visit with Sweetgrass Plastic Surgery
22 was on November 28th of 2016?

23 A Yes.

24 Q What do you remember about that visit?

25 A This visit, I saw Jordan. I went in because I was having a

1 lot of complications, as far as I am concerned. I was feverish,
2 a lot of pain within the breasts. And the black thing that was
3 on the breast was beginning to push outward and was separating
4 from the outer lines of the areola, and you could see where --
5 you can see, I don't even know how to describe it, but you could
6 tell everything was angry. It was red, and it was very painful,
7 and had a very foul odor to it, to the point to where I couldn't
8 leave home.

9 Then down at the bottom, you could see the "T" area was
10 beginning to open up even more. And then to the side of that,
11 you could see another area opening up next to it to where even
12 more drainage was coming from. At this point it was just -- it
13 was draining quite a bit. I mean, it was very painful.

14 Q Was Jordan Harper aware of the odor? Was she able to
15 ascertain the odor?

16 A No, but she did say ... We knew it was coming from the
17 breast. It was very obvious.

18 Q Did you receive any treatment that day?

19 A That's the day that we were unsure if there was an infection
20 but Jordan says, Well, let's just put you on a round of
21 antibiotics just in case.

22 Q Does this refresh your recollection that you actually
23 received the antibiotic on the 28th rather than at the earlier
24 visit as you previously testified?

25 A It does. Excuse me.

1 Q Okay.

2 A Sorry about that.

3 Q Was a follow-up visit scheduled with Dr. Schimpf? If you
4 remember.

5 A I don't remember if there was. I'm sure there was, but I do
6 not remember.

7 Q After that visit with -- well, let me back up. At that
8 visit on the 28th with Jordan Harper, did you see Dr. Schimpf?

9 A I don't think so. I ...

10 Q You don't think so or you don't know?

11 A No. I don't remember.

12 Q All right. What did you do after that visit on the 28th?

13 A First thing we did was went to pick up the antibiotics.
14 Went back home. Changed the bandages. And that's when I finally
15 got to the point to where I said, You know, I need a second
16 opinion. And so I called another doctor, who they were able to
17 schedule me the next day.

18 Q And who did you see?

19 A I saw Dr. Sonny O.

20 Q And what did you do after that appointment with Dr. Sonny O?

21 A After the appointment with Dr. Sonny O, I called Sweetgrass
22 Plastic Surgery and I said, I need to see Dr. Schimpf; I'd like
23 to have an appointment with my doctor, please. And they told me,
24 Well, he's not going to be in the Summerville office, but if you
25 want to see him you can drive down to Daniel Island. And that's

1 what I did.

2 Q Do you know what day you went to the Daniel Island office to
3 see Dr. Schimpf? Was it that day or the next day?

4 A I believe it was November 30th --

5 Q Okay.

6 A -- was the next time I could get in to see him.

7 Q What do you recall about that visit at Sweetgrass Plastic
8 Surgery on November 30th?

9 A On this day, 29 days later, the black thing that was over my
10 breast that was pushing outward -- I guess I don't know if it was
11 so much infection, or I don't know -- I don't know, I never seen
12 it before, but it was pushing outward, had a very foul odor, I
13 was in a lot of pain.

14 And so on this day Dr. Schimpf snipped it, you know, cut it
15 off, away from the rest of the breast. Underneath that, when
16 they cut that black thing off which I know now was my nipple, my
17 dead nipple, there was such an odor that came from it that they
18 had to open up the door just so you could breathe, and they
19 sprayed the room, and went up and down the hallway and sprayed
20 it.

21 And Dr. Schimpf told me -- he was trying to comfort me. He
22 said -- This is just a bump in the road to your recovery. And I
23 believed him. And I walked out with my boyfriend. I wanted to
24 believe him.

25 Q All right, Rebecca. I'm handing you a document. Rebecca,

1 do you recognize what I just handed you?

2 A I do.

3 Q And what is this a photo of?

4 A This is a photo November 30th, the same day that the
5 black -- my dead nipple was cut away from my breast.

6 Q Rebecca, we've got to back up. We've got to get this into
7 evidence. All right. What does the photo taken on November 30th
8 of 2016 depict?

9 A It depicts what was underneath the black, the dead, nipple.

10 Q Did you take the photograph?

11 A I did.

12 Q Okay. Is it an accurate representation of the appearance of
13 your right breast on November 30th of 2016?

14 A It is.

15 ATTORNEY BURKE: Your Honor, at this time I'd move Exhibit
16 11 into evidence.

17 THE COURT: Any objection?

18 ATTORNEY SMYTH: No, Your Honor.

19 THE COURT: All right. It's in.

20 (Plaintiff's Exhibit 11 is marked for identification.)

21 (Plaintiff's Exhibit 11 is received in the record.)

22 ATTORNEY BURKE: Permission to publish?

23 THE COURT: Yes, ma'am.

24 BY ATTORNEY BURKE:

25 Q All right, Rebecca. Why did you take the photograph on

1 November 30th?

2 A First of all, I have family that were very concerned about
3 me that lived in other states, and they wanted to know what was
4 going on. I didn't know how to explain it, so I sent them some
5 visuals of it.

6 I took this picture during another bandage change and what
7 it depicts. This is down at the bottom of the "T" zone. It is
8 raw, opening up even larger. Things were just draining quite a
9 bit from it. And the hole over next to it was opening up even
10 larger, and things were draining from it, too. Very foul odor.

11 Q Rebecca, I want to back up to that visit at Sweetgrass
12 Plastic Surgery. In addition to the antibiotics that had been
13 prescribed by Jordan Harper, at that visit did Sweetgrass Plastic
14 Surgery or Dr. Schimpf -- did they provide any other treatment to
15 you?

16 A They did.

17 Q What was that?

18 A They gave us something to clean the breasts with that had a
19 little bit of bleach. I think it was called -- I can't remember
20 its name. So that way it would basically cover up the odor.

21 Q Did you go back to Dr. Schimpf after November 30th of 2016?

22 A I did not.

23 Q Okay. Hold on one second. All right, Rebecca. I'm going
24 to hand you two documents. Rebecca, we're going to -- I'm going
25 to try to get these into evidence first, and then we'll testify

1 about them.

2 Can you tell the jury what the documents I just handed you
3 are depictions of?

4 A One image is of the right breast with an open wound, and the
5 second image is of the left breast.

6 Q And who took these photos?

7 A On no. 14, my boyfriend took that one. On no. 15, I did.

8 Q Okay. Are these photos an accurate representation of the
9 appearance of your right and left breast on December 6th of 2016?

10 A It is.

11 ATTORNEY BURKE: I move Exhibits 12 and 13 into evidence,
12 please.

13 THE COURT: Any objection?

14 ATTORNEY SMYTH: No, Your Honor.

15 THE COURT: Counsel, is that December 6th and December 7th?

16 ATTORNEY BURKE: Yes, ma'am.

17 (Plaintiff's Exhibits 12 and 13 are marked for
18 identification.)

19 (Plaintiff's Exhibits 12 and 13 are received in the record.)

20 BY ATTORNEY BURKE:

21 Q Okay, Rebecca. Let's start with Exhibit 12. Can you tell
22 the jury where you are at the time Exhibit 12 was taken.

23 A I was in the hospital at MUSC.

24 Q Do you recall how long you had been in the hospital?

25 A I think I was in there five days.

1 Q Okay. And what does Exhibit 12 depict about your left
2 breast?

3 A You can see where the black has sloughed off the areola, and
4 you can see the scar tissue around it. This, you can see where
5 the whole nipple area is just sunken in.

6 And then down at the "T" zone where it had been open for so
7 long, they finally had to use, and I don't know the term/the
8 word, Silverdine [sic], Silvadene, but it's an ointment that you
9 put on the "T" area, that you put on an open wound, and basically
10 it just heals it right up.

11 Q And at the time that Exhibit 12 was taken you were
12 inpatient/admitted at MUSC, correct?

13 A Yes.

14 Q And were you given any treatments at MUSC?

15 A Yes. I believe I was on two different -- I was on two
16 different antibiotics that were given to me, IV, throughout the
17 day, throughout the course of my stay there.

18 Q Anything else?

19 A They debrided the right breast every day. They would come
20 in in the morning. In search of healthy breast tissue, they
21 would cut away from the dead tissue, which was very painful
22 because they're tugging at the dead tissue. You're tugging on it
23 and you're snipping it off, I mean, to the point to where I'm
24 like, That's enough. You have to stop now. I can't take any
25 more of it. And they would say, Okay, Ms. Turisk. We'll come

1 back tomorrow and do some more.

2 Q Do you recall any physicians who treated you during that
3 admission at MUSC?

4 A I do.

5 Q Who treated you?

6 A I don't remember the name of the infectious doctor, but I do
7 know at this time that Dr. Fernando Herrera stepped in and was
8 treating me.

9 Q Rebecca, let's move to Exhibit 13. Rebecca -- and remind
10 me, did you take this photo, or William?

11 A I took this one.

12 Q And what does the photo at Exhibit 13 depict?

13 A This is after a little bit of the debridement. Also, I
14 can't remember -- they had found that there was fluid left in the
15 pocket of my right breast that needed to come out, and the only
16 way to do that was to put a drain back into the breast, which
17 they pushed in and pushed in deep, under ultrasound, but I was
18 wide awake, and it was a very painful experience.

19 Q Rebecca, after you were discharged from the Medical
20 University of South Carolina did you receive any follow-up
21 treatment from MUSC?

22 A I did.

23 Q And who did you follow up with?

24 A Dr. Herrera.

25 Q Okay. And where did you see Dr. Herrera after discharge?

1 A At his office here in Charleston, MUSC.

2 Q And what treatment did Dr. Herrera provide to you after
3 discharge?

4 A After they had debrided so deep down the breast and never
5 could find healthy tissue, so they sent me to an advanced wound
6 care close to my home in Summerville where I went three times a
7 week.

8 And what was given, what advanced wound care did was put a
9 wound VAC in the breast. They did a wet-to-dry dressing.
10 Basically unrolled, you know, a long bandage, and they would push
11 it in the breast. At this time the breast, the hole was
12 three inches deep, and it tunneled around three inches, so each
13 visit they would take out the old bandage, which would tug on the
14 dead debris, which was painful, and then they would put in fresh
15 bandage and push it in, push it in, until it, you know, covered
16 the whole area.

17 And then, on top of that, they applied a wound VAC, the
18 wound VAC that I had to wear 24 hours a day, 7 days a week. And
19 what it was supposed to do is to pull the moisture away from the
20 wound and slightly debride that area by pulling the moisture
21 away, and hopefully stimulating new breast tissue, healthy breast
22 tissue.

23 Q Was that wound care center affiliated with any hospital?

24 A I believe it's -- yes. It's affiliated with Summerville
25 Medical Center.

1 Q And were you treated by any doctors at the wound care
2 center?

3 A I was. Another plastic surgeon. And her name is Tracy
4 Cordray.

5 Q Rebecca, do you recognize the photo I just handed you?

6 A I do.

7 Q And what is the date of that photo?

8 A This is February 3rd, 2017.

9 Q And what does this photo depict?

10 A After undergoing the wound care --

11 Q We'll get it into evidence first.

12 A Okay.

13 Q What does this photo depict?

14 A Was in the emergency room.

15 Q Whoa, whoa. Let's back up.

16 A Okay.

17 Q Let me go about it this way, if there's no objection. Is
18 this a fair representation of the appearance of your right breast
19 on February 3rd of 2017?

20 A It is.

21 ATTORNEY BURKE: All right. I'd like to move this into
22 evidence.

23 ATTORNEY SMYTH: No objection.

24 THE COURT: It's in.

25 (Plaintiff's Exhibit 14 is marked for identification.)

1 (Plaintiff's Exhibit 14 is received in the record.)

2 ATTORNEY BURKE: Thank you. We're up to Exhibit No --

3 THE COURT: Fourteen.

4 ATTORNEY BURKE: -- 14, thank you. Your Honor, may I
5 publish Exhibit 14 to the jury?

6 THE COURT: Yes, ma'am.

7 ATTORNEY BURKE: Okay.

8 BY ATTORNEY BURKE:

9 Q All right, Rebecca. Now, could you please tell what Exhibit
10 14 depicts.

11 A This is the wound VAC that was pushed, you know, into the
12 breast, and it had a tube coming from it that went to a box.
13 Kind of Saran Wrap, I call it Saran Wrap, over the breast area to
14 make sure there was no air coming in, because it was doing like a
15 light suction. And, also, this depicts EKG monitors on me.

16 Q And why were you wearing EKG monitors?

17 A On my last visit, on the visit to the wound care we had
18 noticed that out of the tube was coming -- and excuse me -- it
19 was a chunky, gray material that was coming out of the breast,
20 heavy, just, I mean, continuously. I was feeling really bad. I
21 had a fever. And the wound care center said, You need to go to
22 the emergency room now. Go to the one next-door, which was
23 Summerville Medical Center.

24 Q And, Rebecca, Exhibit 14 -- excuse me. Exhibit 13 that we
25 just reviewed, that exhibit was dated December -- I'm sorry.

1 Exhibit 13 that we just reviewed, that exhibit was dated
2 December 6th or 7th at MUSC, right? The last two exhibits, 12
3 and 13, those were back in December of 2016, right?

4 A Yes. This was back during my hospital stay of --

5 Q And -- okay.

6 A -- December 6th and December 7th.

7 Q And can you tell the jury generally what was going on
8 between early December 2017 and February 3rd of 2017.

9 A You know, I was on antibiotics the entire time, and there
10 was a constant debridement of the breast area.

11 Q So you were following up with --

12 A I had a follow-up visit with the wound care after leaving
13 the MUSC Hospital.

14 Q Okay. And you were also following up with Dr. Herrera?

15 A Yes. And I went to the wound care three days a week. I had
16 to have this process done where they pulled out the wet-to-dry
17 bandage that, you know, they had previously just pushed in
18 everywhere, which was painful.

19 ATTORNEY BURKE: Your Honor, I did not request to publish.
20 She was just talking, and we don't have anything to look at. I'm
21 so sorry.

22 ATTORNEY O'NEAL: No, it was up for a while.

23 ATTORNEY BURKE: Okay. My apologies. All right. We'll
24 take it back down.

25

1 BY ATTORNEY BURKE:

2 Q Rebecca, I'm going to hand you -- You mentioned that --
3 strike that. Rebecca, do you recognize the photo I just handed
4 you?

5 A I do.

6 Q And what does the photo -- when was this photo taken?

7 A February 6, 2017.

8 Q Okay. And what does the photo depict? Is it your right or
9 left breast?

10 A This is the right breast.

11 Q Is this a fair and accurate representation of the appearance
12 of your right breast on February 6th of 2017?

13 A It is.

14 ATTORNEY BURKE: All right. At this time I'd move -- I'd
15 like to have this marked as a exhibit.

16 THE COURT: Any objection?

17 ATTORNEY SMYTH: No, Your Honor.

18 ATTORNEY BURKE: All right.

19 (Plaintiff's Exhibit 15 is marked for identification.)

20 (Plaintiff's Exhibit 15 is received in the record.)

21 ATTORNEY BURKE: Your Honor, may we publish?

22 THE COURT: Yes, ma'am.

23 BY ATTORNEY BURKE:

24 Q All right, Rebecca. What does Exhibit 15 depict?

25 A Again, this is debridement of the breast in order to reach

1 healthy tissue. And this one had to be done by surgery.

2 Q Okay.

3 A This depicts a hole in my breast about three inches deep,
4 that you can see tunnels around, inside, as well. I believe it's
5 three inches around.

6 Q And where did that surgery that you mentioned take place?

7 A This surgery took place at Trident. Excuse me. At
8 Summerville Medical Center.

9 Q And how long were you hospitalized at Summerville Medical
10 Center in conjunction with that surgery?

11 A I believe three or four days.

12 Q And is there any reason you didn't have that surgery at
13 MUSC?

14 A It was during the month of February, and it was flu season,
15 and there were no beds available at MUSC for Dr. Herrera to do
16 his surgery. And because of -- which now I had sepsis, this
17 surgery needed to be done, needed to be done now, so it was done
18 at Trident Medical Center by a doctor that was on call.

19 Q All right, Rebecca. Rebecca, do you recognize the
20 photograph I just handed you?

21 A I do.

22 Q Okay. We're going to get it into the evidence. What is the
23 date of that photograph?

24 A This is February 25th, 2017.

25 Q Okay. And who took that photograph?

1 A I did.

2 Q Is that a fair and accurate representation of your breast on
3 February 25th of 2017?

4 A It is.

5 ATTORNEY BURKE: Okay. At this time I'd like to move
6 Exhibit 16 into evidence, please.

7 THE COURT: Any objection?

8 ATTORNEY SMYTH: No, Your Honor.

9 THE COURT: Okay. It's in.

10 (Plaintiff's Exhibit 16 is marked for identification.)

11 (Plaintiff's Exhibit 16 is received in the record.)

12 ATTORNEY BURKE: Your Honor, may we publish?

13 THE COURT: Yes, ma'am.

14 ATTORNEY BURKE: Thank you.

15 BY ATTORNEY BURKE:

16 Q All right, Rebecca. After you were discharged from
17 Summerville Medical Center did you continue to follow up with
18 Dr. Herrera?

19 A I did.

20 Q And what was the next procedure that Dr. Herrera performed
21 on you?

22 A After finally getting the infection under control, we now
23 moved forward with closing the wound on the right side. We also
24 had to address the left breast, which had dead breast tissue,
25 necrosis, that had to be removed as well.

1 Q Did Dr. Herrera perform the surgery on you?

2 A Yes, he did.

3 Q Do you remember the date of that surgery?

4 A I do.

5 Q And when was it?

6 A I believe it was February 24th.

7 Q And what surgery did Dr. Herrera perform on you at MUSC on
8 February 24th of 2017?

9 A He did a double mastectomy.

10 ATTORNEY SMYTH: Your Honor, may we approach for just a
11 second?

12 THE COURT: Yes, sir.

13 (Sidebar discussion held off the record.)

14 THE COURT: Ladies and gentlemen, we're going to take a very
15 brief recess. If you'd please go to your jury room, we'll be
16 right back with you.

17 Again, please remember, don't discuss the case amongst
18 yourselves. We'll be right back with you.

19 (Jury escorted out of the courtroom at 10:45 a.m.)

20 ATTORNEY BURKE: May she step down? We won't discuss her
21 testimony.

22 THE COURT: Just wait for the jury to leave.

23 (Off-the-record discussion held.)

24 (Court recessed at 10:45 a.m. and reconvened at 10:58 a.m.,
25 without the jury present.)

1 THE COURT: Parties ready to proceed? Let's have our jury.
2 Ms. Turisk, if you'd like to get back on the witness stand, you
3 can go ahead and do that.

4 (Jury seated in the courtroom at the 10:59 a.m.)

5 THE BAILIFF: All jurors present, Your Honor.

6 THE COURT: Thank you. Welcome back, ladies and gentlemen
7 of the jury. We're ready to proceed. You may continue.

8 ATTORNEY BURKE: Thank you, Your Honor.

9 BY ATTORNEY BURKE:

10 Q Rebecca, before the break we were looking at Exhibit 17, and
11 I believe that was --

12 THE COURT: Sixteen.

13 ATTORNEY BURKE: Sixteen, I believe, we published to the
14 jury. Sixteen. Sorry.

15 BY ATTORNEY BURKE:

16 Q Okay, Rebecca. We were talking about Exhibit 16. Do you
17 still have that in front of you?

18 A I do.

19 Q All right. I think we established before the break that you
20 had had surgery with Dr. Herrera on the 24th, right?

21 A Yes.

22 Q Okay. And what was that surgery?

23 A The double mastectomy.

24 Q Okay. And why did Dr. Herrera perform the double
25 mastectomy?

1 A On the right side he had to remove -- he had to close up the
2 breast. It was hollow. Wasn't that much fresh tissue left. In
3 order to close up the wound, you had to cut -- I don't know
4 exactly how it's done, but he had to do a total mastectomy, down
5 to 100 percent, on the right side.

6 On the left side, there was so much dead, necrosis tissue
7 that was sitting up here, that he had to remove it all. And this
8 procedure, he was able to spare the left nipple by cutting it
9 open at the top and removing the dead tissue within. And I
10 believe he took 40 percent of that breast, if I'm correct.

11 Q How were you feeling physically in the immediate
12 postoperative period?

13 A I had a little bit of an infection on the right side. And
14 when I called Dr. Herrera's office -- excuse me. I was taken
15 into the emergency room, and Dr. Herrera met me there, and he
16 aspirated that little bit of infection I had on the right side,
17 took care of it, and I was on antibiotics again for a short
18 period of time.

19 Q All right, Rebecca. Why did you take the picture on
20 Exhibit 16?

21 A You know, when I told my family I had a double mastectomy,
22 they were just like -- didn't believe it. I sent them a picture.
23 It's also part of my epeddeal [ph] diary that I kept for myself
24 toward my road to recovery.

25 Q Rebecca, what did you do in the months following the

1 mastectomy surgery?

2 A I didn't do that much. I didn't drive at all. Didn't want
3 to leave home. Was depressed. My family and friends did
4 everything they could to get me out of the house. Let's go to
5 the movies. Hey, I'll take you shopping. You know, it's a nice
6 day; let's go out to Magnolia Plantation. Don't you want to take
7 a picture of something? You know.

8 I took some time out to heal. I also took some time out
9 because my caretakers were exhausted. My boyfriend, who was
10 slightly older than myself, this is supposed to be a time in his
11 life that we were supposed to be traveling, that he has looked
12 forward to all these years, and I owed it to him, you know, to
13 take a break. And I needed to heal emotionally and physically.

14 Q Rebecca, were you and William able to travel after the
15 mastectomy?

16 A We did.

17 Q When did you go back to see Dr. Herrera?

18 A It was 10 months later.

19 Q Okay. Okay, Rebecca. Do you recognize the photograph I
20 just handed you?

21 A I do.

22 Q Do you know who took that photograph?

23 A Dr. Herrera's office did, his nurse.

24 Q And do you know the approximate date of that photograph?

25 A I want to say October of 2017.

1 Q And is that an accurate representation of your right and
2 left breast in October of 2017?

3 A Yes, after 10 months. Yeah.

4 (Plaintiff's Exhibit 17 is marked for identification.)

5 ATTORNEY BURKE: I'm sorry. 2017. We're moving -- we'll
6 get it into evidence. At this time I'd move what we marked as
7 Exhibit 17 into evidence.

8 THE COURT: Is that dated 12/13? Any objection?

9 ATTORNEY SMYTH: I don't have a photo from October from that
10 set.

11 THE COURT: I think it's 12/13/17.

12 ATTORNEY BURKE: Yes. It's actually December. Sorry about
13 that.

14 ATTORNEY SMYTH: Okay.

15 (Plaintiff's Exhibit 17 is received in the record.)

16 ATTORNEY BURKE: May we publish, Your Honor?

17 THE COURT: Yes, ma'am.

18 BY ATTORNEY BURKE:

19 Q All right, Rebecca. Let's clear something up. You had your
20 mastectomy in February of 2017, correct?

21 A February 24th. I remember.

22 Q And I believe you said you followed up with Dr. Herrera 10
23 months later?

24 A Yes.

25 Q So if that photograph was taken at your next visit with

1 Dr. Herrera, would that make that sometime in December of 2017?

2 A I'm sorry. Yes.

3 Q All right. Do you recall this visit with Dr. Herrera?

4 A I do.

5 Q All right. What do you recall about that visit?

6 A We discussed our options for breast reconstruction.

7 Q And what did Dr. Herrera ultimately end up performing for
8 breast reconstruction?

9 A We used fat grafting.

10 Q And how is fat grafting performed?

11 A So they take the fat from other areas of your body the best
12 that they can, and then they take it and inject it over and over
13 and over again in the breast to create as best a breast mound as
14 they possibly could.

15 Q And how is the fat injected into your breast?

16 A With a syringe, over and over and over again.

17 Q And in total, how many fat-grafting procedures did you have?

18 A Five.

19 Q And where were all of those performed?

20 A MUSC Hospital.

21 Q And who was the plastic surgeon who performed those
22 fat-grafting procedures?

23 A Dr. Herrera.

24 Q Did you have any infections after fat grafting?

25 A Only after the first one, and he quickly aspirated the area

1 where the infection was. After that, no.

2 Q And, Rebecca, I think you testified earlier that you had an
3 infection after your mastectomy. Do you recall that?

4 A I can't --

5 Q Do you recall that testimony?

6 A I do not recall. I'm sorry.

7 Q All right. Because I'm just trying to clear up whether you
8 had the postop infection after the mastectomy or after the first
9 fat graft, the first procedure.

10 A It was after the first fat-grafting procedure.

11 Q So you did not have an infection after the mastectomy?

12 A No, I did not.

13 Q All right. And the process that you described for how the
14 fat grafting is accomplished, was that pretty much the same for
15 each of the procedures?

16 A Yes.

17 Q And was that a surgical procedure?

18 A Yes.

19 Q Rebecca, do you recognize the photo that I just handed to
20 you?

21 A I do.

22 Q And when is this photo dated?

23 A March 2021.

24 Q And what does the photo depict?

25 A This is after one of the fat-grafting sessions. Surgeries.

1 Excuse me.

2 Q And is this photo a fair representation of the appearance of
3 your breasts on March 31st of 2017?

4 A It is.

5 ATTORNEY BURKE: At this time I would like to move Exhibit
6 18 into evidence.

7 THE COURT: Any objection?

8 ATTORNEY SMYTH: No, Your Honor.

9 THE COURT: All right. It's in.

10 (Plaintiff's Exhibit 18 is marked for identification.)

11 (Plaintiff's Exhibit 18 is received in the record.)

12 ATTORNEY BURKE: May we publish, Your Honor?

13 THE COURT: It's in.

14 ATTORNEY BURKE: Okay. Can't be too careful.

15 THE COURT: Yes, ma'am.

16 BY ATTORNEY BURKE:

17 Q All right, Rebecca. Can you tell the jury what is depicted
18 in Exhibit 18?

19 A This is my left and right breast after one of these
20 fat-grafting sessions. Surgeries. Excuse me. I like to call it
21 sessions because it doesn't make it sound so, you know, in my
22 mind.

23 Q Can you explain to the jury what the bruising in your left
24 breast is a result of?

25 A When they took out the dead necrosis on the left breast,

1 it's just dead tissue within the breast, so they just had to cut
2 it out. There's not a pretty way of doing that. And after all
3 that was cut out, I had a lot of scar tissue, and it was very
4 painful. It bothered me constantly. There was webbing within.

5 So Dr. Herrera, when he did the fat grafting, he was more
6 aggressive on injecting the fat into the breast in order to break
7 up that webbing, that scar tissue, the best that he possibly
8 could.

9 Q And did he also do injections on the right?

10 A Yes, he did.

11 Q Okay. And what does the bruising on the right indicate? If
12 you know.

13 A An area that he had to be more aggressive with as far as
14 scar tissue.

15 Q And did you have swelling after fat-grafting surgery?

16 A I did.

17 Q Is there swelling depicted in this exhibit?

18 A Yes.

19 Q And so over time did the swelling go down?

20 A It did.

21 (Plaintiff's Exhibit 19 is marked for identification.)

22 BY ATTORNEY BURKE:

23 Q Final photograph. All right, Rebecca. Can you identify the
24 document that I've just handed you?

25 A Yes.

1 Q And what does the photograph depict?

2 A This is what I look like now.

3 Q Okay. Let's get it in evidence.

4 A Okay.

5 Q Is this a fair representation -- when did you take the
6 photograph?

7 A November 12th.

8 Q Is this a fair and accurate representation of the appearance
9 of your breasts on November 12th of 2022?

10 A Yes, it is.

11 Q All right.

12 ATTORNEY BURKE: At this time, Your Honor, I'd like to move
13 into evidence Exhibit 19.

14 ATTORNEY SMYTH: No objection.

15 THE COURT: All right.

16 (Plaintiff's Exhibit 19 is received in the record.)

17 ATTORNEY BURKE: Permission to publish?

18 THE COURT: Yes, ma'am.

19 BY ATTORNEY BURKE:

20 Q All right, Rebecca. Please tell the jury what is depicted
21 in Exhibit 19.

22 A This is what I look like today after five fat-grafting
23 surgeries. This is the end result.

24 Q Do you remember when your most recent fat-grafting procedure
25 was?

1 A I do.

2 Q When was that?

3 A February 14th, 2022.

4 Q What's this photo show related to your left breast?

5 A You can see on the left side the nipple that I have that
6 remains. And after all the -- after everything I went through,
7 this is the nipple that -- it's irregular in shape around. I'm
8 grateful to have it after everything I've been through, but it's
9 far from perfect.

10 Q What about your right breast?

11 A This is it.

12 Q Have you had any nipple reconstruction on the right?

13 A No.

14 Q Do you plan to have any further reconstruction procedures on
15 your breasts?

16 A I'm done. I'm done.

17 Q Do you have any pain or discomfort in your breasts?

18 A I do.

19 Q Can you describe that for the jury.

20 A It's a nerve pain. It's achy. It's cold in here right now,
21 so my breasts -- everything around is just -- it's nerve damage.
22 It's just achy. You can feel it in the nerves, just kind of
23 firing. And it's -- some days are better than others.

24 Q Rebecca, do you know from memory the number of times you
25 went to the hospital or to see a physician or sought treatment

1 related to the injuries and damages you're claiming in this case?

2 A No.

3 Q Can you recite by memory the number of medical bills that
4 you received for your injuries and damages that you're claiming
5 in this case?

6 A No.

7 Q Did you review all of your bills that you received related
8 to your care and treatment with your lawyers?

9 A Yes.

10 Q With your assistance, did we prepare a compilation and a
11 spreadsheet of all the bills you received?

12 A Yes, we did.

13 Q If Dr. Schimpf's lawyers were to ask you for any particular
14 bill and what it was for, can you recite that from memory?

15 A No.

16 Q And a couple of minutes ago, Rebecca, I handed you a
17 document. Do you recognize that document?

18 A I do.

19 Q Is this document the spreadsheet compilation of all the
20 medical bills that you received related to your injuries in this
21 case?

22 A Yes, it is.

23 Q Are each of the bills on this spreadsheet for treatment you
24 received related to your postoperative complications following
25 the breast surgery performed by Dr. Schimpf on November 1st of

1 2016?

2 A It is.

3 ATTORNEY SMYTH: Objection, Your Honor.

4 THE COURT: The basis for your objection?

5 ATTORNEY SMYTH: She's not qualified to make that
6 connection. She's not an expert witness to connect those two.

7 THE COURT: She can --

8 ATTORNEY SMYTH: I was there.

9 THE COURT: Your objection is --

10 ATTORNEY SMYTH: The question talks about proximate cause of
11 the complication, and that's a different issue.

12 THE COURT: She can testify as to the medical bills that she
13 received and why she went for treatment, so I'll allow it.

14 ATTORNEY BURKE: Thank you, Your Honor.

15 BY ATTORNEY BURKE:

16 Q And I'll rephrase my question just to be extra careful. Are
17 each of the bills on the spreadsheet for treatment you received
18 related to your postoperative treatment following the breast
19 surgery performed by Dr. Schimpf on November 1st of 2016?

20 A Yes, it is.

21 Q Just generally, for what treatments did you incur these
22 bills?

23 A After the initial surgery?

24 Q Yes.

25 A Debridement, trips to the emergency room, wound care, wound

1 care VAC, trip to the emergency room because of the pain that I
2 could not control myself, infections, infections, breast pain,
3 double mastectomy, pain control, breast pain, breast abscess,
4 breast-reconstruction surgery, postop infection, breast
5 debridement, breast-wound debridement, breast ultrasound, drain
6 removal, double mastectomy.

7 Q Rebecca, let me just ask you, what is the total dollar
8 amount of the bills reflected on this compilation?

9 A \$579 677 78 cents.

10 Q All right. Let's try that again.

11 A Excuse me. \$579,677.78.

12 Q Okay.

13 ATTORNEY BURKE: At this time, Your Honor, I move Exhibit 20
14 into evidence.

15 THE COURT: Any objection?

16 ATTORNEY SMYTH: Subject to our prior objections, Your
17 Honor.

18 THE COURT: Same ruling. It's in.

19 (Plaintiff's Exhibit 20 is marked for identification.)

20 (Plaintiff's Exhibit 20 is received in the record.)

21 ATTORNEY BURKE: Thank you. And, Your Honor, may I publish?

22 THE COURT: Yes, ma'am.

23 BY ATTORNEY BURKE:

24 Q And, Rebecca, just for reference, does this look like the
25 bills that we reviewed with you?

1 A Yes, it is.

2 Q All right. Rebecca, I don't have any further questions.

3 I'm sorry. Just one moment. I do not have any further questions
4 for you at this time. Please answer any questions that
5 Dr. Schimpf's attorneys may have for you.

6 A Okay.

7 THE COURT: Cross-examination.

8 ATTORNEY SMYTH: Thank you, Your Honor. May it please the
9 Court.

10 THE COURT: Yes, sir.

11 ATTORNEY SMYTH: We may need just a second to switch over
12 the computers.

13 THE COURT: Take your time.

14 ATTORNEY SMYTH: Your Honor, may we proceed?

15 THE COURT: Yes, sir.

16 ATTORNEY SMYTH: Thank you, Your Honor.

17 **CROSS-EXAMINATION**

18 BY ATTORNEY SMYTH:

19 Q Good morning, Ms. Turisk. How are you this morning?

20 A Good morning.

21 Q It's my understanding that when you first came to see
22 Dr. Schimpf, the reason that you came to see him was because your
23 breasts were bothering you in terms of the pain and weight that
24 they were putting on your back, correct?

25 A Yes. Yes.

1 Q And you weren't going for cosmetic reasons; you were going
2 to relieve that pain that was causing you pain in your neck and
3 your back; is that correct?

4 A Primarily, but, you know.

5 Q And you had a number of back surgeries before you came to
6 see Dr. Schimpf to address some of the chronic pain you had in
7 your back, correct?

8 A Two, yes.

9 Q And one was in your lower back, and one was in your neck,
10 correct?

11 A Yes, sir.

12 Q And you had an automobile accident that injured a disk in
13 your neck, correct?

14 A Yes.

15 Q And you injured your low back, and you also had to have a
16 cage put in; that's correct?

17 A Two cages.

18 Q Two cages. And you've been under the care of a pain
19 management specialist since about 2008 --

20 A Yes, sir.

21 Q -- for pain related to your back, correct?

22 A Uh-huh.

23 Q Is that a yes?

24 A Yes, sir.

25 Q And through those pain management specialists, they were

1 prescribing you regular narcotics, oxycodone, to help you deal
2 with that pain, correct?

3 A Yes, they did.

4 Q And that's a pain medicine that you required to deal with
5 that pain for some time?

6 A Yes.

7 Q At the initial visit when you saw Dr. Schimpf in July of
8 2016, he took a history from you?

9 A Yes, he did.

10 Q He performed a physical examination?

11 A Yes.

12 Q And he discussed your goals with having surgery?

13 A Yes.

14 Q And he explained to you some of the surgical options?

15 A Yes, he did.

16 Q And you also discussed the risks that were associated with
17 those surgical options, correct?

18 A Yes.

19 Q And you understood from that very first preoperative visit
20 in July of 2016 that those risks included things like not being
21 satisfied with the outcome?

22 A Yes.

23 Q You could get an infection?

24 A Yes.

25 Q There might be a problem with asymmetry, or your breasts

1 becoming different sizes?

2 A Yes.

3 Q And you had a general list of things that you knew could
4 happen with any surgery?

5 A Yes.

6 Q And you knew even there was a risk of death?

7 A Yes.

8 Q And you had the opportunity to talk to Dr. Schimpf about
9 those risks, and he answered all your questions?

10 A Yes, he did.

11 Q There weren't any questions that you had for him that he
12 didn't answer or wouldn't answer for you?

13 A No.

14 Q And you knew that those risks that you talked about were
15 very real, correct?

16 A Yes.

17 Q And, in fact, I think you said you had been all over the
18 internet researching this particular procedure before you decided
19 to have it?

20 A Yes.

21 Q And you were comfortable proceeding knowing that those risks
22 were real?

23 A Yes.

24 Q You had another visit with Dr. Schimpf, I think, before the
25 surgery in October of 2016; is that correct?

1 A Yes.

2 Q And you recall that you signed a number of forms during that
3 visit?

4 A Yes.

5 ATTORNEY SMYTH: Permission to approach, Your Honor?

6 THE COURT: Yes, sir.

7 (Defendant's Exhibit 2 is marked for identification.)

8 BY ATTORNEY SMYTH:

9 Q I'm showing you a two-page document there marked as
10 Defendant's Exhibit 2, and ask you if you recognize that
11 document?

12 A Yes, I do.

13 Q Can you tell us what it is, please?

14 A This is a document that tells you/explains the most likely
15 risks and complications of a reduction that were discussed with
16 me.

17 Q And if you look at the second page of this, is it a document
18 that you signed?

19 A Yes, it is.

20 Q And is it a fair and accurate representation of the form
21 that you signed in the October visit with Dr. Schimpf?

22 A Yes.

23 ATTORNEY SMYTH: At this time, Your Honor, we would offer
24 Defendant's Exhibit 2 into evidence.

25 THE COURT: Any objection?

1 ATTORNEY BURKE: No objection from the plaintiff, Your
2 Honor.

3 THE COURT: It is in.

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

5 ATTORNEY SMYTH: Permission to publish?

6 THE COURT: Yes, sir.

7 BY ATTORNEY SMYTH:

8 Q We're going to put this up on the screen so we can see what
9 you're reviewing here. At the top of that page it says, This
10 breast reduction is usually performed to relieve back, neck, and
11 shoulder pain?

12 A Yes, sir.

13 Q And it says, The best candidates for this procedure are
14 those mature enough to understand and have specific and realistic
15 expectations about the results; is that correct?

16 A Yes.

17 Q And then it goes down a number of bullet-point items that
18 you were asked to initial as having read and understood, correct?

19 A Yes.

20 Q And first one says: That the details of this procedure,
21 including the anticipated benefits and material risks, have been
22 explained to me in the terms that I understand. And did you put
23 your initials beside that?

24 A Yes.

25 Q The next line says: That alternative methods and therapies,

1 their benefits, material risks, and disadvantages have been
2 explained to me. And did you initial beside that?

3 A I did.

4 Q And then the third line, it says: I understand and accept
5 that the most likely material risks and complications of
6 reduction mammoplasty have been discussed with me and may
7 include, but are not limited to, the following: The first one
8 there, does that say asymmetry?

9 A Yes.

10 Q And you've got bleeding?

11 A Yes.

12 Q And changes in nipple and skin sensation?

13 A Yes.

14 Q Delayed healing?

15 A Yes.

16 Q Different size than expected?

17 A Yes.

18 Q Discoloration and swelling?

19 A Yes.

20 Q Discomfort, and in parenthesis it says, pain and
21 sensitivity?

22 A Yes.

23 Q Failure to improve your symptoms?

24 A Yes.

25 Q Infection?

1 A Yes.

2 Q And the next one says nipple retraction or poor contour?

3 A Yes.

4 Q Restricted activity?

5 A Yes.

6 Q And then skin, nipple, flap loss?

7 A Yes.

8 Q Is that correct? And then wound separation?

9 A Yes.

10 Q And then unsatisfactory results?

11 A Yes.

12 Q And it goes on to say, I understand and accept that there
13 are complications, including the remote risk of death or serious
14 disability that exist with any surgical procedure. And did you
15 initial by that?

16 A I did.

17 Q And then the bottom blank there it says, I understand that
18 tissue cannot heal without scarring, and that how one scars is
19 dependent on individual genetic characteristics. The physician
20 will do his or her best to minimize the scarring but cannot
21 control it. Did I read that correctly?

22 A Yes.

23 Q And you initialed that paragraph?

24 A I did.

25 Q And then on the second page of the document it says -- about

1 midway through there -- I'm aware and accept that no guarantees
2 about the results of this procedure have been made; is that
3 correct?

4 A Yes.

5 Q And you initialed beside that as well?

6 A Yes, sir.

7 Q And then on the bottom there's a place for you to sign. Is
8 that your signature?

9 A Yes, it is.

10 Q And there's the date, October 27th?

11 A Yes.

12 Q And your signature was witnessed, it looks like by your
13 friend, Ms. Sareen Sa'd; is that correct?

14 A Yes.

15 Q Sorry. There were a couple more I meant to ask you about.
16 Back at the top there, under the one I highlighted before, it
17 says: I have been advised -- sorry. The one below that. I've
18 been informed of what to accept postoperatively including, but
19 not limited to, estimated recovery time, anticipated activity
20 level, and the possibility of additional procedures. Did I read
21 that correctly?

22 A Yes. Yes.

23 Q And you signed this form and you agreed that you understood
24 that these were all real risks that could happen with the
25 procedure, correct?

1 A I did.

2 Q And I believe you said at the time that you were approaching
3 surgery you were over-the-moon excited to have the surgery
4 despite knowing that these were real risks; is that correct?

5 A Yes.

6 Q And you were shown a number of photos. You had surgery on
7 November 1st, 2016, correct?

8 A Yes.

9 Q And I understand you were probably groggy, in and out of it.
10 You don't have much recollection of what happened during the
11 surgery or any of that time period, correct?

12 A No.

13 Q And you were shown a number of photos during the direct
14 examination, and the first one, I believe, was dated November the
15 6th, so about five days after the surgery; is that correct?

16 A Yes.

17 Q You weren't shown any photos on November 2nd, or November
18 3rd, or November 4th, or November 5th, correct?

19 A No.

20 Q And you were recovering at your friend's, Ms. Ackerman's
21 house, while you stayed at her house and watched her cats while
22 she was on vacation?

23 A I didn't watch the cats but, yes, I stayed at her home.

24 Q And during that initial postop period when you got home, you
25 said you felt -- complained about being light-headed?

1 A I did.

2 Q And your caregivers were in regular contact with
3 Dr. Schimpf, correct?

4 A Yes.

5 Q And you were thought to be dehydrated, and so you got
6 additional fluids and improved, correct?

7 A Yes.

8 Q And you didn't have any conversations with Dr. Schimpf on
9 the 2nd, the 3rd, the 4th, or 5th, did you?

10 A No.

11 Q Are you're not aware of your caregivers having any
12 conversations about your wounds during those time periods?

13 A No.

14 Q And Dr. Schimpf, when your caregivers called, offered to
15 have you come into the office to be seen on November the 2nd,
16 didn't he?

17 A Yes.

18 Q And you didn't take him up on that offer?

19 A I couldn't.

20 Q Did you call 911?

21 A No.

22 Q Did you go to the emergency room?

23 A No.

24 Q But you gradually started to improve over the next several
25 days, correct?

1 A Yes.

2 Q Then you had follow-up visits with Dr. Schimpf's office on
3 November the 8th, November the 15th, and November the 28th,
4 correct?

5 A Yes.

6 Q And no other phone calls in the interim between those
7 visits?

8 A Excuse me?

9 Q No other phone calls with his office in between those
10 visits?

11 A Not that I'm aware.

12 Q There wasn't any time where you called the office and he
13 said, You can't come in, or, I won't see you?

14 A Excuse me?

15 Q There wasn't any time during that window that we just talked
16 about where you would have called and asked to see Dr. Schimpf
17 and he said, I can't see you, or, Don't come in, was there?

18 A No.

19 Q And you were asked a little earlier about having seen
20 another doctor after you saw Dr. Schimpf, I think, for the last
21 time on November 28th. Do you recall that?

22 A I do.

23 Q And do you remember who that doctor was?

24 A Dr. Sonny O.

25 Q Okay.

1 ATTORNEY SMYTH: Permission to approach, Your Honor?

2 THE COURT: Yes, sir.

3 (Defendant's Exhibit 3 is marked for identification.)

4 BY ATTORNEY SMYTH:

5 Q I show you what has been marked as Defendant's Exhibit 3,
6 and ask you if you recognize that document?

7 A This is the first time I've seen this document.

8 Q Do you understand what it is?

9 A May I take time to read it?

10 Q Absolutely. Yes, ma'am.

11 ATTORNEY BURKE: Objection. Hearsay.

12 THE COURT: He asked her if she can identify it.

13 ATTORNEY BURKE: We'll withdraw.

14 THE COURT: Depends on her answer.

15 ATTORNEY BURKE: We will wait until she finishes reading it.

16 THE WITNESS: So what is your question?

17 BY ATTORNEY SMYTH:

18 Q Yes, ma'am. I'm asking you if you recognize what the
19 document is.

20 A These are notes that were taken by Jordan Harper.

21 Q If this was a note from -- I think I handed you the wrong
22 thing. I apologize. That may be what is confusing. I'm sorry.

23 THE COURT: You mismarked it?

24 ATTORNEY SMYTH: I mismarked that No. 3, so I don't know
25 how -- do you want to change that to 4 and move 3 out, or do you

1 want to make that 3?

2 THE COURT: Did she already put a sticker on it?

3 ATTORNEY SMYTH: She did.

4 THE COURT: Just make that 4.

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

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

7 ATTORNEY SMYTH: Permission to approach.

8 THE COURT: Yes, sir.

9 BY ATTORNEY SMYTH:

10 Q Since I didn't recognize the document, I'm going to ask you
11 to do this over again. We've handed you now what's been marked
12 as Defendant's Exhibit 4. And, do you recognize that document?

13 A No, I do not.

14 Q Have you ever seen your medical records from Dr. Sonny O's
15 office?

16 A No.

17 Q Do you dispute that this is a record from his office for
18 that visit?

19 A May I take a moment to read it?

20 Q Absolutely. Yes, ma'am.

21 A Okay. Thank you. Okay.

22 Q You had a chance to read the document?

23 A Yes, I did.

24 Q Does that refresh your recollection as to your visit with
25 Dr. O on November the 29th, 2016?

1 A No.

2 Q It does not. You're not familiar with the contents of that
3 document?

4 A I remember going to see Dr. Sonny O, but I do not remember
5 everything in between that is said here.

6 Q So you don't have any recollection of the items that are
7 contained in Dr. O's notes from that visit?

8 A I remember that this is the first time that I heard, Your
9 right nipple is dead.

10 Q Do you remember the contents of this document, or do you
11 dispute any of the contents of the document?

12 A I don't dispute it. No.

13 Q Does it accurately reflect what happened at the visit that
14 you had with Dr. O?

15 A I do not remember.

16 Q We'll move on. If Dr. O told you that you had a good
17 relationship with Dr. Schimpf and he suggested that you go back
18 to him because you had faith and confidence in him, is that
19 advice you would have followed?

20 A No.

21 Q Did you go back to see Dr. Schimpf the next day?

22 A Yes.

23 Q You don't recall Dr. O telling you that you should return to
24 see Dr. Schimpf?

25 A Yes.

1 Q You do recall that?

2 A I do.

3 Q Moving forward in time, you saw Dr. Schimpf for the last
4 time, I believe, on November the 30th; is that correct?

5 A That is.

6 Q And during that particular visit you didn't express any
7 dissatisfaction to him; is that correct?

8 A No. It's not in my nature to complain, and at this point I
9 still ... I don't know what was going on.

10 Q You were asked a number of questions, too, about the damages
11 and things that you've been through. You don't dispute that
12 you've had a lot of difficult and painful other medical
13 conditions during your life, do you?

14 A No, I do not dispute that.

15 Q In fact, you've been sidelined and disabled since about
16 2012?

17 A I wouldn't exactly say sidelined.

18 Q But you've been disabled since 2012?

19 A Medically is the term, yes, disabled, but I'm still an
20 active person.

21 Q And you've got regular chronic pain still from those
22 conditions in your back that we talked about and from
23 fibromyalgia, correct?

24 A Not the fibromyalgia.

25 Q You dispute that that's part of the reason for your

1 disability?

2 A It was initially.

3 Q It's a debilitating condition that causes pain, correct?

4 A It does.

5 Q And it's something that you're still carrying as a
6 diagnosis?

7 A It's something I maintain.

8 Q And you still require treatment for it?

9 A No, I do not. I know I take care of myself now. I mean, I
10 was diagnosed with it back in 2008, and I'm aware of
11 lifestyle/physical activities. It's a lot of trial and error,
12 but I've learned how to manage on my own.

13 Q It's true that none of the doctors that you've seen have put
14 any limitations on your activities as they relate to your
15 breasts, correct?

16 A No.

17 Q And you still have been able to be active, as I understand
18 it?

19 A Yes.

20 Q And you've still been able to do things like travel, take
21 photographs, spend time with friends, those types of things?

22 A Yes.

23 Q In fact, you posted some of those things on your Facebook
24 page, correct?

25 A Yes.

1 ATTORNEY SMYTH: Permission to approach, Your Honor?

2 THE COURT: Yes, sir.

3 (Defendant's Exhibit 5 is marked for identification.)

4 BY ATTORNEY SMYTH:

5 Q Ms. Turisk, I'm going to show you what's been marked as
6 Defendant's Exhibit 5, and ask you to take a look at it.

7 A You do not have the comments that were under these pictures?

8 Q Which picture are you referring to, ma'am?

9 A In any of these pictures. Under this picture, I had 18
10 comments.

11 Q No. I didn't attach the comments that were made by other
12 people. No, ma'am. I was just going to ask you about the posts
13 that you made.

14 A Okay.

15 Q Do you recognize the items that are contained in Defendant's
16 Exhibit 6 as posts from your Facebook account?

17 A I do.

18 Q Let's go through just a few of those.

19 ATTORNEY SMYTH: I'm sorry, Your Honor. I don't think I
20 moved -- At this time, Your Honor, we'd move Defendant's Exhibit
21 6 into evidence.

22 THE COURT: Any objection?

23 ATTORNEY BURKE: Not from the plaintiff, Your Honor.

24 THE COURT: Is that 5 or 6?

25 THE COURT REPORTER: Five.

1 ATTORNEY SMYTH: Sorry, 5. Got myself offkey earlier. I
2 apologize. All right.

3 (Defendant's Exhibit 5 is received in the record.)

4 BY ATTORNEY SMYTH:

5 Q So let's look at some of these together. December 2016.
6 And what's the date of that photograph?

7 A December 18, 2016.

8 Q So that would have been after you had surgery with
9 Dr. Schimpf and after you had been to MUSC, correct?

10 A Yes.

11 Q And that's a picture with you and your friend having an
12 Italian dinner on John's Island?

13 A Yes.

14 Q What's the date of this next post?

15 A December 31st, 2016.

16 Q Again, after your surgery with Dr. Schimpf and after your
17 time at MUSC, correct?

18 A Yes.

19 Q And on this particular date it looks like you went to
20 Magnolia Plantation?

21 A Yes.

22 Q The next post is now into 2017. What's the date of it?

23 A January 2nd, 2017.

24 Q And it looks like you went back to Magnolia Plantation to
25 look at flowers?

1 A I did. I'm a master gardener. Everything was blooming.

2 Q The next one here, what's the date of it?

3 A This is March the 1st.

4 Q Of 2017?

5 A Yes.

6 Q And again, back at Magnolia Plantation?

7 A I would like to say that when I go to Magnolia Plantation, I
8 will take a variety of pictures. I also use Lightroom, which I
9 will take each picture on different days, look at it, like it,
10 and post it. It does not mean that I went to Magnolia Plantation
11 on that particular day.

12 Q Okay. So this is a picture that you took from your prior
13 visit then?

14 A Yes.

15 Q Okay. The next one is -- what's the date of it, please?

16 A April the 10th, 2017.

17 Q And that's a post about one of your favorite places to go,
18 which is in Jekyll Island, Georgia?

19 A Yes.

20 Q The next picture, what is the date of that?

21 A July 2nd, 2017.

22 Q And it looks like on that day you were a tourist in your own
23 town and used a water taxi to go to several different locations
24 around town?

25 A I did.

1 Q You were able to enjoy that trip?

2 A Yes.

3 Q The next one, what do we have here? The date of this one is
4 what, please?

5 A October 13th, 2017.

6 Q Okay. And does that depict a road trip that you took from,
7 it looks like, Connecticut to Maine that lasted about -- a
8 six-hour drive?

9 A Yes.

10 Q Okay. And this looks like a picture, maybe, from that trip?

11 A Yes.

12 Q And what's the date of it?

13 A This is October 20th, 2017.

14 Q And you were hiking in the Acadia National Park, I believe?

15 A It was an incline. I mean, it wasn't a hike, but to me it
16 was.

17 Q And then on the next visit, it looks like we're October 28th
18 of 2017; is that correct?

19 A Yes.

20 Q And you were able to go to New York and see the sites?

21 A Yes.

22 Q Including the Statue of Liberty?

23 A Yes.

24 Q Next photo is December 22nd, 2017. Is this what you
25 referred to earlier when you said that you liked to photograph

1 ballet?

2 A I do. Yes.

3 Q And you were able to do that at the end of December of 2017?

4 A From a sitting position.

5 Q Moving to 2018. What's the date of this post?

6 A February 26.

7 Q And that's 2018, so we're now --

8 A It doesn't have the date on it.

9 Q Okay. And do you remember taking a trip to Florida where
10 you rode one of the airboats and got to go to an alligator farm?

11 A Yes. These trips were made with my boyfriend, who's
12 retired, and he drove the entire time. I was not driving at all
13 during this period, but I enjoyed the day. I mean, it wasn't 48
14 hours, you know, but he did his best to pull me out of a dark
15 spot I was in and get me out as much as possible, and I enjoyed
16 it.

17 ATTORNEY BURKE: Your Honor, I've had an opportunity -- I'm
18 sorry. I apologize. I have an objection. I've had an
19 opportunity to review the exhibit in full. And counsel has
20 provided dividers with dates on these. The actual posts do not
21 have dates, so I object to everything from those dividers to be
22 in unless the witness can provide the dates. But she's not been
23 asked, I don't think.

24 ATTORNEY SMYTH: It's already in evidence, Your Honor, but I
25 think she's confirmed all the dates. If some of the dates aren't

1 accurate, we can certainly clear that up.

2 THE COURT: I'll allow it.

3 THE WITNESS: To the best of my knowledge.

4 BY ATTORNEY SMYTH:

5 Q Sure. All right. Looking at the next photo, this one has
6 the date of March the 3rd. Do you remember taking a trip to
7 Florida in 2018 around this timeframe?

8 A I do.

9 Q Okay. And you don't dispute that these photos that we're
10 looking at here came from that trip?

11 A No, I do not dispute that.

12 Q And then on this particular set of photos it looks like
13 you're in a plane and maybe got to see a fort there in the Key
14 West area?

15 A Yes, I did.

16 Q The next photo is March the 30th. And do you recall this
17 photo?

18 A It doesn't have the year on it but, yes, I do recall the
19 photo.

20 Q It's a photo that you posted on your Facebook account?

21 A I did.

22 Q It says that you're a week out from surgery and feeling
23 pretty good and heading to the Footlights, which is a theater,
24 right, to photograph some of your favorite dancers?

25 A Yes.

1 Q Is that consistent with your recollection that it would have
2 been in March of 2018?

3 A I do not remember if it was in the month of March, but I do
4 remember photographing the Footlight Players. I do a lot of
5 volunteer work for them. Didn't want to let them down.

6 Q All right.

7 A Something I enjoy. Enjoy giving back to the community.

8 Q Moving forward to the next one, which we believe was taken
9 in 2020, the date of it is February 12th. Do you recall taking a
10 trip out west to Utah?

11 A I do. I do not remember the year. Was this 2020?

12 Q Right.

13 A No. William died January of 2020.

14 Q When did you take the trip to Utah?

15 A Before he died.

16 Q So that would have been in 2019?

17 A No. This was taken -- I saw Dr. Schimpf in -- I believe
18 this was taken before the surgery.

19 Q So you think this was a trip that you and William took
20 before you had breast surgery?

21 A Yes.

22 Q Move on from that one. The same would be true for this one
23 where you went to the national park again, Glacier National Park?

24 A Yes.

25 Q That was part of the trip before surgery then? Or was that

1 taken after surgery?

2 A I believe this was done after the double mastectomy. This
3 doesn't have the year on it. All it says is June 17th, so it's a
4 little confusing.

5 Q I apologize for that. The only way we could take it was a
6 screenshot, and it just doesn't the capture a year when you do
7 that. So that's why I'm relying on you to tell me if the dates
8 are right. The next photo is --

9 A Can you go back to the previous picture, please?

10 Q Sure.

11 A So in the comment above the pictures, it says, This time
12 last year we were on a four-month-long road trip. So this is a
13 picture, an archived picture.

14 Q Okay. Do you know what year it was that you went on the
15 four-month-long road trip out west?

16 A The year is not dated on the screenshot.

17 Q And you just don't recall?

18 A No.

19 Q Okay. We'll move on. The next photo here is July 24th.
20 And it looks like you got a puppy?

21 A Yes, after my boyfriend died I replaced him with a puppy.

22 Q And this was taken in 2020; do you agree?

23 A Yes.

24 Q So that's when you got the dog. And it looks like he's got
25 a lot of energy. Required five walks that day?

1 A To me, it took a lot of energy.

2 Q The next one, this is dated September 11th, and it looks
3 like you went to San Francisco and saw China Town. Do you recall
4 taking that trip?

5 A I do. But again, the year is not on here.

6 Q Do you remember what year it was that you went to San
7 Francisco? And it looks like you also went to Long Beach,
8 California, as well, on that same trip.

9 A Yes. My family was in San Francisco, and my son, my
10 youngest son, was on Long Beach, so I took an opportunity to see
11 him while I was out there.

12 Q Do you remember when that was?

13 A September 11th.

14 Q Of what year?

15 A I'm not really sure. It doesn't have it on here.

16 Q After your surgery?

17 A I believe so. The sad thing is is that you don't have the
18 comment where people say, You know, Rebecca, I'm so happy to see
19 you out and about. You really -- you deserve to enjoy some
20 time --

21 ATTORNEY SMYTH: Objection, Your Honor. Hearsay.

22 THE WITNESS: -- after everything you went through. So they
23 have don't have any comments listed.

24 THE COURT: Ma'am, if there's an objection, you have to stop
25 talking until it's ruled on.

1 THE WITNESS: I didn't hear him.

2 THE COURT: You can only answer a question. You can't just
3 --

4 THE WITNESS: I'm sorry. Sorry about that.

5 THE COURT: You can answer yes or no and then explain, but
6 you can't just put forth a statement without there being a
7 question.

8 THE WITNESS: Okay. I'm sorry.

9 BY ATTORNEY SMYTH:

10 Q That's okay. Just wrapping up here, you agree that
11 Dr. Schimpf didn't do anything on purpose to cause you any
12 injury, correct?

13 A I did know he didn't do it on purpose. I mean ...

14 Q I'm sorry. Were you finished?

15 A I don't think anyone would do that, you know, on purpose.

16 Q And you agree that he always treated you courteously and
17 professionally?

18 A He's very quite, and communication was a little difficult,
19 but he did. He was professional.

20 Q And he was always responsive to you? If you'd call, he
21 would call you back or have you come in to be seen?

22 A Yes.

23 Q And no one has told you that Dr. Schimpf did anything to
24 cause the infections that you ended up having, correct?

25 A Can you repeat that?

1 Q Yes, ma'am. No one has told you that Dr. Schimpf did
2 anything to cause you to have the infections that you had to deal
3 with?

4 A During the original -- during the surgery process?

5 Q Right.

6 A Not during the surgery process. No.

7 Q And Dr. Schimpf was still willing to care for you up until
8 the time you decided to change doctors to MUSC; correct?

9 A That's true.

10 Q And you never told Dr. Schimpf directly that you were
11 dissatisfied with any aspect of his care, did you?

12 A I didn't. I just walked away. My trust in him was done.

13 Q And you're also not claiming that anyone from the practice,
14 any of his staff or any of the nurses or PAs, did anything wrong
15 in this case, are you?

16 A That's right.

17 Q And you agree that the complications that you ended up
18 suffering were all things that were covered with you before the
19 surgery that you decided to have, correct?

20 A Yes.

21 Q Those are all my questions, ma'am. Thank you.

22 A Thank you.

23 THE COURT: Any redirect?

24 ATTORNEY BURKE: Yes, ma'am. With the Court's indulgence.
25 Just a moment, please. Very brief redirect.

REDIRECT EXAMINATION

BY ATTORNEY BURKE:

Q All right. Ms. Turisk, just a couple more questions. The consent forms that you signed prior to the surgery you had with Dr. Schimpf, did those consent forms mention negligence?

A Mentions what? Excuse me?

Q Negligence. Did those consent forms mention negligence?

A No, they do not.

Q Did they mention breach of the standard of care?

A No.

Q And Dr. Schimpf's lawyer asked you, Where are the photos from November 1st, 2nd, 3rd, and 4th? So, are there any photos from November 1st, 2nd, 3rd, or 4th that you're aware of?

A No, there are not.

Q And let's take a look at Defense Exhibit 5. And I want you to flip to the area labeled 2018. Actually, let's back up. I want to go to the July 2nd, 2017, post, if you can find that one.

A July?

Q 2nd of 2017.

A Okay.

Q And could you read your comment to your post to the jury.

A Water taxi. Charleston Waterfront Park, Mount Pleasant Marina. Sullivan's Island. I feel like a real tourist, and I'm very grateful to be healthy enough to enjoy this day. Praise God for everything.

1 Q At that point how far out are you from the double
2 mastectomies performed by Dr. Herrera?

3 A Six or seven months.

4 Q I don't have any further questions. Thank you.

5 THE COURT: You may step down, ma'am. Thank you.

6 Could counsel approach?

7 (Sidebar discussion off the record.)

8 THE COURT: Ladies and gentlemen, it's 12:00. Our next
9 witness is expected to be pretty lengthy, so it's a good time for
10 us to take our lunch break. I need you, today, to take a little
11 bit of an extra lunch break due to another matter that I must
12 handle outside of your presence. It's not related to this case.
13 So if you would return to your jury room at 1:30, we will resume
14 with the trial of this case. Have a nice lunch.

15 (Jury escorted out of the courtroom at 12:00 p.m.)

16 THE COURT: All right. Anything further before we recess
17 for lunch?

18 ATTORNEY BURKE: Nothing from the plaintiff, Your Honor.

19 THE COURT: Okay, thank you. Have a good lunch.

20 (Court recessed at 12:01 p.m. and reconvened at 1:40 p.m.,
21 without the jury present.)

22 THE COURT: Everyone ready to proceed?

23 MATTER(S) OF LAW

24 ATTORNEY MAPLES: Your Honor, before we proceed, it's our
25 understanding that plaintiff intends to call Jordan Harper as

1 their next witness via her discovery deposition. And in
2 preparing for trial, the parties negotiated denudations for
3 Ms. Harper's deposition. However, they disagreed on the
4 inclusion of seven lines, and so we'd like to take that up at
5 this time.

6 THE COURT: All right. Yes, ma'am.

7 ATTORNEY MAPLES: So particularly, the defendants have
8 objected to the inclusion of page 20, lines 13 through 20, as an
9 improper opinion.

10 THE COURT: Do you have a copy for me?

11 ATTORNEY MAPLES: Oh, yes.

12 THE COURT: Oh, is it in the notebook? I'm sorry.

13 ATTORNEY MAPLES: No, I have one handy.

14 THE COURT: Okay. Thank you. What page?

15 ATTORNEY MAPLES: Page 20.

16 THE COURT: Okay.

17 ATTORNEY MAPLES: Lines 13 through 20.

18 THE COURT: So tell me the nature of your objection and what
19 we're looking at here.

20 ATTORNEY MAPLES: Yes. Your Honor, the question calls for
21 an improper question. And we would like to strike not only the
22 question but also Jordan Harper's answer, as it's speculative.
23 So the question is: And what caused that? Do you know? Answer:
24 I am definitely not a plastic surgeon, but so I feel like -- and
25 not physician, you know, but I'm thinking would be just blood

1 flow, an issue with blood flow. Question: Lack of blood flow?

2 Answer: Correct, but, yeah, that's what I think.

3 So for context, Jordan Harper was a nurse practitioner for
4 defendant, and she qualified in her answer that she is not
5 qualified to render an opinion as to what causes -- and directly
6 proceeding that is -- the eschar appearance, as seen in
7 photograph 83 that counsel was referencing in the deposition. So
8 her answer alone qualifies that she is not qualified to render an
9 opinion about what would cause that.

10 And additionally, plaintiff had not laid any foundation in
11 any other portions of the deposition that she should be qualified
12 to render such an opinion. In fact, just subsequent, on page 22,
13 she again qualifies that she is not a physician; she is not a
14 surgeon.

15 So asking her to comment on what would cause the eschar
16 appearance would necessarily require her to speculate. This is
17 outside the scope of her practice as a nurse practitioner.

18 THE COURT: Thank you. Response?

19 ATTORNEY TANENBAUM: May it please the Court.

20 THE COURT: Yes, sir.

21 ATTORNEY TANENBAUM: I took that deposition, I'm pretty
22 sure, which is pretty typical of my meeting out certain portions
23 of things. However, let me say that with her -- I think under
24 Rule 72 -- with her experience and with her practice with
25 Dr. Schimpf, and for a long time taking care of these types of

1 wounds, that she would have the experience necessary to offer an
2 opinion, which she says, I'm not a physician but this is what I
3 believe.

4 Second, and most important, each one of the defendant's
5 experts, the two experts, and the defendant, have all
6 acknowledged that there was the disruption of the blood flow,
7 which is what caused the infection.

8 So I don't really see what the issue is. Everybody
9 acknowledges that this infection was caused by disruption of the
10 blood flow.

11 THE COURT: However, if she wasn't properly qualified to
12 render that opinion as far as her education and training and
13 experience in the deposition, I don't think it's a proper --

14 ATTORNEY O'NEAL: If I may, Your Honor. She actually
15 testified as to her education, experience, and background, which
16 we have designated as portions to be read onto the record. She
17 testified that she was a nurse practitioner with nine years of
18 experience at the time of her deposition as a nurse practitioner;
19 four of those as a -- I'm sorry -- at the time of her deposition;
20 four of those as a nurse practitioner; five years experience as
21 an ICU nurse at MUSC; and experience treating what she quotes, a
22 fair amount of patients receiving this particular implant-removal
23 surgery from Dr. Schimpf, whom she had been working for nearly
24 three years at the time of her deposition.

25 It's our opinion that, in that capacity as a nurse

1 practitioner who had worked with Dr. Schimpf for three years at
2 this point, who had assisted with several patients receiving the
3 surgery, and their postoperative care, and that based on her
4 personal knowledge seeing the patient at that visit, is qualified
5 to give this testimony.

6 THE COURT: I highly disagree, and I don't think it
7 prejudices the other two experts, who basically put that in
8 anyway. So I'm going to agree with that redaction.

9 ATTORNEY MAPLES: Thank you, Your Honor. That concludes our
10 objection to Ms. Harper's deposition.

11 THE COURT: Are we ready to proceed?

12 ATTORNEY BURKE: Yes, Your Honor.

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

14 (Jury seated in the courtroom at 1:47 p.m.)

15 THE BAILIFF: Jurors are all present, Your Honor.

16 THE COURT: Welcome back, ladies and gentlemen of the jury.
17 I hope that you have had a nice lunch. We're now ready to
18 proceed with the trial of this case. You may call your next
19 witness.

20 ATTORNEY ROBINSON: Your Honor, plaintiff calls Jordan
21 Harper by way of deposition testimony. My colleague, Ms. O'Neal,
22 will be reading Ms. Harper's testimony.

23 THE COURT: Yes, ma'am. If you would please come on up.
24 Madam Clerk, if you'd please swear in the witness.

25 MISTY BLACK O'NEAL, duly sworn in, read answers to questions

1 posed in the deposition of Jordan Harper.

2 JORDAN HARPER,

3 having first been duly sworn, was examined and testified by
4 deposition.

5 (Deposition of Jordan Harper was read for the jury, with
6 questions being read by Ty Robinson, Esquire, and answers by
7 Misty Black O'Neal, Esquire.)

8 ATTORNEY ROBINSON: That's the end of the deposition, Your
9 Honor.

10 THE COURT: You may step down, ma'am.

11 ATTORNEY O'NEAL: Thank you.

12 THE COURT: You may call your witness.

13 ATTORNEY BURKE: Judge, the plaintiff will present Dr. Scott
14 Hultman. I need just a minute to get set up.

15 C. SCOTT HULTMAN, M.D.,

16 having first been duly sworn, was examined and testified as
17 follows:

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

20 THE WITNESS: My name is Charles Scott Hultman. Last name
21 is spelled H-u-l-t-m-a-n.

22 THE COURT: Your witness.

23 ATTORNEY BURKE: Thank you.

DIRECT EXAMINATION

(on voir dire)

BY ATTORNEY BURKE:

Q Good afternoon, Dr. Hultman. We're going to talk a little about your background first. Can you just tell the jury if you're married and if you have any children.

A Yes. I am married and have three children, ages 24, 22, and 20.

Q And can you tell us where you went to college and medical school.

A Yes. I attended Brown University for undergraduate, and then went to University of Pittsburgh for medical school.

Q And did you do a residency or a fellowship after medical school?

A Yes. I did my general surgery training at the University of North Carolina, Chapel Hill, and that's also where I did a fellowship in critical care surgery. I then went on to Emory University where I did plastic-reconstructive surgery training.

Q Dr. Hultman, can you tell the jury what it means to be board-qualified or board-certified.

A Yes. Board certification is a way that we can ensure that our physicians are safe to practice medicine and surgery for the public. This is the last step in basically the stamp of approval for these providers after they finish their training, as they are entering practice.

1 Q And are you board-certified?

2 A Yes, I am.

3 Q And have you been recertified?

4 A Yes. I have recertified in all three of my specialties;
5 critical care, general surgery, and plastic surgery.

6 Q How long have you been in practice in plastic surgery?

7 A This is my 23rd year in continuous practice.

8 Q And where have you practiced during the course of your
9 career?

10 A I spent my first 18 years at the University of North
11 Carolina in Chapel Hill. I was recruited back there to join
12 their faculty. And then in 2018 I went to Johns Hopkins as a
13 professor of plastic surgery, and I took over their burn center
14 and ran that for about five years. And then just two months ago
15 I was recruited back to North Carolina where I'm the chair of
16 plastic surgery of WakeMed in Raleigh.

17 Q Are you happy to be back in the south?

18 A Yeah, I'm excited.

19 Q Welcome back.

20 A Thank you.

21 Q Dr. Hultman, have you been published?

22 A Yes. I published books, chapters, and scientific articles.

23 Q And were those articles in peer-reviewed journals?

24 A Yes.

25 Q And can you explain to the jury what a peer-reviewed journal

1 is.

2 A A peer-reviewed journal is a scientific publication in which
3 we have our own research evaluated by our peers, by other
4 reviewers in our field, who then will give us feedback,
5 recommendations, first whether or not it's publishable; secondly,
6 if it is, then how can we improve the manuscript.

7 Q And what is the American Board of Plastic Surgery?

8 A The American Board of Plastic Surgery is one of 24 medical
9 boards that's recognized that confers board certification to
10 plastic surgeons. I was just in Phoenix this weekend giving oral
11 boards for our new candidates and examinees.

12 Q How many members of the American Board of Plastic Surgery
13 are chosen to give the boards?

14 A There are about 30 of us who write the written questions,
15 which I do, and then about, on any given time, about 150 of us
16 who actually give the exam to the candidates.

17 Q And getting back to your publications, what areas have you
18 been published in?

19 A Yes. I published in the areas of breast surgery, breast
20 reconstruction, including one book that I edited in that area,
21 burn care or burn reconstruction, surgical education, and the
22 business of healthcare.

23 Q And what is the Plastic Surgery Foundation?

24 A The Plastic Surgery Foundation is the research and
25 philanthropy arm of the American Society of Plastic Surgeons. So

1 I led that organization about two years as their president.

2 Q As a part of your practice, do you see and perform -- do you
3 perform patient surgery on patients for breast reduction and
4 implant removal?

5 A Yes, I do.

6 Q And how often do you do that in your practice?

7 A Well, when you combine those two operations like what was
8 done here, it's not that frequent. I do anywhere between one to
9 two per year, although in my new practice I've already done two
10 operations like this.

11 Typically I like to stage the operations into two different
12 procedures, but they can be combined and I have done that
13 successfully and safely.

14 Q Why do you like to stage the operation?

15 A Well, I'm always concerned about blood supply to the breast
16 and the body's ability to heal the surgical incisions. It is a
17 safer approach to stage this. There are complicated issues of
18 removing the implants, which may also involve removing capsules
19 that may be 10 - 20 years old and scarred, and then there are the
20 issues of actually reducing the volume of the breast and raising
21 the breasts back up.

22 And for very complicated cases, I think most surgeons would
23 stage these. For more straightforward cases, they can be done in
24 a combined fashion.

25 Q And when you say stage it, what do you mean by staging it?

1 A So, for example, one may elect to remove the implants first,
2 take the capsules out to make sure there are no other problems
3 with the breast, and then once things heal then raise the breast
4 back and up reduce it further. One can also do it the other way
5 around; raise the breast up, and then take the implant out. But
6 I think most of us would remove the implant first if we were
7 concerned about that.

8 Q How many times have you testified in court?

9 A I've done at least 10 trial appearances, roughly one per
10 year for the years I've been doing this expert witness work.

11 Q And how many cases have you been deposed in?

12 A It's been about 50 or 60, which would be about, on average,
13 five to six per year.

14 Q And what do you charge to serve as an expert?

15 A I do an initial review for \$1,800, and then my hourly fee is
16 \$800 an hour for trial and appearance and deposition. And if I
17 have to go out of town, then I might increase that as well.

18 Q How did you arrive at a fee of \$800 an hour to testify?

19 A It's based on two things: One, it's sort of the market rate
20 for experts in my field; but it's also the opportunity costs, to
21 leave my practice and forego a day of surgery and a day of
22 clinic. So that's sort of the break-even point for covering my
23 expenses back up.

24 Q A lot of people think that university-affiliated physicians
25 are teachers. Is there a teaching component to your practice?

1 A There is a teaching component. Yes.

2 Q And is there also a clinical component?

3 A Yes. And that's the main component of what I do, is take
4 care of patients.

5 Q And, Dr. Hultman, have you worked with me and with
6 Mr. Tanenbaum in prior cases?

7 A I worked with your team once before on a case.

8 Q And when is the first time you met Mark and myself?

9 A Yesterday.

10 Q And you mentioned the 10 times that you had testified in
11 court previously. Were you testifying as an expert?

12 A For almost all of those, yes. One or two were criminal
13 cases involving child abuse after burn injury.

14 Q Have you ever been found unqualified to testify in court in
15 a case?

16 A No.

17 ATTORNEY BURKE: At this time, Judge Murphy, I move to a
18 admit Dr. Hultman as an expert witness in plastic surgery.

19 THE COURT: Any voir dire?

20 ATTORNEY SMYTH: Defendant has none, Your Honor.

21 THE COURT: He's qualified.

22 ATTORNEY BURKE: Thank you.

23 **DIRECT EXAMINATION**

24 BY ATTORNEY BURKE:

25 Q And, Dr. Hultman, will you agree that any opinions that you

1 express today, that you're going to give those to a reasonable
2 degree of medical certainty?

3 A Yes, I will.

4 Q Dr. Hultman, when were you first contacted about Rebecca
5 Turisk's case?

6 A This was before our pandemic, and it was, roughly, in 2018,
7 perhaps.

8 Q Do you know how much you billed for your work on Rebecca's
9 case?

10 A The total billing is between 5- and \$6,000 to this point,
11 not including today's appearance.

12 Q Have you reviewed the medical records for Ms. Turisk?

13 A Yes, I have.

14 Q What do those records include?

15 A Those include her records from Dr. Schimpf and his
16 colleagues, records from emergency room visits, and the MUSC
17 records, which are mostly condensed.

18 Q Is that an exhaustive list of what you reviewed?

19 A I believe it is. Yes.

20 Q And have you reviewed any of the depositions in the case?

21 A Yes, I have.

22 Q And have you reviewed Dr. Schimpf's deposition?

23 A Yes.

24 Q Did you form an opinion as to whether there was a breach of
25 the standard of care in the procedure performed by Dr. Schimpf on

1 November 1st of 2016?

2 A Yes, I have reached an opinion about that.

3 Q And what is your opinion?

4 A I believe that the standard of care was not met in that the
5 wrong approach was used for breast-reduction procedure.

6 Q Did you find any other breaches of the standard of care?

7 A I do have one other opinion, and that is that, as the
8 plaintiff was going through her postoperative period, there was
9 window in which antibiotics should have been started earlier than
10 they were, so I do believe that the initiation of antibiotics
11 should have been done on early in that process and the standard
12 of care was breached by not giving those antibiotics.

13 Q Dr. Hultman, we're going to take those two opinions
14 separately. So we'll start first with your first opinion. Can
15 you explain why you believe that Dr. Schimpf violated the
16 standard of care in his surgical technique? And I believe we
17 have some demonstratives to help you with that.

18 A Sure. Would you like me to --

19 Q If you would like to come down, you're welcome to --

20 A Sure.

21 Q -- or we can set them up so that you and the jury can see
22 them.

23 A It might be easier just to say a few forewords first about
24 it to answer your question, and then go to those pictures.

25

1 Q Perfect.

2 THE COURT: Counsel, if you could set them up over there,
3 that way I can see as well.

4 THE WITNESS: So I think that the key principle in this case
5 is that the wrong operation was chosen to do the
6 breast-reduction/implant removal, and that's because the patient
7 had previous surgical scars that compromised the blood supply to
8 the nipple and part of the breast, and that a different approach
9 could have been done to greatly improve the safety of the
10 operation and to ensure success.

11 So that's really what my main opinion is. And I'd be happy
12 to demonstrate why that would be in terms of the anatomy.

13 BY ATTORNEY BURKE:

14 Q Sure. I'm going to take it over there so that the Judge can
15 see. I'm trying to figure out how to do this.

16 THE COURT: He can stand right next to it, if that works.

17 ATTORNEY BURKE: Okay. I just want the jury to be able to
18 see these. Everybody's got to be able to see them, so I'm trying
19 to figure out. Is there a favorite spot?

20 THE COURT: How about maybe in front of the bailiff right
21 there and kind of facing us. And that way the jury can see from
22 that angle.

23 ATTORNEY BURKE: They can turn around. Okay. All right.

24 THE COURT: Can everybody see okay?
25

1 BY ATTORNEY BURKE:

2 Q Dr. Hultman, were you here this morning when Rebecca Turisk
3 testified?

4 A I was here in the courtroom. Yes.

5 Q Did you see her draw her scars on this -- that's not the
6 right one. Where -- there was a -- this one does not have the
7 exhibit sticker on it.

8 THE WITNESS: It's right here.

9 ATTORNEY BURKE: All right. That's what I'm looking for.
10 Okay. Now we're on track.

11 BY ATTORNEY BURKE:

12 Q Dr. Hultman, again, you were here this morning when Rebecca
13 testified, correct?

14 A Yes.

15 Q And you saw her indicate her scars on Exhibit 4?

16 A Yes.

17 Q Okay. What is the significance, if any, to the placement of
18 Rebecca's scars?

19 A So these scars were used to access her breasts for her
20 breast augmentation over 20 years ago. It might be helpful for
21 me to emphasize those scars, or should we --

22 ATTORNEY TANENBAUM: Do not mark up the exhibit.

23 BY ATTORNEY BURKE:

24 Q We need to create a new exhibit.

25 A I don't know if we can see these scars compared to where I

1 may be drawing.

2 Q All right. Let me get you a new exhibit.

3 A So when assessing a patient like this for breast-reduction
4 surgery and implant removal, you have to incorporate the
5 patient's body shape, how much smaller they want to be, how much
6 breast tissue's coming out, but probably as important or more
7 important, where the surgical scars are from any previous
8 surgeries because that will influence how you make your new
9 scars, your new incisions.

10 So she had previously drawn out the scars right there. And
11 this would have been the approach 20 years ago to put in her
12 implants. There are several different ways to put in breast
13 implants. In this particular technique, the incision is made
14 below the nipple complex. That tunnel is made all the way down
15 to the base of the breast, and the breast is lifted off the chest
16 wall, and the implant's placed under that.

17 Another approach is to actually make that cut at the base of
18 the breast, under the breast, at what's called the inframammary
19 fold, and the implant goes behind that.

20 And you can also do this through a scar in the armpit, and
21 you can do it through the umbilicus, although those two methods
22 are not as common.

23 So when you look at these incisions, you have to then
24 modify, or plan, your new operation so that you want to preserve
25 blood flow to the nipple, and sensation, if you can.

1 Should I show the blood supply to the breast now?

2 Q Sure.

3 A So we have another picture which demonstrates the blood
4 supply to the breast. And this is her right breast, just like
5 Rebecca's. Here is her nipple complex. And, as you can see,
6 there's a cluster of blood vessels, so the nipple has very good
7 blood flow normally, but it can be divided into three main
8 territories: So there's a territory from the middle part of the
9 breast that comes out underneath your breastbone; there's a
10 territory that comes out laterally from the chest wall here; and
11 then there are blood supply vessels that come from the top, as
12 well as out from the chest wall.

13 So you have to save some version of this plexus of vessels
14 if you want the blood supply to the nipples to remain intact.
15 And if you make this incision first below the nipple, then you
16 sort of cut off that potential blood supply from below, meaning
17 that you have to rely on blood supply from the sides, medially or
18 laterally or from the top, when you make your new
19 breast-reduction surgery. And should we show this?

20 Q Please.

21 A So we have, fortunately, a lot of different operations to
22 choose from to do a breast reduction, and these are all based on
23 surgery preference and training but mostly anatomic reasons.

24 So again, if a patient wants a really big reduction, you
25 might pick this operation because it takes out the most skin and

1 the most volume. If they have very, let's say, narrow breasts,
2 you might want to pick another type of operation in which you
3 don't really need to take out much tissue but just lift the
4 breast.

5 In Rebecca's case, she had operation no. A, or letter A.
6 I'm sorry. And this is called the inferior pedicle. You
7 basically make this sort of anchor-type incision. The nipple is
8 kept alive on tissue that goes straight down to the inframammary
9 fold.

10 So this is an inferior pedicle, meaning the blood supply is
11 going to come up from the bottom into the nipple, but essentially
12 you're cutting off blood supply from the lateral side, the medial
13 side, and up above, relying on blood supply here, as well as on
14 the backside of the nipple, the chest wall.

15 So the reason why I believe that the standard of care was
16 breached is that, in Rebecca's case, she has, first of all, an
17 implant behind the nipple, so that blood supply is gone; that you
18 might have small, little branches that come out from the chest
19 wall. There's an implant behind there.

20 And secondly, she has a scar that presumably crosses most of
21 this surface area, meaning that any blood supply down here is
22 going to stop as soon as it gets near the nipple. So in that
23 case, you go to a different technique.

24 And I like this particular technique. It's a superior
25 pedicle in which the nipple's blood supply is from the top. Many

1 of my colleagues like to do a, what's called a, medial pedicle.
2 It's very similar to these two operations, except you're going to
3 rely on blood supply from over here, which may be a little bit
4 more robust, and this nipple transposes up into here and this
5 closes down here.

6 So in each of these scenarios you must leave the nipple
7 attached to tissue that has a good, solid blood supply. And
8 remember, it's not just the nipple that has to survive, but it's
9 also the breast tissue itself, so there's a whole cone of breast
10 tissue underneath this nipple that also is relying on a blood
11 supply.

12 And going back to the original operation that she had, her
13 breast augmentation, remember, this was done through the
14 circumareolar incision. And the reason why this is particularly
15 problematic when you make this plan is that not only now you have
16 this scar right here where the blood is not going to get up to
17 the nipple, but, remember, when her implants were put in, the
18 original surgeon had to tunnel down, around, and up in the chest
19 to put that implant in, so the entire blood supply under this
20 tunnel, under this piece of skin, is also disrupted. So we're
21 dealing with a scar that's on the surface like you might see for
22 a breast biopsy, but we're also dealing with a scar that goes the
23 whole way down to her inframammary fold.

24 And that's why, in this case, she would have been an
25 excellent candidate for the inverted-T anchor pattern but basing

1 it on a medial skin pedicle, or superior, not inferior.

2 Q Dr. Schimpf [sic], if you could indicate the technique you
3 were just describing on the poster. Either circle it or put a
4 checkmark by it.

5 A Yes. There was another photograph that I think we had, or a
6 schematic, that showed three different versions of an inverted-T.
7 So if you weren't comfortable with circumvertical, or vertical
8 pedicle, or even what's called a horizontal/no vertical scar, you
9 still have three choices with this technique that was chosen.

10 In this case, it will become more apparent. So if we decide
11 that this anchor incision is the best for her to take out tissue
12 from here, here, and here, then we wouldn't want to do this
13 because we know that blood supply to the nipples can be very,
14 very tenuous, or nonexistent.

15 Instead, you would design your pedicle medially or
16 superiorly, with the nipple going up and then these points
17 meeting down here to cover everything up.

18 So again, if we were to choose this overall technique, you
19 would do B or C and not A.

20 Q And, Dr. Schimpf [sic], you reviewed -- Dr. Hultman. I'm
21 sorry. You reviewed Dr. Schimpf's chart?

22 A Yes. You want me to sit back up here?

23 Q Yes, you may go back to the witness stand. Dr. Hultman, I
24 am going to hand you that photograph. Take a look at that and
25 see if you recognize that photo.

1 A Yes. This is an interoperative photograph, presumably from
2 the day of surgery, November 1st, 2016, in which the patient's
3 implants that have been removed are shown, as well as breast
4 tissue, skin, and breast capsule.

5 Q Was this photograph something that you considered in forming
6 your opinion as to the breach of the standard of care?

7 A Yes, it was, actually.

8 Q In what way?

9 A Well, first of all, it's a nice photograph in that it
10 documents what's been taken out of the patient. But it
11 demonstrates that quite a bit of breast tissue has been removed,
12 as well as the capsules, which would have been indicated
13 potentially based on findings, but by removing the capsules,
14 that's another problem because that will diminish the blood
15 supply to remaining breast tissue.

16 So these are important photographs just documenting the
17 thoroughness of the reduction but also suggesting additional
18 problems with the blood flow.

19 ATTORNEY BURKE: Is there any objection to moving that
20 photograph into evidence?

21 ATTORNEY SMYTH: No.

22 ATTORNEY BURKE: Your Honor, at this time I'd like to move
23 Exhibit, Plaintiff's Exhibit, 21 into evidence and publish to the
24 jury.

25 THE COURT: Any objection?

1 ATTORNEY SMYTH: No, Your Honor.

2 THE COURT: All right. It's in.

3 (Plaintiff's Exhibit 21 is marked for identification.)

4 (Plaintiff's Exhibit 21 is received in the record.)

5 BY ATTORNEY BURKE:

6 Q And, Dr. Hultman, the jury can now see what's been marked
7 Exhibit 21, so if you could tell the jury what they're looking
8 at.

9 A Yes. So this is the type of picture that we take in the
10 operating room when we remove body parts and implants. You see
11 two intact silicone implants at the bottom, marked right breast
12 and left breast. And on top of that, the sort of orange-red-tan
13 tissue is breast tissue, skin, and then especially on the left
14 side, you can see the scarring, or the capsule, that was taken
15 off.

16 The volumes are also noted; total of 740 grams on the right
17 side, 700 grams on the left. And I believe that represents the
18 combined volume, or weight, of the implant, plus the breast
19 tissue, so we're looking at 1440 grams, 1.4 kilograms, which
20 would be in the order of several pounds of tissue.

21 Q And have you reviewed Dr. Schimpf's operative report?

22 A Yes, I have.

23 Q And can you explain to the jury how the implants were
24 removed and the breast size was reduced?

25 A Yes. The operative note mentions the creation of this

1 pedicle to help preserve blood flow to the nipple, 10 centimeters
2 wide. It also mentions then the removal of the breast tissue
3 from the medial, or inner part, of the breast, going up to the
4 top of the breast, and then going out lateral, to the side of the
5 breast.

6 And I believe that the implants were taken out when some of
7 that tissue was removed and the capsule was opened, so that may
8 have occurred on the outer portion of the breast when that
9 capsule was opened and the breast tissue was removed.

10 Q Does this chart discuss in detail the procedure used for the
11 breast reduction?

12 A Well, the operative note gives me enough information to know
13 what he did. There really isn't much discussion preoperatively
14 about why he chose this technique and why this would be the best
15 technique for her.

16 Q Does Dr. Schimpf's chart indicate the presence of scars from
17 the prior implant-replacement surgery?

18 A No. Those are not mentioned at all in the chart, nor his
19 operative report.

20 Q Why was it important to note that?

21 A Well, it's perhaps the most critical part of this entire
22 procedure, is to know where those surgical scars are. And you
23 would need to notate those for your own recollection in the
24 initial consultation, and then in the operative notes you should
25 dictate those as a roadmap to know what you're doing and then why

1 you did what you did.

2 So it's really essential to include that kind of data,
3 because the data is so critical for the outcome of the operation.

4 Q Dr. Schimpf's lawyer told the jury in his opening statement
5 that the technique that Dr. Schimpf selected for Rebecca was the
6 gold standard and the most commonly used technique for removal of
7 breast implants and reducing the breast size. Do you agree with
8 that statement?

9 A Well, I do agree that the Wise pattern for this inferior
10 pedicle, inverted-T, is the sort of the gold standard and is the
11 most common operation used for breast-reduction surgery,
12 especially in the United States.

13 However, it would not be used at all for this particular
14 situation. This would be extremely rare to use this particular
15 operation with the knowledge ahead of time that there were
16 serious risks to the nipple and to the breast tissues.

17 So I would not call this the gold standard for this patient
18 whatsoever. I would call this a wrong operation and a
19 contraindicated operation.

20 Q So when you say that the operation was contraindicated for
21 Rebecca, what does this mean?

22 A That means that you would not select this particular
23 operation. There are reasons to not do it, accurate reasons.
24 There are reasons -- it's not just a matter of patient preference
25 or doctor preference, but it would be considered a dangerous

1 operation, an operation that would have a high chance of failure.

2 Q Dr. Schimpf [sic], I'm going to hand you some photographs
3 that were admitted into evidence earlier today when Ms. Turisk
4 testified. If you can just take a look at those and see if you
5 recognize those photographs.

6 A Yes, I do recognize the photographs. They are her
7 postoperative photographs showing different stages of healing.

8 Q Could you take a look at the photograph dated November --
9 well, there are actually two photographs dated November 6th.

10 ATTORNEY SMYTH: Your Honor, may I see what the witness has
11 been handed?

12 THE COURT: Yes, sir.

13 ATTORNEY BURKE: I'm sorry. I apologize. And for the
14 record, Your Honor, I have handed Dr. Hultman Plaintiff's Exhibit
15 5, Plaintiff's Exhibit 6, Plaintiff's Exhibit 7, and Plaintiff's
16 Exhibit 8, and Plaintiff's Exhibit 9.

17 THE WITNESS: Thank you.

18 BY ATTORNEY BURKE:

19 Q Dr. Hultman, I want to turn now -- well, first of all, the
20 photographs that you've been handed, have you seen those
21 photographs prior to today?

22 A Yes, I have.

23 Q And did you rely on those photographs in forming your
24 opinions in this case?

25 A Yes.

1 Q And I want to turn now to the second part of your opinions.
2 And I believe you indicated that, in addition to choosing the
3 incorrect surgical technique, you also believe Dr. Schimpf
4 violated the standard of care with relation to the use of
5 antibiotics?

6 A Yes.

7 Q Okay. Can you explain that opinion to the jury.

8 A Yes. I'm basing this on the picture from November 6, 2016.
9 I am looking at her right breast, with some soiled Steri-Strips.
10 There appears to be significant bruising of the tissues and
11 swelling. And of greatest concern, the nipple itself is
12 struggling, to put it mildly. It looks like it's very dark, has
13 poor blood flow.

14 So the standard of care would be to remove these
15 Steri-Strips at this point in time and apply a topical
16 antibiotic. There's nothing to indicate that she has a systemic
17 infection at this time so I would not feel compelled to start a
18 whirl of antibiotic, but because the tissues are now struggling,
19 this represents a potential portal for bacteria to get in. So
20 you would want to coat the suture line with an antibiotic at this
21 point.

22 Q Is there anything else you would have done at that point?

23 A I think standard of care would just be to wear a padded bra
24 with some gentle compression to take tension and pressure off
25 this repair. And then I would have a very short follow-up, maybe

1 see her within a week, depending on her, of course.

2 Q Based on your knowledge of Rebecca's record, what resulted
3 from the breaches of the standard of care that you just
4 described?

5 A Well, ultimately she required a complete mastectomy on the
6 right side and a partial mastectomy on the left, but in the short
7 run she ended up with a very severe infection on the right side,
8 with complete loss of the nipple, severe fat necrosis which
9 continued to progress with infection, and ultimately loss of
10 those tissues.

11 And on the left side, it was a very, very close call. She
12 ended up almost losing her nipple. Looks like she lost about a
13 third of that, but the rest of it did regenerate. But, as we
14 know, she ended up having to have a partial mastectomy there for
15 fat necrosis.

16 Q Based on your review of this case, do you have an opinion as
17 to whether Rebecca did anything to cause the fat necrosis and
18 infection?

19 A There is nothing in the record that indicates that she did
20 anything to hasten this course or to cause this.

21 Q Did Rebecca's use of any of her medications have anything do
22 with the fat necrosis and infection?

23 A I don't believe so.

24 Q And in particular, did you see anything in Rebecca's medical
25 records to indicate that her use of steroids contributed to the

1 outcome?

2 A I don't believe so. There is a record of her getting
3 steroids intermittently, but you have to qualify that. You know,
4 there's occasional use of steroids which might have a minor
5 effect on healing, but then there are patients who are on
6 full-blown steroids for organ transplants, and so that latter
7 group you might worry about healing, but not in someone like
8 Rebecca.

9 Q Did the fact that Rebecca have fibromyalgia have any impact
10 on her outcome?

11 A Had none.

12 Q Did Rebecca's records reveal that she took her medications
13 as prescribed and directed by her physician?

14 A Yes.

15 Q And do the records reveal that she kept her follow-up
16 appointments with Dr. Schimpf and her providers?

17 A Yes.

18 Q Is there any significance, in your opinion, to -- well, let
19 me ask you this. Are you aware of the result of the wound
20 cultures that were performed on Rebecca by her caregivers?

21 A Yes, I am.

22 Q And what did those wound cultures reveal?

23 A The cultures end up growing out several organisms, including
24 gram-negative rod. I can't remember which specific one it was,
25 but it was a multiple antibiotic -- or, multiple bacterial

1 infection. I think it was either enterococcus or E. coli. I
2 can't remember which one it was.

3 Q Does enterococcus faecalis ring a bell?

4 A Yes.

5 Q Was that one of the organisms that Rebecca grew?

6 A Yes, I believe that was.

7 Q Is there any significance, in your opinion, as to the fact
8 that that particular antibiotic -- I'm sorry -- that particular
9 bacteria was found in Rebecca's breast wound?

10 A Not at all. As someone who's taken care of wounds for 23
11 years, any bug can grow in any wound on the body. The key is
12 whether or not that wound has blood supply. So, yes, some
13 transplant patients end up with very bizarre infections, but
14 enterococcus, if the tissue is not viable and it's necrotic, it
15 can get infected with enterococcus.

16 Q And the fact that Rebecca's -- one of the bacteria in
17 Rebecca's wound was enterococcus faecalis, does that suggest to
18 you in any way that Rebecca or her caregivers did anything to
19 cause that?

20 A No, not at all.

21 Q And why is that?

22 A Well, first, that's a common bacteria that we see in
23 healthcare settings. Patients who are admitted in hospitals or
24 clinics may be exposed to those bugs and can get those
25 infections.

1 Yes, there are cases where poor hygiene might cause this,
2 but that's where there's a deliberate act to sabotage the wound
3 or the tissue, and there's no evidence in this case that that
4 occurred.

5 Q And so if I understood you correctly, enterococcus faecalis
6 is also a hospital-borne infection?

7 A Yes.

8 Q And is it -- I hate to be -- is it a bacteria that we're all
9 exposed to every day?

10 A Yes. We all have it in our bodies right now.

11 Q Can you explain why more of the left breast tissue survived
12 than the right?

13 A Well, I think that when I put these two sets of tissue
14 together and try to come up with a theory, the previous incisions
15 clearly had an impact on wound healing, and it's possible that
16 the pedicle on the left side might have been shifted over
17 somewhat, allowing some blood flow to part of the nipple, whereas
18 the pedicle on the right side clearly had that scar across it
19 right in the middle.

20 So that's my theory, is that there may have been a shift in
21 where that was placed to account for some of that reserve blood
22 flow.

23 Q And, Dr. Hultman, do your ... Give me one second. In your
24 practice as a plastic surgeon, do you discuss the risk of surgery
25 with your patients?

1 A Yes, I do.

2 Q And if you were to see a patient like Rebecca and
3 consultation for removal of her implants and a breast reduction
4 and the lift, what would be your discussion of the possible risks
5 associated with that procedure?

6 A Well, first I would tell her that your risks are going to be
7 higher than a standard breast-reduction procedure, or a standard
8 explantation procedure. If we're going to do both procedures at
9 the same time, there's a higher risk that you're going to get the
10 typical complications you might expect; likely being infection,
11 tissue loss, need for revision, fat necrosis.

12 In all that come in for a breast reduction, perhaps one out
13 of 50 might lose their nipple. That, maybe, is a generous
14 number. In my own practice, I've lost one in 23 years.

15 But what I would tell them is that adding additional risk
16 factors makes it more complicated. So if you're a smoker, if
17 you've had radiation, if you're diabetic, all of these things
18 just keep adding risks to the operation.

19 And I think that the placement of incisions on a breast
20 absolutely has to be discussed and reviewed and accommodated. I
21 think the surgeries can be done safely but, again, you have to
22 modify your plan or go to a different type of breast reduction,
23 as we talked about.

24 Q Dr. Hultman, I'm going to hand you what was marked earlier
25 today as Defendant's Exhibit 2. If you could take a look at

1 that.

2 A Yes.

3 Q What is Defendant's Exhibit 2?

4 A It's a consent for surgery, indicating the risks of the
5 operation. And the risks are all initialed by the patient.

6 Q And, Dr. Hultman, do your patients sign a document similar
7 to Defendant's Exhibit 2?

8 A They do sign a document for consent which lists the name of
9 the procedure, the surgeon. We might add on there some specific
10 complications that we're concerned about, or risks. In general,
11 we don't go into this level of detail, but we have a place where
12 we can add these to the consent.

13 Q And, Dr. Hultman, you reviewed Exhibit 2 before today,
14 correct?

15 A Yes.

16 Q It was in Dr. Schimpf's chart?

17 A Correct.

18 Q So does Defense Exhibit 2, the informed consent form, is
19 there anything in that form that says that if a patient signs
20 this form the doctor is not liable for a breach of the standard
21 of care?

22 ATTORNEY SMYTH: Objection, Your Honor. That's outside the
23 scope of the testimony. She's asking for a legal conclusion and
24 not a medical conclusion.

25 ATTORNEY BURKE: I'll withdraw it.

1 THE COURT: Thank you.

2 ATTORNEY BURKE: Thank you, Judge.

3 BY ATTORNEY BURKE:

4 Q And, Dr. Hultman, when Dr. Schimpf performed the inverted
5 pedicle -- the inferior pedicle, Wise pattern, did he technically
6 execute the procedure properly?

7 A Yes. The operation looks like it was done well, just
8 ignoring those previous scars.

9 Q And in your opinion was there ever a time when Dr. Schimpf
10 executed this procedure -- I mean, what were the odds of it
11 turning out well?

12 A Well, I think this result was predictable, unfortunately.
13 This is exactly what I would have thought would have happened, so
14 I would never do this operation in this patient.

15 Q Bear with me one moment. Dr. Hultman, I want to go back to
16 your earlier testimony about the preexisting scars from the
17 implant surgery of about, you know, 20 or 25 years ago. Can you
18 explain to the jury how that scar is formed beneath the skin? I
19 mean, we see the little line on there, but it's hard to know
20 what's going on inside the breast.

21 A Yes. So the implants that were placed have to go either
22 around the breast or through the breast to get behind the breast.
23 You're not going to go through the breast, because that's a lot
24 of surgery, that's a lot of bleeding, you're going to destroy the
25 breast architecture. So almost everybody would go around the

1 breast. And, therefore, to get around the breast from the
2 nipple, you'd have to tunnel, or dissect, under the skin, all the
3 way down to the bottom of the breast.

4 And what's happening here is that that tunnel is disrupting
5 all of that blood supply between the breast and the skin on the
6 outside. So there may be some healing that will occur and some
7 new blood supply that occurs, but it will never be as robust as
8 the original breast.

9 And I would never do a breast reduction like this on that
10 type of patient in which I knew that the skin had been lifted off
11 the breast and put back down. It just would not be reliable
12 enough when there are other very good operations that could have
13 been done.

14 ATTORNEY BURKE: Your Honor, I would like to admit the
15 demonstrative exhibits that Dr. Hultman used in his testimony
16 today into evidence.

17 THE COURT: Any objection?

18 ATTORNEY SMYTH: Yes, Your Honor. Those are for
19 demonstrative purposes. They don't at all emulate the
20 plaintiff's actual records in this case, so I don't think
21 demonstrative exhibits should go back into the jury room.

22 BY ATTORNEY BURKE:

23 Q Dr. Hultman, the exhibits that we used today in the course
24 of your testimony, or the demonstrative exhibits, are those
25 similar to demonstratives that you would use as a teaching

1 physician in a university hospital?

2 A Yes, they are.

3 Q Okay. Are these standard pictures of breast tissue?

4 A Yes.

5 Q Are they accurate depictions of -- well, I guess we'll do it
6 one by one. Let's start with this one. And, Dr. Hultman, I
7 think you've explained to the jury what this depicts, but is this
8 an accurate depiction of the blood supply to the breast tissue?

9 A Yes, it is.

10 ATTORNEY BURKE: At this time, Your Honor, I would move -- I
11 would move this exhibit into evidence.

12 THE COURT: The blood supply. Anything?

13 ATTORNEY SMYTH: I still object, Your Honor. I don't think
14 there's any basis on putting that into evidence. It's not part
15 of the medical record. It does not represent the blood supply
16 that we're dealing with in this particular case.

17 THE COURT: Your objection's overruled. I think it's
18 relevant, and its probative value outweighs the prejudicial
19 effect.

20 ATTORNEY BURKE: Thank you very much, Your Honor.

21 (Plaintiff's Exhibit 22 is marked for identification.)

22 (Plaintiff's Exhibit 22 is received in the record.)

23 BY ATTORNEY BURKE:

24 Q Dr. Hultman, we used this demonstrative earlier in your
25 testimony. And is this demonstrative of the seven different

1 various skin resection patterns and pedicles for breast
2 reduction? Is this an accurate depiction of the various skin
3 resection patterns and pedicles for breast reduction?

4 A I would say that this represents seven approaches. There
5 may be more that are out there, as well, that are variants of
6 these, and not all of these are going to be done in most
7 patients, but these are seven different operations that one can
8 choose from when planning a surgery for a patient.

9 Q And is this an example of something that you would use as a
10 teaching physician in a university hospital?

11 A Yes. We have these.

12 ATTORNEY BURKE: At this time, Your Honor, I would move the
13 various skin resection patterns and pedicles for breast reduction
14 into evidence.

15 THE COURT: Same objection?

16 ATTORNEY SMYTH: Yes, Your Honor. And I think he just said
17 those aren't techniques that he would recommend in every patient,
18 so I don't know that the relevancy has been established.

19 BY ATTORNEY BURKE:

20 Q Dr. Schimpf [sic], is there a technique on this board that
21 you would recommend in a patient such as Rebecca Turisk, or is it
22 on --

23 A Yes. I would actually recommend one on the other page.

24 Q On the other board?

25 A So the initial one.

1 Q We will not use this one.

2 A I would recommend either B or C, with the medial or superior
3 pedicles.

4 Q And if you wouldn't mind, do you still have -- do we have a
5 marker here?

6 A Yes.

7 Q If you could just come down and maybe notate on here clearly
8 the two that you think are acceptable for Rebecca and the one
9 that you think is not acceptable.

10 A We'll put a check on this one. This would be reasonable.
11 And I would not do this.

12 Q And while you're up here, is this poster that we've been
13 marking up, is this an accurate depiction of the three patterns
14 for creating a pedicle in reducing the breast?

15 A Yes.

16 ATTORNEY BURKE: Your Honor, at this time I would move this
17 picture into evidence.

18 THE COURT: Any objection?

19 ATTORNEY SMYTH: Same objection.

20 THE COURT: Same ruling. It is relevant, and its
21 prejudicial effect is outweighed by the probative value.

22 ATTORNEY BURKE: Thank you, Judge.

23 (Plaintiff's Exhibit 23 is marked for identification.)

24 (Plaintiff's Exhibit 23 is received in the record.)

25

1 BY ATTORNEY BURKE:

2 Q Dr. Hultman, earlier when we reviewed your qualifications I
3 failed to mark your curriculum vitae as an exhibit.

4 ATTORNEY BURKE: So, I don't know if there's any objection.

5 ATTORNEY SMYTH: Yes, Your Honor. His qualifications are
6 already in the record. I think it's cumulative. The CVs
7 typically do not go back as evidence.

8 THE COURT: I'll sustain that objection.

9 ATTORNEY BURKE: Thank you, Judge.

10 BY ATTORNEY BURKE:

11 Q Dr. Hultman, you testified earlier today that you write
12 questions and give oral boards for the board certification; is
13 that correct?

14 A Yes, that's correct.

15 Q If you presented Rebecca Turisk as a patient to a board
16 candidate and they responded to the question, either oral or
17 written, as to which approach would be appropriate for that
18 patient, if the candidate responded with the approach that
19 Dr. Schimpf used, what grade would you give that candidate?

20 A Well, let me qualify my answer by saying that the way in
21 which we evaluate candidates is confidential, so I can't get into
22 the details of the different components. In applicants --

23 Q Well, just as a hypothetical.

24 A Yes. So an applicant to the board who, either it's their
25 case or it's an unknown, we would grade them on a number of

1 different parameters, and I can say, based on their medical
2 knowledge, their performance, and their safety. And I would
3 definitely give very low scores for some of those components.

4 I can't state if I would actually, quote, fail a person, but
5 that is for the rest of the examiners to decide.

6 Q But, in your opinion, the answer would have been incorrect?

7 A Yes.

8 Q All right. Apparently I'm not quite done, Dr. Hultman, and
9 I apologize. I'm close. Okay. What is the significance to you
10 of the fact that Rebecca's implants had been in place for 25
11 years at the time of the surgery?

12 A Well, again, the fact that she has implants that are this
13 old, to me, would indicate a number of different things. First,
14 I'd want to find out if they were ruptured or not beforehand,
15 because that would affect how we took them out.

16 Secondly, I would assess the amount of scar tissue that she
17 had around the implants, because that might also need to be
18 removed. And we now know that there are breast cancers
19 associated with breast implants. So all this has to be worked up
20 before you begin with the surgery.

21 But the placement of those implants, to me, is an alarm that
22 goes off that means I have to be very, very, very careful about
23 how I preserve blood supply to her nipple. I have to be
24 extremely careful, and I have to pick the best operation for her
25 that's going to preserve not only blood flow but hopefully

1 sensation, as well, to her nipples.

2 So, the implants very much complicate a breast-reduction
3 surgery.

4 Q What does the term "collateral" mean, or
5 "collateralization"?

6 A Collateralization, in this sense with blood vessels, is when
7 they reconnect with each other. And they can be done, as we saw
8 on the exhibits, wherein branches meet with each other, so from
9 one side to another. So the nipple might get the blood flow from
10 the top, from the sides, from the bottom, and there's a
11 collateral blood flow around the nipple.

12 Q And, Dr. Schimpf [sic], can you explain to the jury why
13 Rebecca Turisk lost her nipple on the right?

14 A Yes. It's very clear to me that the blood flow was
15 nonexistent, or very much reduced because, again, there's no
16 blood supply from behind the nipple because of the implant.
17 There's no blood supply from the inner part of the breast because
18 tissue has been taken off. There's no blood tissue from the
19 outer part of the breast because that tissue's been removed. The
20 blood supply from the top is gone because that tissue has been
21 removed.

22 So the only blood supply left for the entire nipple and
23 everything under it would be from below, and we know there's a
24 scar that go as across that. So, there's really no way for that
25 nipple to get enough blood supply to survive.

1 Q And can you explain to the jury the relationship of the
2 technique employed by Dr. Schimpf to the necrosis infection and
3 ultimately the loss of the breast tissue?

4 A Yes. So the sequence of events would be that the incisions
5 were made; breast tissue was removed; the nipple is in the
6 process of basically dying over the course of the next one to two
7 weeks. You might get a little bit of blood flow from across that
8 scar, but not enough to support, what we call, the metabolic
9 demand of the tissue. This is more than just skin. I mean, it's
10 nipple, it's ductwork, it's glands that have to have a blood
11 supply, and now it's all gone.

12 So this turns into basically a scab, or an eschar. And then
13 when that -- as that is occurring, bacteria get in; the bacteria
14 eat away at the tissues; and then the cycle continues because, as
15 the bacteria eat at the tissues, any remaining blood supply is
16 also gone. And so when you remove blood supply to the breast,
17 that's when you get fat necrosis, or breast-tissue necrosis.

18 So it's setting up a cycle of events that we know what
19 happened. I mean, she ended up with a mastectomy.

20 Q One second. Dr. Hultman, we were talking early on about the
21 records that you reviewed in your process of evaluating Rebecca's
22 case. And can you tell me again, did you review the MUSC
23 records?

24 A Yes, I did.

25 Q The Summerville Medical Center records?

1 A Which one? Sorry.

2 Q Summerville Medical Center.

3 A I believe I did. Yes.

4 Q Did you see her wound care records?

5 A Yes.

6 Q And the various ER visits?

7 A Yes.

8 Q Okay. And as a part of your review of MUSC records, did you
9 also see her reconstructive surgery records?

10 A Yes, I did.

11 ATTORNEY SMYTH: Your Honor, may we approach?

12 THE COURT: Yes, sir.

13 (Sidebar discussion off the record.)

14 BY ATTORNEY BURKE:

15 Q Dr. Hultman, I don't have any further questions for you
16 right now. Please answer any questions that counsel for
17 Dr. Schimpf may have for you.

18 THE COURT: Cross-examination? Do you need a break?

19 ATTORNEY SMYTH: Do you mind taking a break? If you don't
20 mind, please.

21 THE COURT: Sure, we can take a quick break.

22 Ladies and gentlemen of the jury, we'll take a quick comfort
23 break for the afternoon. We'll be right back with you, let's
24 say, about five, ten minutes. And let us know when you're ready
25 to proceed, and we'll be ready.

1 Please remember not to discuss the case amongst yourselves.

2 (Jury escorted out of the courtroom at 3:03 p.m.)

3 THE COURT: Dr. Hultman, you're welcome to step down during
4 your break. You just can't discuss your testimony.

5 THE WITNESS: Thanks.

6 (Court recessed at 3:03 p.m. and reconvened at 3:19 p.m.,
7 without the jury.)

8 THE COURT: Everyone ready to proceed?

9 ATTORNEY SMYTH: Yes, Your Honor. Just a matter of
10 housekeeping, I just found out that I think this is going to be
11 plaintiff's last witness for the day. If the Court would indulge
12 us, we would be ready to start our case in the morning. I've got
13 to argue directed verdict motions and those kind of things this
14 afternoon. For scheduling purposes --

15 THE COURT: Sure.

16 ATTORNEY SMYTH: -- we've got two experts, in addition to
17 Dr. Schimpf, and maybe one other witness. One of the experts is
18 coming from the West Coast. He was scheduled to come in tomorrow
19 night. I thought he would be coming up Thursday because I
20 thought their case would be a little bit longer. So we're trying
21 to make arrangements to see if he can get here a little sooner,
22 but a little bit of a juggling act at the moment.

23 THE COURT: And hopefully his flight won't be delayed like
24 most of them have. No, that's not a problem.

25 ATTORNEY SMYTH: Okay. Thank you.

1 THE COURT: If you all would, too, go ahead and submit any
2 proposed jury instruction to my clerk, that way we can get
3 working on those. And a proposed verdict form. Anything else
4 before we begin?

5 ATTORNEY SMYTH: If we break early today, we can have those
6 two by the end of today with no problem.

7 THE COURT: Thank you. Let's have our jury, please.

8 (Jury seated in the courtroom at 3:21 p.m.)

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

10 THE COURT: Thank you. You may proceed with your
11 cross-examination.

12 ATTORNEY SMYTH: Thank you, Your Honor. If it please the
13 Court.

14 THE COURT: Yes, sir.

15 **CROSS-EXAMINATION**

16 BY ATTORNEY SMYTH:

17 Q Good afternoon, Doctor.

18 A Hi. Good to see you.

19 Q Good to see you. It's my understanding that you've been
20 working as an expert witness in lawsuits like this since about
21 2005; is that correct?

22 A Yes.

23 Q And you review an average of 5 to 10 cases a year?

24 A Yes.

25 Q You've given, I think you said, 50 to 60 depositions in

1 legal cases like this?

2 A Yes.

3 Q And you testified at trial, I think, 10 to 20 different
4 times?

5 A Yes.

6 Q And you average at least once or twice a year going to
7 trial?

8 A Yes.

9 Q And this is not your first time testifying for the lawyers
10 in this case?

11 A No.

12 Q And, in fact, you're going to be back here in two more weeks
13 testifying across the street in federal court with these same
14 lawyers --

15 A Yes.

16 Q -- against another local plastic surgeon?

17 A Yes.

18 Q And in the last five years, I think you estimated for me
19 that 90 percent of the time that you get hired as an expert, it's
20 for the patient suing the doctor?

21 A That's about right. Yes.

22 Q And you've never been hired as an expert in a case involving
23 this particular procedure, as I understand it, correct?

24 A No.

25 Q And I think you said you're charging \$800 an hour for your

1 time here today?

2 A Yes.

3 Q And do you also work with an expert witness referral
4 service?

5 A Yes.

6 Q And that's called the Expert Institute?

7 A Yes.

8 Q And are you aware that they tack on additional charges to
9 your normal charges when you serve as an expert for them?

10 A Yes.

11 Q And I believe the quote for your appearance at trial through
12 that outfit was \$8,150?

13 A I believe so. Yes.

14 Q And I think when we first met -- I know this case has been
15 going on a while -- when the case started, you were working at
16 University of North Carolina, is that correct, in 2017?

17 A Yes. That would be right.

18 Q And when I took your deposition, you had gone to the burn
19 center in Maryland?

20 A Yes.

21 Q And now you're at Wake in Raleigh?

22 A Yes.

23 Q You're a hard guy to keep up with. That's a lot of
24 movement. I understand from your prior deposition testimony that
25 most of your -- the emphasis in your practice has been on burn

1 care and treatment of burn patients. Is that fair?

2 A In the last five years, yes.

3 Q And I believe, your biography, at the new job that you have
4 taught you as an expert in burn reconstruction and burn care?

5 A Yes.

6 Q And you were asked a little bit about your publications.
7 And I don't believe you published anything regarding the surgery
8 at issue in this case, correct?

9 A That is correct.

10 Q And when you were working, when I got to depose you at the
11 burn center in Maryland, you had not done any of these procedures
12 while you were there?

13 A I think I had done one or two, but it was very rare and
14 infrequent. I think maybe the -- well, the last one I may have
15 done was 2015 or 2016, so that would be before.

16 Q Right. That's what I was going to ask you next. When I
17 took your deposition in 2019 you told me the last one you had
18 done was 2015.

19 A Yes.

20 Q So that's accurate?

21 A Yes.

22 Q And for the last 20 years of your career, you said, I think,
23 you've done one or two of these surgeries in a year?

24 A Yes, of the combined approach.

25 Q And on those occasions when you've done that surgery you

1 agree that it carries risks and complications even when the
2 surgery's done correctly?

3 A Yes.

4 Q No matter which approach is used?

5 A Correct.

6 Q And you would also agree that it's important and that the
7 standard of care requires a physician like Dr. Schimpf or
8 yourself have a discussion with your patient about those risks?

9 A Yes.

10 Q That's part of what a reasonable and prudent physician would
11 do when they undertake an operation with their patient?

12 A Yes.

13 Q And you would discuss things like bleeding, infection,
14 nipple loss, fat necrosis, and the need for more surgery,
15 correct?

16 A Yes.

17 Q And you reviewed the informed consent form that you were
18 shown earlier today?

19 A I did.

20 Q And you agree that that form complies with the standard of
21 care?

22 A Yes, it does.

23 Q And I understand it's your opinion that Dr. Schimpf did not
24 choose the right technique for this particular patient, but you
25 do agree that the inferior pedicle is a medically accepted and

1 approved technique for breast-reduction surgery?

2 A Yes, it is.

3 Q And, in fact, I believe you referred to it as the go-to
4 technique in your field?

5 A Yes.

6 Q You have not met Ms. Turisk before, have you?

7 A No.

8 Q And you've not examined her?

9 A No.

10 Q But you do agree that she was an appropriate candidate for
11 breast-reduction surgery and the implant removal?

12 A Yes.

13 Q And you agree that patients like Ms. Turisk who have
14 implants that had been placed previously can suffer consequences
15 related to the blood supply even if the surgeon does everything
16 correctly and within the standard of care?

17 A Yes, I do.

18 Q And I think you said earlier on direct examination you've
19 actually had a patient who's lost their nipple during one of the
20 procedures you performed?

21 A Yes.

22 Q And did you perform that procedure according to the standard
23 of care, or were you negligent?

24 A I did perform it according to the standard of care.

25 Q I think you had the opportunity to review Dr. Schimpf's

1 operative note in this case?

2 A Yes.

3 Q And you agree that the way the procedure was described in
4 that operative note is appropriate and meets the standard of care
5 in terms of performing the inferior-pedicle technique?

6 A Yes, I do.

7 Q And I think you said that you thought performing the
8 inferior-pedicle technique was a contraindication in your
9 opinion, but you're not relying on any medical literature for
10 that conclusion, are you?

11 A No. Just my experience and education.

12 Q In fact, you haven't pulled any literature that would
13 support that it's an absolute contraindication, have you?

14 A No.

15 Q And you agree that during the course of the procedure there
16 are opportunities for the surgeon to check and make sure that the
17 nipple and the rest of the breast tissue is receiving appropriate
18 blood supply?

19 A Yes.

20 Q And one way to do that is you can press on the nipple to see
21 if it's getting blood flow. In return, the nipple changes colors
22 in response to what you're doing, correct?

23 A Correct.

24 Q You check for capillary refill?

25 A Yes.

1 Q And in your review of Dr. Schimpf's note, did you note that
2 he did that?

3 A Yes, he did do that.

4 Q So he checked for capillary refill; he checked to make sure
5 there was adequate blood flow during the procedure?

6 A Yes.

7 Q And he checked again when he closed the procedure, at the
8 very end of the surgery, and said that everything looked viable
9 and appropriate with the nipple-areolar complex, correct?

10 A Yes.

11 Q And you agree that that's an appropriate thing for him to
12 have done?

13 A I do.

14 Q Meets the standard of care?

15 A Yes.

16 Q And if there had been a problem with blood flow during the
17 surgery, that's the time to address it, correct?

18 A Correct.

19 Q And there wasn't one that you're aware of?

20 A Based on his interoperative finding, that's correct.

21 Q And you would expect a doctor who's acting within the
22 standard of care in a reasonably and prudent manner to check the
23 blood flow during that procedure, correct?

24 A Yes.

25 Q And Dr. Schimpf did that?

1 A Yes.

2 Q And you're not here to tell the jury that Dr. Schimpf
3 injured any particular blood vessel? I know you had the map of
4 bloods vessels up there, but you're not saying there was an
5 injury to any particular blood vessel during the surgery?

6 A No. I think blood vessels are divided, but there was no
7 inadvertent injury to a blood vessel.

8 Q And you agree with the fact that a patient's blood flow may
9 be affected in some ways postoperatively doesn't necessarily mean
10 the surgery was performed the wrong way?

11 A Correct.

12 Q And when Dr. Schimpf noted in his operative note that there
13 was no evidence of congestion or ischemia, that indicates that
14 the blood supply to the nipple was appropriate at that time?

15 A Yes.

16 Q And that's exactly what you want to see?

17 A Yes.

18 Q And then at the end he commented that the nipple-areolar
19 complex was intact and viable. Again, that's exactly what you
20 want to see when you close that procedure, correct?

21 A Correct.

22 Q You agree that a patient can experience fat necrosis and
23 nipple loss even when the surgeon has done everything according
24 to the standard of care and checked to make sure that the blood
25 supply was appropriate?

1 A I do.

2 Q You talked a little bit about a possible infection. You
3 agree that Dr. Schimpf and the operating team took appropriate
4 steps to minimize the risk of an infection during the surgery?

5 A Yes.

6 Q You saw that Ms. Turisk was given antibiotics
7 interoperatively?

8 A Correct.

9 Q She was given Ancef, and that meets the standard of care,
10 doesn't it?

11 A Yes, it does.

12 Q She was also prepped with a chlorhexidine solution?

13 A Yes.

14 Q And that's an appropriate intervention to try to help
15 prevent the spread of infection on operative sites?

16 A Correct.

17 Q And you agree that both of those things are appropriate and
18 meet the standard of care?

19 A Yes.

20 Q You suggested that perhaps a topical antibiotic would be
21 used, but you would agree that the photos that you were shown in
22 the immediate postoperative period only showed bruising?

23 A Correct.

24 Q And you don't put a topical antibiotic on bruising?

25 A No.

1 Q And I think you recommended that you would want to see the
2 patient within a week or so, very quickly, for follow-up,
3 correct?

4 A Yes.

5 Q And you're aware that Dr. Schimpf did see the patient
6 multiple times in the postoperative period?

7 A Yes.

8 Q And you agree that there was nothing in the record to
9 indicate that Ms. Turisk had an infection during her initial
10 postoperative visit on November the 7th?

11 A That's correct.

12 Q And the same is true on November the 15th when the wounds
13 were noted to be clean, there was no redness, no warmth, no
14 discharge? That's all a description of a wound that's not
15 infected, correct?

16 A Yes.

17 Q And then Ms. Turisk went about two weeks before she returned
18 to see Dr. Schimpf again, and that's when she developed the
19 infection, correct?

20 A I think she had an infection at that point. Yes.

21 Q And that's when the culture showed that she did have an
22 infection?

23 A Yes.

24 Q And that's where I think we got into a discussion earlier on
25 direct exam about the bacteria. Is it safe to say that she had

1 multiple bacteria in that wound?

2 A Yes.

3 Q And when that was identified, were those bacteria addressed
4 appropriately with antibiotics?

5 A Yes, they were.

6 Q And that meets the standard of care?

7 A Yes.

8 Q You find out what the bacteria is, and you treat it with one
9 what works for it?

10 A Correct.

11 Q And that was done for Ms. Turisk?

12 A Yes.

13 Q You also talked a little bit about wound care treatment.
14 You agree that the prescription of antibiotics empirically is
15 appropriate when an infection might be suspected?

16 A Yes.

17 Q And Ms. Turisk received those from Dr. Schimpf's office in
18 this case?

19 A Yes.

20 Q She was also receiving wet-to-dry dressings and
21 debridements. You agree those are appropriate interventions for
22 an open wound?

23 A Yes.

24 Q And that meets the standard of care?

25 A It does.

1 Q And you agree that all of the postoperative care and
2 treatment that Dr. Schimpf and his staff gave Ms. Turisk were
3 appropriate and met the standard of care?

4 A Mostly, yes.

5 Q And you're not offering any opinions that any of the
6 employees of the practice, any of the nurses, physician
7 assistants, anyone else that worked for the practice, did
8 anything that was negligent or below the standard of care in this
9 case?

10 A No.

11 Q And you saw, I believe, in your review of the other medical
12 records, that Ms. Turisk went on to develop infections in the
13 years beyond her time with Dr. Schimpf, correct?

14 A Yes. That is correct.

15 Q And you don't have an opinion that any of the care providers
16 who were caring for her at that point were negligent in allowing
17 her to develop those infections, do you?

18 A I do not.

19 Q And we talked a little bit about fat necrosis, but you agree
20 that that's a well-documented and well-recognized complication of
21 any breast surgery?

22 A Yes.

23 Q And it can occur no matter where the incisions are made?

24 A Correct.

25 Q And just because a patient experiences fat necrosis or an

1 infection after this doesn't mean the physician did anything
2 wrong or it was below the standard of care?

3 A I agree with that.

4 Q And you're not here to offer any opinions about any of the
5 damages that are being claimed in this case, are you?

6 A I'm not.

7 Q And you're not here to testify that Ms. Turisk can't
8 participate in any activities or anything of that nature?

9 A No.

10 Q Bear with me just a second. Those are all my questions.
11 Thank you.

12 A Thank you.

13 THE COURT: Any redirect?

14 ATTORNEY BURKE: Yes, ma'am, very briefly. Thank you.

15 **REDIRECT EXAMINATION**

16 BY ATTORNEY BURKE:

17 Q Dr. Hultman, do you find the breach of standard of care in
18 every case you review for plaintiffs' lawyers?

19 A No, not at all.

20 Q Did you need to examine Rebecca for your opinions that
21 you've provided in court today?

22 A No, I did not.

23 Q And the nipple case, the unfortunate case that happened in
24 your practice where your patient lost a nipple, did that patient
25 also go on to lose 100 percent of the breast tissue under the

1 nipple?

2 A No, she did not.

3 Q Very quickly I want to go back to these photographs that you
4 referred to earlier. Dr. Schimpf [sic], earlier I handed you
5 Plaintiff's Exhibits 5 through 9. Just take a look at those
6 again. Let me know when you're ready.

7 A Yes.

8 Q Dr. Schimpf's attorney asked you about the bruising on some
9 of those photographs.

10 A Yes.

11 Q And I believe he asked you if you would put topical
12 antibiotic on the bruising.

13 A Yes.

14 Q And where would you have recommended that the topical
15 ointment be applied based on your review of Exhibits 5 through 9?
16 And if you're looking at a particular photograph, if you could
17 call out the number, and we can share it with the jury.

18 A Yes. We can do Exhibit 5, which is --

19 Q Okay. What is the date of Exhibit 5?

20 A That is 11/6/2016.

21 Q Okay.

22 A The skin is bruised. And as I've already indicated, that
23 doesn't require any topical antibiotics. That should resolve on
24 its own. But I would apply topical antibiotics onto the suture
25 lines. First, I would remove all those soiled Steri-Strips

1 because I have no idea what is going on underneath, but it's a
2 source for potential bacteria to get in. But my biggest concern
3 is the appearance of that nipple. It's very dark, it's
4 congested, it looks like a dying nipple at day six after surgery.

5 So with that information, I would be very aggressive about
6 local wound care and local application of an antibiotic on the
7 nipple.

8 Q And what would the local application of an antibiotic
9 potentially have prevented?

10 A Further necrosis and loss of the tissues due to that. The
11 nipple is basically laden with bacteria to begin with. It's
12 the exit point of all the ducts of the breast, and so bacteria
13 live in this area. And if there's no blood supply to help fight
14 this bacteria, then they will eventually result in a mastitis or
15 some type of severe breast infection, so this is a situation
16 where I would put topical antibiotics on this area.

17 Q I don't have any further questions, Dr. Hultman. Thank you.

18 A Thank you.

19 THE COURT: You may step down, Doctor. Thank you. You may
20 call your next witness.

21 ATTORNEY BURKE: Your Honor, the plaintiff rests.

22 THE COURT: Thank you, counsel. Ladies and gentlemen of the
23 jury, the plaintiff has rested their case. And although they
24 have rested their case, that does not mean that you can discuss
25 it quite yet. Obviously we need to take some matters up outside

1 of your presence. And I know it's not quite 4:00.

2 Counsel, would y'all approach real quick?

3 (Sidebar discussion off the record.)

4 THE COURT: Ladies and gentlemen, again, we must take up
5 some matters outside of your presence. If you would return back
6 to your jury -- I don't want to send you out and bring you back
7 and keep you waiting and waste your time, so we will resume with
8 the trial of the case at 9:15. Again, if you'd be back in your
9 jury room by then, we'll resume with the trial of the case. Have
10 a nice evening.

11 And again, please remember not to discuss this case amongst
12 yourselves or with anyone else.

13 (Jury escorted out of the jury room at 3:40 p.m.)

14 MATTER(S) OF LAW

15 THE COURT: Any motions?

16 ATTORNEY BURKE: I'm sorry. None from the plaintiff. I
17 wanted to make sure I hadn't totally forgotten what I was
18 supposed to do at this point.

19 ATTORNEY SMYTH: Your Honor, we do have a few motions. Can
20 I ask for about five minutes just to get my thoughts together on
21 exactly what those are --

22 THE COURT: Sure.

23 ATTORNEY SMYTH: -- so I make sure I can present them as
24 eloquently as possible?

25 THE COURT: Yes, sir.

1 ATTORNEY SMYTH: Thank you. Sorry, Your Honor. I'm ready
2 now. At this time, Your Honor, the defendants would move for --
3 I need another minute. I apologize.

4 Now I'm really ready. At this time, Your Honor, the
5 defendants would move for directed verdicts. I think we have
6 four different grounds that we can address individually.

7 The first one is one that we've dealt with already on some
8 of our objections, and it goes to the heart of the matter of this
9 case. As the Court's well aware, in order for damages to be
10 admissible, they have to be shown to be the proximate cause
11 related to a negligent act in this case. And I think the
12 plaintiffs have failed to carry their burden of proof.

13 There's no evidence from any experts that says these bills
14 were proximately caused by this negligence. You've got lay
15 witness testimony which doesn't carry the day in terms of the
16 weight of that. She can certainly say what bills she got, but
17 that doesn't fill the gap in terms of an expert coming in behind
18 that and saying these were the proximate cause of those damages,
19 these negligent acts.

20 And I would point the Court to the *David v. McLeod* case.
21 And in that case, it's -- I'll approach and hand you a copy of
22 it.

23 THE COURT: Thank you.

24 ATTORNEY SMYTH: And the Supreme Court in that case held
25 that plaintiff must show that defendant's departure from such

1 generally recognized practices and procedures was the proximate
2 cause of the plaintiff's alleged injuries and damages.

3 And so there we've got it in black letter what the Supreme
4 Court requires. And that has to be done by expert testimony.

5 And reading further -- and I'm at Headnote 6, The plaintiff
6 must provide expert testimony to establish both the required
7 standard of care and defendant's failure to conform to that
8 standard, unless the subject matter lies within the ambit of
9 common knowledge, so that no special learning is required to
10 evaluate the conduct of the defendant.

11 Clearly this is not a common-knowledge case, and clearly the
12 plaintiffs have not put forth any expert testimony to connect the
13 damages that they put in to show that they were proximately
14 caused by a negligent act.

15 All they have shown is that they followed them in time. And
16 that's a very big distinction in the law. So we would move for
17 directed verdict on that basis first.

18 THE COURT: Mr. Tanenbaum.

19 ATTORNEY TANENBAUM: May it please the Court. Your Honor, I
20 know I'm getting hard of hearing but I'm pretty sure that
21 Dr. Hultman testified that the breach of the standard of care was
22 choosing the wrong technique which impacted and destroyed the
23 blood flow which, in turn, led to the loss of the nipple and the
24 infection that subsequently followed.

25 Then he and Dr. Herrera both testified that the treatment

1 she received after that was appropriate and was a result of the
2 original infection and loss of nipple.

3 And I think the plaintiff, herself, has testified that she
4 underwent these many, many procedures as a result of the event.

5 So I appreciate my friend's position, but at the same time I
6 beg to differ. I think it's an abundance of evidence that's been
7 presented from the witness stand that supports plaintiff's
8 contentions here.

9 THE COURT: And, of course, Dr. Hultman did testify
10 regarding the breaching of the standard of care and the failure
11 to conform to that standard. The plaintiff testified as to the
12 bills that she received as a result of having to undergo the
13 further treatment. It does create a question of fact for the
14 jury to determine. Your motion is respectfully denied.

15 ATTORNEY TANENBAUM: Thank you, Your Honor.

16 ATTORNEY SMYTH: Your Honor, the next grounds -- before we
17 leave that, Your Honor, I just want to point out for the record
18 that Dr. Herrera's testimony and Dr. Hultman's testimony on this
19 issue was pretty clear. I asked him just a second ago on
20 cross-examination, You're not here to testify about any of the
21 damages in this case?, and he said no.

22 And then at the trial deposition of Dr. Herrera -- I'm going
23 to read an excerpt from it, from page 82, lines 5 through 23. It
24 says: So, Dr. Herrera, I'm going to ask you, in your opinion,
25 were each of the surgeries that you performed on Rebecca related

1 to her postoperative complications and infection following her
2 prior breast surgery with Dr. Schimpf on November 1st, 2016?

3 Answer: No. It clearly says she had previous surgery by
4 Dr. Schimpf. That's really all I can comment on.

5 THE COURT: Remind me again, plaintiffs, as far as the
6 plaintiff's counsel, on his deposition, I thought he had
7 testified that they were reasonable and were medically necessary
8 as a result of the breach of care.

9 ATTORNEY TANENBAUM: Yes, Your Honor. There was an issue
10 that the defense tried to draw a distinction between treating the
11 infection and then restoring the breast.

12 And as we discussed earlier in the week when that was first
13 raised, certainly once she suffers that injury and that
14 condition, like having plastic surgery for a dog bite scar, she
15 can choose to undergo further restorative treatment caused by
16 that particular -- a necessity which was caused by that
17 particular result. So I think Your Honor called it correctly
18 then. And we stand on the record as it exists.

19 I'd be glad to answer anything that's specific, and I can
20 pull out Dr. Herrera's deposition. The whole deposition's in
21 there, as agreed to by both parties.

22 THE COURT: It still creates, counsel, a genuine issue of
23 material fact for the jury to determine as to the facts and
24 determination, the standard, as Dr. Hultman testified, was
25 breached. Dr. Herrera has testified as to the procedures and the

1 processes she underwent through after when he took care of her,
2 so I think that does create a question of fact.

3 ATTORNEY SMYTH: I understand, Your Honor. I appreciate
4 your ruling.

5 The second ground that we'd move for directed verdict on,
6 lack of evidence of the standard of care being violated in this
7 case, I think when you listen carefully to Dr. Hultman's
8 testimony today, he said that the technique that Dr. Schimpf used
9 complies with the standard of care, it's an appropriate choice
10 for this type of surgery, and that these complications happen
11 regardless.

12 He failed to identify any negligent act during the surgery
13 itself. Said that it was conducted and completed all according
14 to the standard of care, as were his preoperative or
15 postoperative visits with the patient.

16 The law on medical malpractice is very clear. It says that
17 physicians have a lot of latitude in terms which method of
18 treatment they elect to pursue for their patient as long as it's
19 within the standard of care. And that's exactly what we have in
20 this situation. Dr. Hultman said, Yes, this is definitely
21 standard-of-care operation. It's the go-to gold standard.

22 And so there's no evidence in the record that Dr. Schimpf
23 did anything that was outside of the standard of care when he
24 used the go-to technique, and he did it appropriately.

25 So we would move for directed verdict on that ground, Your

1 Honor.

2 ATTORNEY TANENBAUM: May it please the Court. We agree that
3 that's a perfectly proper technique except for patients who are
4 in the position the plaintiff was in. And that's what
5 Dr. Hultman said. The technique was fine, the performance of the
6 technique was fine, except it should not have been the technique
7 used with this patient.

8 THE COURT: In his testimony, he did state that it was the
9 wrong procedure, and the procedure itself violated the standard
10 of care; not the technique used in the procedure, but the
11 procedure itself. It was the procedure based upon the
12 presentation of the patient.

13 Your motion is respectfully denied.

14 ATTORNEY SMYTH: Thank you, Your Honor. Our third ground
15 for directed verdict would be a complete lack of evidence of
16 any -- an allegation in any of the testimony of any grossly
17 negligent conduct, so we would move that punitive damages be
18 taken out of the case.

19 The only testimony that has been taken on that issue is when
20 I asked the plaintiff on cross-examination, You're not contending
21 that Dr. Schimpf did anything that was malicious, reckless,
22 wanton, or willful? There's absolutely -- the record is devoid
23 of any reference to that whatsoever. So I believe punitive
24 damages should be taken out of the case on that basis.

25 ATTORNEY TANENBAUM: I'm afraid he's right.

1 THE COURT: I agree.

2 ATTORNEY SMYTH: Hey. All right.

3 ATTORNEY TANENBAUM: Unless the jury brings back a verdict
4 for that on their own.

5 ATTORNEY SMYTH: The final one. There are two parties on
6 this side. They sued the doctor and the practice, Sweetgrass
7 Plastic Surgery. There's been no testimony whatsoever that
8 anyone on behalf of the practice did anything that was below the
9 standard of care, or negligent. I just confirmed that again with
10 Dr. Hultman.

11 I don't believe that there's any evidence whatsoever that
12 the practice should be included in the case or that there's any
13 evidence that anyone from the practice deviated from the standard
14 of care based on evidence submitted by plaintiffs.

15 ATTORNEY TANENBAUM: I think that Dr. Hultman, himself, in
16 his deposition -- but certainly he is the practice. I mean, he's
17 the professional who owns the practice. And unless I'm mistaken,
18 he is an agent, servant, and employee to the practice. And I can
19 certainly asked him that, but I don't see any -- I mean, if you
20 go to the website, I think, there it is, here's our -- about our
21 doctor, and it's Dr. Schimpf.

22 Now, we didn't put that into evidence yet, but she said she
23 went to Sweetgrass to see Dr. Schimpf, and that's where his
24 office is, with the sign, Sweetgrass Plastic Surgery.

25 ATTORNEY SMYTH: Very briefly, Your Honor. If that was part

1 of the claim, then it should have been put into evidence before
2 the plaintiff rested. There's nothing in the record that
3 suggests that whatsoever in plaintiff's case, so there's no
4 basis, no legal basis, for a claim against the practice that was
5 presented by any of the evidence plaintiff offered in this case.

6 THE COURT: Counsel, I'll allow you to look at the record
7 and see if that was testified to.

8 ATTORNEY TANENBAUM: Yes, Your Honor. But, also, his chart,
9 which is in evidence, or portions of his chart, including the
10 consent form, says the at the top, Sweetgrass Plastic Surgery.

11 THE COURT: Counsel, there you go. Question is --

12 ATTORNEY SMYTH: I don't know. I mean, how does that create
13 liability? All it creates is -- it identifies whether care was
14 provided. It doesn't say that anybody on behalf of the practice
15 did anything. That's what's required. If you're going to pursue
16 a negligence action against a company, you've got to establish
17 all of the requisites, and they're not in the record.

18 THE COURT: So how does the form say -- does the form say
19 Dr. Schimpf is the owner, or?

20 ATTORNEY SMYTH: Sweetgrass Plastic Surgery. We can look.

21 THE COURT: It doesn't really say much as far as Dr. Schimpf
22 is concerned as far as the connection with the practice.

23 ATTORNEY TANENBAUM: I guess under that theory, the consent
24 form was only on behalf of Sweetgrass and not Dr. Schimpf. So we
25 then move to strike that from their answer. I'd have to take a

1 look.

2 THE COURT: How was it worded in the complaint?

3 ATTORNEY TANENBAUM: I'm sorry?

4 THE COURT: How was it worded in the complaint?

5 ATTORNEY BURKE: We've got to pull it out. It's been a
6 while, so just a moment.

7 ATTORNEY SMYTH: Your Honor, I've got plaintiff's complaint.
8 Looks like I'm looking off the right one. It was filed
9 April 23rd of 2018. And it alleges that Sweetgrass is a limited
10 liability corporation. But thereafter, in the rest of the
11 pleadings, it doesn't distinguish between the allegation.

12 And my point is, if you're going to allege medical
13 malpractice, you have to prove it, and nothing of that nature has
14 been suggested or offered in the plaintiff's case, so we're
15 completely devoid of any evidence for them to be able to proceed
16 against that entity.

17 THE COURT: All right. Well, here's what we'll do. We have
18 plenty of time this afternoon. I'm going to take that one under
19 advisement. If you would provide a brief summary and argument
20 for me, I can rule on that in the morning.

21 ATTORNEY TANENBAUM: Thank you, Your Honor.

22 THE COURT: All right. Thank you.

23 ATTORNEY BURKE: Thank you, Your Honor. And tomorrow, will
24 you be able to complete your case tomorrow? Just asking.

25 ATTORNEY SMYTH: I'm not sure. So I think our plan tomorrow

1 is, we would start the day with Dr. Schimpf. We'll work in that
2 expert in from California. He's trying to take a redeye, but I'm
3 not exactly sure where that will come into play. Then I've got
4 one other expert from Lexington that I'm hoping can drive down.
5 So I have three witnesses, two and the defendant. I think we can
6 accomplish that potentially.

7 ATTORNEY BURKE: Do you anticipate we'll close tomorrow?

8 THE COURT: I wouldn't want to give this to the jury after
9 3:30.

10 ATTORNEY BURKE: I don't want to, either. Thank you.

11 THE COURT: Yeah, I just don't think that's fair to anybody.
12 So maybe try to plan to finish the testimony tomorrow, and then
13 charge Thursday morning.

14 ATTORNEY SMYTH: If everything lines up perfectly.

15 THE COURT: All the stars align. All right. We'll keep our
16 fingers crossed. Anything further before we recess for the
17 evening?

18 ATTORNEY BURKE: Nothing from the plaintiff.

19 THE COURT: All right. See everyone at 9:15.

20 (Court recessed for the day at 3:56 p.m.)

21 (End of Transcript of Record, Volume II of IV.)
22
23
24
25

CERTIFICATE OF REPORTER

I, Cathy J. Provost, Official Court Reporter for the Fourteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial/proceedings of the captioned case in the Court of Common Pleas for Charleston County, South Carolina, on the 15th day of November, 2022.

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

Date: January 7, 2023

/s/ Cathy J. Provost
Cathy J. Provost, RMR
Official Circuit Reporter

STATE OF SOUTH CAROLINA	)	COMMON PLEAS COURT OF THE
	)	
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
REBECCA TURISK	)	NO. 2018-CP-10-02109
VS.	)	
DENNIS K. SCHIMPF, M.D.	)	TRANSCRIPT OF RECORD
	)	Jury Trial - Volume III of IV
	)	(Pages 257 - 430)

B E F O R E:

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

DATE: Wednesday, November 16, 2022
9:41 a.m.

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

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

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

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

4 MATTER(S) OF LAW

5 THE COURT: Counsel, I'm in receipt of both your memorandums
6 regarding the directed verdict motion, and had an opportunity to
7 read them, along with considering your previous arguments from
8 yesterday. Is there anything further that you'd like to place on
9 the record before I rule? Sorry, Mr. Tanenbaum. Is there
10 anything further that y'all would like to place on the record
11 before I rule?

12 ATTORNEY TANENBAUM: There is, Your Honor. Ms. O'Neal will
13 argue that for us.

14 ATTORNEY O'NEAL: Honestly, Your Honor, I think that our
15 brief pretty much covers everything that we would like to present
16 in support of our response, unless defense has something to add.
17 I'll be happy to respond to anything he has.

18 THE COURT: Thank you, ma'am. Anything further from defense
19 counsel?

20 ATTORNEY SMYTH: Your Honor, I don't think so. I mean, I
21 think that the points that I made yesterday were read into the
22 record that this is completely devoid of any evidence pertaining
23 to the practice. There's certainly no expert testimony that
24 suggests that the practice or any of its employees did anything
25 negligent specifically, so that's our position.

1 ATTORNEY O'NEAL: And our position is that, based on the
2 exhibits that we provided to the Court in our response in
3 opposition to defense's motion, there is sufficient evidence to
4 show that Dr. Schimpf was acting on behalf of Sweetgrass Plastic
5 Surgery as an agent and an employee. He's held out not just
6 individually, but as a representative, on Sweetgrass Plastic
7 Surgery discharge instructions, Defense Exhibit 1; on Sweetgrass
8 Plastic Surgery's informed consent form, Defense Exhibit 2; and
9 then Jordan Harper, in the testimony that was read into evidence
10 yesterday, also testified and made no distinction between her
11 employment of working for Sweetgrass Plastic Surgery versus
12 working for Dr. Schimpf. And she also noted that she was taking
13 photographs of the patient in that testimony for purposes of
14 sending them to Dr. Schimpf for further guidance in the treatment
15 and care of Rebecca Turisk.

16 THE COURT: Thank you, counsel. And obviously in reviewing,
17 I'm going must take the evidence in the light most favorable for
18 the nonmoving party. And in looking at evidence, there has been
19 evidence presented that the care provided by Dr. Schimpf in his
20 capacity as an agent of Sweetgrass Plastic Surgery, with two of
21 the documents which are in evidence, the informed consent form,
22 and along with the discharge instruction, this creates a question
23 of fact that is proper for the jury to consider as to whether or
24 not an agency-physician relationship has been established. Your
25 motion is respectfully denied.

1 ATTORNEY SMYTH: Thank you, Your Honor.

2 THE COURT: Are we ready to proceed with the jury?

3 ATTORNEY SMYTH: Yes. I was just going to give you a heads
4 up for our scheduling purposes today. So we'll have Dr. Schimpf
5 up first, and then we'll have Rebecca Johnson as our second
6 witness. We'll probably need to break for lunch, because I think
7 Dr. Joseph's flight lands around 11:00, so we need a couple
8 minutes to get him in a suit and get him ready. So we'll have
9 two experts in the afternoon, and then reset.

10 THE COURT: All right. Thank you, counsel.

11 ATTORNEY O'NEAL: Your Honor, if I may. There may be some
12 evidentiary issues with the demonstratives that we've been
13 provided from defense counsel. It's my understanding that
14 defense counsel intends to use the video clips and photographs of
15 surgeries performed by Dr. Schimpf of nonparty patients.

16 It's our position that while these may be used generally as
17 a demonstrative of what a surgery might look like, any references
18 to successful surgeries, outcomes, his successful rate, is
19 completely inadmissible into evidence --

20 THE COURT: Counsel.

21 ATTORNEY O'NEAL: -- and should be excluded.

22 ATTORNEY SMYTH: Your Honor, I think yesterday was a first
23 for me seeing demonstratives moved into evidence. I never seen
24 that before. So I think we've had a lot of latitude in terms of
25 what we can use as demonstratives.

1 I think Dr. Schimpf is entitled to explain why he chose the
2 procedure that he did and what the difference are between these
3 procedures, and that's what these picture do.

4 We're not revealing any HIPAA protected information. We're
5 not suggesting that this is Ms. Turisk or this was her surgery,
6 so we'll make that very clear so the jury is not confused about
7 it, but I believe he is allowed to demonstrate why he did what he
8 did.

9 THE COURT: Certainly that was brought up by plaintiff's
10 testimony, the different types of surgeries, and Dr. Hultman
11 testified to the different procedures. I imagine that's what
12 you're going trying to do, is just show his version of it.

13 ATTORNEY O'NEAL: Agree, Your Honor. It's our position that
14 it carries a different weight when the surgery was performed,
15 photos and surgeries performed, by Dr. Schimpf, the defendant.

16 I'd also like to direct Your Honor's attention to the
17 Supreme Court case of *Kuhlmann v. Wilson*. I'm happy to provide
18 you a copy of that, as well, which states, quote, Evidence
19 relating to treatment of a nonparty patient is irrelevant to a
20 plaintiff's negligence claim, and that it cannot be used to show
21 the defendant breached the standard of care with a particular
22 patient.

23 Just like we can't show evidence of nonparty patients that
24 were found to have been wrongly treated by Dr. Schimpf, we think
25 the inverse is also true, Your Honor.

1 THE COURT: Mr. Smyth, tell me exactly what you're planning
2 to put up as far as demonstratives.

3 ATTORNEY SMYTH: Sure. And I'm happy to show you, if you'd
4 like.

5 THE COURT: Sure.

6 ATTORNEY SMYTH: These are pretty simple things. So these
7 are examples of surgeries that Dr. Schimpf has performed showing,
8 kind of, the different techniques that are used. And I provided
9 copies of all those to everybody so that they're on the same
10 page. But he's essentially just going to explain -- because the
11 criticism yesterday from Dr. Hultman on the stand was that this
12 was the wrong procedure for this patient.

13 He's going to explain what the procedure he talked about
14 yesterday was and why he didn't think it was appropriate here and
15 why he thinks the one that he did was appropriate. So these are
16 just simply to help him explain to the jury the differences of
17 the surgery and how they're done.

18 THE COURT: Anything in response real quick?

19 ATTORNEY O'NEAL: Again, our position is that because a
20 reference is being made that these are, instead of being
21 demonstrative exhibit of this is what the surgery looked like,
22 this is how I approached this type of surgery, he is using his
23 own patient, which is making an inference to the jury of his
24 successful outcome and success rate in performing these
25 procedures.

1 THE COURT: Well, your expert got to do the same thing,
2 basically. I mean, your expert got to put up the different types
3 of surgeries; that he was able to perform them at what he labeled
4 as a success rate.

5 Dr. Schimpf is going to testify regarding -- I mean, he
6 can't say, I did this 99 percent of the time and every time it
7 worked, certainly, but he's entitled to rebut your evidence as
8 far as the types of surgeries and the different aspects and what
9 he considered to be appropriate in this case.

10 Now, Mr. Smyth, if you start going into performing thousands
11 and thousands, and every single time, I don't know that we have
12 that type of wide latitude, but I think you're just rebutting
13 what plaintiff's expert testified to yesterday.

14 ATTORNEY SMYTH: Sure. I think I'm entitled to ask the
15 doctor how many he's done.

16 THE COURT: Right. And I think that's appropriate.

17 ATTORNEY SMYTH: I don't want to be limited to that --

18 THE COURT: Sure. I don't want him to get up there and say,
19 It's my first time, it's my first rodeo up here.

20 ATTORNEY SMYTH: Right.

21 THE COURT: So I think that's appropriated. But unless I'm
22 missing something, counsel, he's just rebutting what your expert
23 testified to yesterday.

24 ATTORNEY BURKE: Your Honor, if I may. Ms. O'Neal's doing a
25 great job. I just want to say we don't object to illustrations.

1 It's the use of actual patient photos and actual patient
2 surgeries. And I think that just goes too far in suggesting that
3 his success rate and his success rate with patients that may not
4 even be like Rebecca. We don't know anything about these
5 patients' background. We won't know their risk factors. And I
6 just think it goes a little bit too far.

7 Illustrations are one thing, but actual patient surgeries, I
8 think, go too far, and the risk of undue prejudice to the
9 plaintiff is great.

10 THE COURT: From my understanding of what Mr. Smyth is
11 saying, Dr. Schimpf is going to testify this is the type. He's
12 not going to say, I performed this surgery on Jane Doe and this
13 is, you know, any type of revealing information. But certainly
14 he's got the experience to perform a certain type of surgery, and
15 he can illustrate that this is a type of surgery that I performed
16 in this case. I don't see anything wrong with that.

17 ATTORNEY BURKE: With an actual patient, even though he
18 doesn't give away the patient identifying information?

19 THE COURT: Well, I don't think he's performing surgeries on
20 dummies. I mean, it's got to be a patient. I mean, it's his
21 experience that's on the line here, so I think that's
22 appropriate.

23 ATTORNEY BURKE: I understand your ruling, Your Honor.
24 Thank you.

25 THE COURT: All right. Thank you. Anything further before

1 we bring the jury out?

2 ATTORNEY SMYTH: No, Your Honor. We're ready.

3 ATTORNEY BURKE: No, Your Honor.

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

5 (Jury seated in the courtroom at 9:52 a.m.)

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

7 THE COURT: Good morning, ladies and gentlemen of the jury.
8 Welcome back. We're now ready to proceed with the trial of the
9 case. You may call your first witness.

10 ATTORNEY SMYTH: May it please the Court, Your Honor. The
11 defense calls Dr. Dennis Schimpf to the witness stand.

12 DENNIS K. SCHIMPF, M.D.,
13 having first been duly sworn, was examined and testified as
14 follows:

15 CLERK OF COURT: You may have a seat.

16 THE WITNESS: Thank you.

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

19 THE WITNESS: Sure. Dennis Kenneth Schimpf, S-c-h-i-m as in
20 Mary-p as in Peter-f as in Frank.

21 THE COURT: Your witness.

22 ATTORNEY SMYTH: Thank you, Your Honor.

23 **DIRECT EXAMINATION**

24 Q Good morning, Dr. Schimpf.

25 A Good morning.

1 Q Your name has been used a lot during the trial of this case
2 thus far. Would you like the opportunity to tell your side of
3 the story to the jury?

4 A Yes, sir.

5 Q Let's start, if you would, please, by introducing yourself
6 and tell us a little bit about your education and what you've
7 done in that regard.

8 A Sure. I went to a college up in Buffalo, New York, Daemen
9 College, a smaller private school. Played sports there; was on
10 an athletic scholarship. And then decided late that I was going
11 to go into medicine. So in order to graduate, you had to do
12 volunteer work, and I had waited till the last moment, so it was
13 my senior year, and the only way to get those hours in was to go
14 to an emergency room because it was open 24 hours a day, so I did
15 that and really fell in love with it and spent the next few years
16 doing basic science courses, prerequisites, and ended up going to
17 medical school at Ross University, which was a nontraditional
18 school, but I had come from a nontraditional background, so the
19 first two years went out of the country, and then I came back to
20 the states, and then I actually went back to Europe and spent a
21 year clinically training.

22 After that, I went to the University of Buffalo for five
23 years to do general surgery. And moved here to Charleston end of
24 2005, beginning of 2006, to do a plastic surgery fellowship at
25 the local academic center here. And I stayed on staff there for

1 five years, and finished an additional degree, an MBA degree,
2 from the University of South Carolina, and started Sweetgrass in
3 2013, in July of 2013.

4 Q Okay.

5 A We started out as myself and then two or three employees,
6 and we've grown to five locations, three surgeons, and about 80
7 employees.

8 Q And so if my math is correct, you went through about 7 years
9 of training and 18 years of performing surgeries?

10 A Yes, sir.

11 Q And you're licensed to practice medicine in South Carolina?

12 A Yes, sir.

13 Q Are you board-certified in plastic surgery?

14 A I am.

15 Q We heard a little bit about that yesterday from Dr. Hultman.
16 Did you pass your board certification test for plastic surgery
17 the first time you took it?

18 A Yes, uh-huh.

19 Q And have you been board-certified throughout your entire
20 career?

21 A Yes. And I re-certed. You have to do it every 10 years. I
22 did it probably two years ago, a year and a half ago.

23 Q Are you a member of any professional societies or
24 organizations in the field of plastic surgery?

25 A Yes, the American Society of Plastic Surgery and the

1 American Board of Plastic Surgery, which, you know, Dr. Hultman
2 spoke a little bit yesterday about board certification and how he
3 was an examiner, and I think it's important to distinguish,
4 they're giving exams to somebody in their first year of practice.

5 And so I agree with him, I don't -- this is a complex breast
6 case, very complex. In fact, you know, my junior surgeons, their
7 first year in practice, we keep complex cases away from them
8 because you don't want those in your collection period. So this
9 is not a case that somebody in their first year or second year of
10 practice, or somebody that doesn't do any large volume of complex
11 breast surgery, should be doing.

12 So, you know, I did this case in 2016. I completed training
13 in 2008, so I had eight years, five of which were at an academic
14 center doing primarily breast reconstruction. The destination --
15 there were people that come from outside of the area for breast
16 surgery, so I had done, you know, I think about 4,000 surgeries
17 those first few years, and about 90 percent of them were actually
18 breasts and complex breasts.

19 So I agree with Dr. Hultman, but it's not a board case.
20 But, you know, I think you go to people who are experienced in
21 certain areas, and you want them to be the ones to help you. So
22 it's a case that I do extremely regularly and quite confident in
23 doing.

24 Q You spoke a little bit about your experience in breast
25 surgery. Can you tell the jury kind of a little bit about that

1 in terms of what types of things you've done throughout your
2 career and then maybe how many breast surgeries that you've done.

3 A Yes. So I started out running a breast-reconstruction
4 program for an NCI Cancer Center, so I basically did everything
5 from implant reconstruction, breast lifts, really specialized in
6 doing what was called microsurgery where we take tissue off of
7 the body and then move it up to the breast, and you would
8 together 1 and 2 and 3 millimeter arteries and veins, and so
9 surgeries that would take 8, 10, 12 hours to do.

10 So we became a center where folks from the outside areas
11 would come who had had failed surgeries, who had had, you know,
12 difficulties, or who desired a procedure that just wasn't offered
13 in local markets.

14 Q Is it fair to say you had the necessary experience to take
15 care of a patient like Rebecca Turisk then?

16 A Yes.

17 Q Have you authored any textbooks or any publications on
18 breast surgery?

19 A Yes. So we've done articles and, you know, papers and stuff
20 like that through the years when I was involved in teaching at
21 the residency program my first few years of practice in
22 academics.

23 But, the last two editions of Cameron, which is the gold
24 standard of general surgery text used throughout the world, we've
25 authored the breast-reconstruction chapter for that book. So

1 James Cameron's probably in his 80s now. He's a professor
2 emeritus at Johns Hopkins. He reached out a few years back, and
3 myself and a couple other guys that I work with wrote that
4 chapter.

5 Q And it sounds like you may have mentored or taught other
6 plastic surgeons a little bit about breast surgery. Is that
7 something that you can tell the jury about?

8 A Yes. I was involved in the residency training program for
9 plastic surgery, so we would have residents and fellows assigned
10 to us. They would follow us, and we would do didactic teaching,
11 as well as clinical. I was heavily weighed towards clinical
12 activities. I didn't -- I was not a research scientist, so I
13 operated a lot.

14 Q I was going to say, when you say clinically, you're
15 referring to being in the operating room?

16 A Yes. Academic centers have kind of two paths, where you're
17 either more of a research scientist supported by like NIH grants
18 or stuff like that, or folks who operate and generate clinical
19 revenue.

20 Q And then I believe you said you opened a private practice in
21 2013; is that right?

22 A Yes, July of 2013.

23 Q And what types of procedures have you done since you've gone
24 into private practice? Have they been different, or more of the
25 same?

1 A Well, it sort of evolved over the last 10 years. I still
2 did a lot of reconstruction early on, but now I primarily do
3 cosmetic surgery related to the whole body. I do face surgery,
4 as well as abdominal and breast surgery. We do about 1200 --
5 this year we'll go well over 1200 cases in our operating rooms in
6 our practice.

7 Q And do you operate in a hospital setting, as well,
8 sometimes?

9 A I do. Not as much anymore because of scheduling, but I do.

10 Q And the practice where you work, that's a surgical center?

11 A Yes. We have three of them.

12 Q And are those accredited?

13 A Yes, by a triple agency.

14 Q What does that mean?

15 A Once every three years a doctor and a clinical nurse or
16 administrator will come and go through all of our charts.

17 They'll follow us around for a couple of cases to see sterility
18 technique, you know, how the instruments are cleaned, record
19 keeping, that kind of stuff.

20 Q Is it a thorough inspection process?

21 A Yes. It's a full two days of -- at least two days.

22 Q Aside from your medical practice, do you have any
23 involvement in any type of community activities or organizations?

24 A Yes. A few years back a colleague of mine from business
25 school and I started a charity where we give new bikes to

1 disadvantaged kids. We work with Boeing and local police
2 departments, and we've given away about 2500 bikes. Kind of an
3 idea I got from one of my daughters.

4 Q Okay. Let's change gears now and talk about why we're here
5 this week. Do you remember taking care of Ms. Turisk?

6 A Yes, sir.

7 Q I'm going to show you --

8 ATTORNEY SMYTH: Bear with me just a moment, Your Honor.
9 May I approach the witness?

10 THE COURT: Yes, sir.

11 (Defendant's Exhibit 6 is marked for identification.)

12 BY ATTORNEY SMYTH:

13 Q Doctor, I showed you what's been premarked as Defendant's
14 Exhibit 6, and ask you if you recognize the contents of that
15 notebook?

16 A I do.

17 Q What do you recognize it to be?

18 A Patient chart.

19 Q Which patient?

20 A Rebecca Turisk.

21 Q Is that the chart that your office kept in the regular
22 course of business during the time that you were caring and
23 treating Ms. Turisk?

24 A Yes, sir.

25 Q And were the entries in there made at or near the time that

1 they happened?

2 A I believe so.

3 Q And do you believe that's a complete chart of Ms. Turisk?

4 A I do.

5 ATTORNEY SMYTH: At this time, Your Honor, we would move
6 Defendant's Exhibit 6 into evidence.

7 ATTORNEY TANENBAUM: No objection, Your Honor.

8 THE COURT: All right. It's in.

9 (Defendant's Exhibit 6 is received in the record.)

10 BY ATTORNEY SMYTH:

11 Q When did you first meet Ms. Turisk?

12 A The summer of 2016.

13 Q And tell the jury a little bit about what happens in that
14 first visit that you had with her in July.

15 A Sure. Our first visit is designed to get to know the
16 patient, to understand what they're interested in, what their
17 goals are. And I think our job -- I tell patients all the time a
18 couple things. One is, you know, I'm not really here to tell you
19 what you should or shouldn't do; I'm here to tell you what I
20 think you're doing, is it safe, and can we hopefully meet your
21 expectations.

22 Most common reason for unhappy patients, I believe, is the
23 lack of consistency in sort of the objective of the surgery. So
24 there's nothing worse for a patient to go through surgery, spend
25 money, time, recovery, and it not deliver the outcome that they

1 had hoped. And so we try to line those two up. So that's a big
2 part of it.

3 And then the second is the safety of the patients, seeing if
4 they have underlying medical issues and things that we need to
5 work up.

6 Prior to surgery we provide them usually with a quote so
7 that they know the financial responsibilities, and they can think
8 about that. We send them home with a folder to go through, and
9 we leave them a contact number for one of our coordinators, and
10 await their decision on whether or not to proceed.

11 Q And would you have recorded a note about your initial
12 history and physical appointment that you had with Ms. Turisk?

13 A Yes, sir.

14 Q All right. If you would open your notebook there and maybe
15 turn to page 2.

16 ATTORNEY SMYTH: Your Honor, permission to publish this?

17 THE COURT: Yes, sir.

18 ATTORNEY SMYTH: Thank you.

19 BY ATTORNEY SMYTH:

20 Q While we're getting that pulled up, Doctor, is this the note
21 that you made from your initial visit with Ms. Turisk?

22 A Yes.

23 Q And scrolling down to the subjective area there, maybe we
24 can zoom in a little bit. At least my eyes aren't that good.
25 Tell us a little bit about the process that you went through in

1 this particular visit in terms of what your initial assessment
2 was.

3 A Sure. We get background information about kind of why
4 they're there that day, and we include information about past
5 medical history, past surgical history, allergies, and things
6 like that that we want to document, we get a medication list, and
7 we physically examine them.

8 Q And what were Ms. Turisk's complaints to you at the time of
9 this visit?

10 A Basically that she had longstanding back/neck pain that
11 progressed. After getting an implant placed several years ago,
12 over 20 - 25 years earlier, her breasts had enlarged, and she had
13 heavy, dense, pendulous breasts that were affecting her activity
14 and her quality of life.

15 Q So is it fair that you knew Ms. Turisk had breast implants
16 on this very first visit?

17 A Yes.

18 Q Does it go without saying that when somebody's had prior
19 surgery for breast implants that they're going to have a scar?

20 A Yes.

21 Q And did you make any measurements or do anything like that
22 during this visit?

23 A Yes. The measurement that we're interested in is from the
24 clavicle to the nipple, and it's a pretty standard number that we
25 look for, a range of 19 to 21 centimeters. That's the ideal sort

1 of range. And Ms. Turisk was 30 centimeters on the right and 28
2 on the left.

3 Q And did you take any photographs of Ms. Turisk at that time?

4 A We did, uh-uh. Actually, the photographs were probably
5 taken the day of surgery, not at that time, because we tend not
6 to take photographs until someone's committed to surgery. We
7 don't want sensitive photographs of everybody that comes through
8 the office.

9 Q And would there have been a follow-up appointment with
10 Ms. Turisk where she would have gone over some forms with you?

11 A Yes. Once they've committed to surgery, they pay, usually,
12 a deposit to get a surgery date. Within two to three weeks,
13 usually somewhere in that range prior to the actual surgery, we
14 bring them in for their preop evaluation.

15 Q And in your chart is there an informed consent form?

16 A Yes. Referring to this chart?

17 Q Yes.

18 A I believe so.

19 Q And it may help you to go to page 17.

20 A Yes. Thank you.

21 Q Pull that up. Have you found that page?

22 A Yes. Thank you.

23 Q And I think we saw this yesterday when we were talking to
24 Ms. Turisk. Is this the informed consent form that you would
25 have asked Ms. Turisk to sign prior to surgery?

1 A Yes, sir.

2 Q Would you review the contents of this form with her?

3 A We do.

4 Q And what types of things do you tell your patients like
5 Rebecca Turisk who's going to undergo a surgery that involves
6 removing breast implants, breast reduction, and a breast lift?

7 A Well, I start off telling every patient basically the same
8 thing to some degree, that unfortunately there's no zero or
9 100 percent with surgery.

10 So every procedure has a known risk and a known complication
11 rate, so we try to hit the ones that are most pertinent to that
12 surgery. And certainly we hope that that doesn't happen, but I
13 think for somebody that's not in medical, undergoing a procedure,
14 they need to have some understanding of what can happen even in
15 the best of circumstances, and even when the surgery goes great.

16 Q Are these hypothetical risks or are they real risks?

17 A No, they're actually real. I mean, every procedure in the
18 literature has a percentage of complication. Breast reduction,
19 in general, is 1 to 13 percent, which is straightforward breast
20 reduction, so over 1 in 10.

21 Q And was Ms. Turisk a straightforward case?

22 A No.

23 Q How was hers different?

24 A She had had previous surgery. She had large, pendulous
25 breasts, and it was definitely not just a straightforward garden

1 variety.

2 Q Give the jury an idea -- maybe we can zoom in on that bullet
3 point just a little bit so they can see -- what types of things
4 you discussed specifically with Ms. Turisk.

5 A Yes. The things I covered, we go through those in virtually
6 every surgery, and then specific to breast surgery is skin loss,
7 nipple/flap loss, and revisional surgery is a big part of breast
8 surgery.

9 So when we do a breast surgery, we're putting tissue in the
10 position that, over a four-month period, swelling, changes,
11 gravity takes effect, so it's kind've like trying to hit a moving
12 target.

13 Q And you had that discussion with Ms. Turisk?

14 A Yes, sir.

15 Q And did you have any concerns that she didn't understand the
16 risks associated with this surgery?

17 A No, sir.

18 Q And did she sign the form?

19 A Yes.

20 Q And did you sign it as well?

21 A Yes.

22 Q I think you said chronologically in time the next thing that
23 happened would be she showed up for surgery and you took
24 pictures. Did I understand that correctly?

25 A Yes.

1 Q And you took some preoperative photos of Ms. Turisk?

2 A We did.

3 Q If you would turn to page 74, please.

4 A Yes.

5 Q Can you tell us what that is.

6 A A picture of the patient with her breasts, preoperatively
7 taken.

8 Q And that was taken before the surgery at issue in this case?

9 A Yes.

10 Q We talked a little bit about your initial physical
11 examination.

12 A Yeah.

13 Q What specific findings did you make with regard to
14 Ms. Turisk based on her appearance in this photograph?

15 A Well, looking at her breasts, this distance -- I guess it
16 doesn't work on there. Basically looking at this, her breasts
17 have dropped dramatically, so they're no longer up on top of the
18 implant. So the implant, you can see, is up higher, and her
19 breast tissue has descended. She has what appears to be dense,
20 heavy breast tissue. And she does have some asymmetry. Her
21 right breast is longer and larger.

22 Q And I saw reference in your initial note of something called
23 ptosis.

24 A Yes.

25 Q What is that?

1 A If you were to imagine where the breast fold is behind her
2 breast, that's kind of the point of reference; and then Grade 1
3 is slightly below that; Grade 2 is halfway down, say; and Grade 3
4 is at the bottom. So her nipple-areolar complex are at the
5 bottom of the breast, and that's grade 3 ptosis.

6 Q Is that the most severe level of ptosis?

7 A It is, uh-huh.

8 Q You were in the courtroom yesterday, I believe, when
9 Dr. Hultman used some of these exhibits --

10 A Yes.

11 Q -- that were up on the boards here. And I'm referring now
12 to Plaintiff's Exhibit 33.

13 A Yes.

14 Q Does this illustration represent the situation you
15 encountered when you saw Ms. Turisk?

16 A No.

17 Q How is it different?

18 A Well, you can see from that picture, if you'll hold it up --

19 Q Sorry.

20 A -- you can see that her nipple and areolae are basically at
21 her fold, so she doesn't have true ptosis. That's simply, you
22 wouldn't do a lift on that patient. That's a diagram for
23 teaching purposes; it's not a realistic representation of a
24 patient.

25 And you can see by looking at that, just even with reference

1 to Ms. Turisk's armpit, where her nipple sits in comparison to
2 her armpit versus that diagram. So the diagram is, as he said
3 accurately, a teaching tool.

4 Q And when you talk about fold, is that this area under the
5 blue line here?

6 A Yeah. Yeah. And so that's theoretical, and this is
7 practical practice.

8 Q All right. We can take that other photo down, please. So
9 based on these findings of the level of ptosis that you diagnosed
10 Ms. Turisk with, did you have a conversation with her about her
11 surgical options?

12 A Yes, uh-huh.

13 Q And what types of things would you have discussed with her
14 in terms of the approaches?

15 A Well, we basically go through a generalized discussion
16 about, you know, we have to move your nipple areola up, we're
17 going to remove tissue, and we're going to remove your implant.

18 I probably -- I wouldn't say that I go deeply into approach
19 with a patient because most people get kind of a glared look when
20 you start doing that and don't really want to hear that or need
21 to hear that, but we do talk about, obviously your options are
22 not to have surgery at all, to simply go in and take out the
23 implants, or take out the implants and do a lift. And those are
24 discussed.

25 Q And what did Ms. Turisk tell you she wanted out of those

1 options?

2 A She wanted the implants removed and some tissue resected.
3 You know, she -- I felt bad for her. I mean, she had been
4 through a lot with back and neck pain. She had, obviously,
5 large, heavy breasts. I felt strongly that removing that tissue
6 and the implant would improve her neck and back pain. It's one
7 of the better surgeries we do. Most people wake up feeling
8 better. Even a few hundred grams make a huge difference in
9 quality of life.

10 So I think in her circumstances, especially her, she was
11 doing this for the right reason. She didn't come in wanting, you
12 know, to be a cover model and having some unreasonable outcome.
13 She wanted to feel better. And I thought that was achievable.

14 Q And then did you -- let me back up a second. Would you have
15 reviewed the potential complications that are associated with
16 those surgeries?

17 A Yes, Uh-huh.

18 Q You mentioned that there were options of no surgery, just
19 removing the implants. If you were just to remove the implants
20 alone, what kind of condition would that leave the breasts?

21 A Extremely inflated, especially with the elongation, or
22 length, of her breasts. And she would still have some of the
23 other issues, which was rashing, irritation, and moisture, and
24 those things that occur with skin on skin when you have tied [ph]
25 breasts -- or, low hanging breasts.

1 Q So prior to walking into the operating room on November 1st
2 of 2016, had you given any consideration as to the type of
3 technique that you would use on Ms. Turisk in this surgery?

4 A Yes.

5 Q Can you tell the jury a little bit about that.

6 A Sure. From the moment I saw her, my experience is that the
7 inferior pedicle, as referred yesterday, is the gold standard.
8 The previous incision 25 years ago, I don't believe, is a factor
9 in a procedure like this. We regularly cross scar lines in
10 plastic surgery.

11 In fact, if you lose a part of your nose to cancer, the
12 technique we do is basically turn down the skin, leave it
13 attached here, and 10 days later you can go back and sever that
14 primary blood flow and it grows into your nose. And we do that.
15 Cross-leg flaps. We do it in the palate.

16 The practice of plastic and reconstructive surgery is moving
17 tissue. And so, there's very good data with other procedures.
18 Even somebody who has breast-cancer risk and has breasts that are
19 large and tied [ph], we'll go and do a lift first, and three
20 months later go back and do a mastectomy and remove all of the
21 tissue, and the nipple survives at a 360-degree scar.

22 So that idea of not crossing scars is sort of antiquated.
23 It's an older kind of mentality, and I think it's been very well
24 disproven. But I think, you know, that speaks a little bit to
25 Dr. Hultman. I agree with, you know, a lot of what he said, that

1 from his approach and his experience and what he does.

2 And I did a lot of burn surgery and general surgery at a big
3 burn center. I would not testify as a burn surgeon today. I
4 don't do it. People know way more about it. They do it every
5 day. So I think that's similar to this. You know.

6 He testified to textbook knowledge, or what is taught to
7 people early on in training, but the practicalities of everyday
8 life in practice are different than that.

9 Q Did you consider alternative techniques as well?

10 A Yes, uh-huh.

11 Q Would it help you to be able to show the jury with a
12 demonstrative what the differences are in the surgical approaches
13 that we're talking about?

14 A Sure. Yeah.

15 ATTORNEY SMYTH: Your Honor, permission to have the witness
16 come down out of the stand?

17 THE COURT: Yes, sir. Mr. Smyth, would you mind angling
18 that to hold it this way so --

19 ATTORNEY SMYTH: Absolutely. Is it where everybody can see?

20 THE COURT: Yes, sir.

21 THE WITNESS: So this patient up top came in. She has
22 breast ptosis and had had a previous mastectomy, so you can see
23 she had a 360-degree incision and some vertical component.

24 JUROR: I'm sorry. I can't -- there's a glare or something.

25 ATTORNEY SMYTH: Oh. Your Honor, can you see it?

1 THE COURT: No. That's all right, though.

2 ATTORNEY SMYTH: Would you like a printed copy of it,
3 perhaps?

4 THE COURT: Sure. That would be helpful.

5 THE WITNESS: Can you see that?

6 THE COURT: Does that work right there for everybody on the
7 jury?

8 JUROR: I'm good.

9 THE WITNESS: So she has -- if you remember yesterday, they
10 drew about a 4 centimeter incision, which is standard for
11 nipple-areolar incision for breast augmentation. This patient
12 had a previous lift, has a 360 degree previous incision, and has
13 some vertical component. Now, I drew here where that nipple
14 needs to go.

15 And you can see here, this dotted line is the procedure that
16 Dr. Hultman was talking about. This is a very small amount of
17 rotation. And I would agree with him, the superior pedicle here
18 would be fine.

19 This is what an inferior pedicle looks like, and I'll draw,
20 in a second, the difference. So this incision is usually 4
21 centimeters. I left a 10 centimeter diameter across here, so
22 that means even if you can see there's no blood flow across this
23 4 centimeters, there's still 6 additional centimeters of blood
24 flow. So this only reduces the blood flow by 40 percent.

25 Q In your experience, is 60 percent of the blood flow enough?

1 A Yes, more than enough.

2 Q Why do you say it's more than enough?

3 A Because this tissue doesn't have a high metabolic demand, so
4 it doesn't need a huge amount of -- it's a small skin paddle and,
5 in fact, is very metabolically low. It's not like muscle or bone
6 where it has a high metabolic need.

7 Q One term we've been using a lot this week that I don't know
8 has been fully explained is the word "pedicle." What do you mean
9 when we talk about a pedicle?

10 A So I'll show it on the next picture a little bit better, but
11 if you envision -- this is a pedicle once the skin's taken off.
12 So down here, I've actually gone and excised the tissue around
13 the nipple inside of the scar and showing that there's blood flow
14 across it, and that nipple is still vascularly alive. So the
15 idea that a small incision, 4 centimeters, with an inferior based
16 pedicle, killed all that tissue is just not accurate.

17 And we'll talk a little bit more about something. In this
18 picture you can see it's pink, so that means it's getting
19 adequate blood flow. If it gets blue or black or dark, it means
20 it's actually getting too much blood flow in and not enough out.

21 So their argument that I cut off all the blood supply is
22 impossible, because the nipple was actually venous congested, so
23 it actually had more blood than less. If it were cut off, it
24 would have been bright white, blanching like dead tissue that's
25 not getting any blood flow. And there are ways to address that,

1 and we can talk about those later.

2 Q You mentioned that you wanted to draw a little bit about the
3 pedicle itself.

4 A Yeah. So this pedicle here is the injured pedicle. So if I
5 draw that -- and I'll take exact measurements. So that's, say, a
6 10 centimeter pedicle. And the nipple areolae are up here. Four
7 centimeter incision here would be here and there.

8 And in their pictures yesterday, you could see that blood
9 flow here is very unpredictable. We actually have another
10 diagram, the picture that Dr. Hultman put up yesterday of the
11 breasts.

12 Q The one that they used?

13 A Yes. I think we have that on the computer. Right?

14 Q This one?

15 A Yeah, that one. So if you look at the difference in what
16 they put up yesterday, is that it was very -- this is not a real
17 body; this is just an artist who's not --

18 Q Could you hold that up just a little bit so the back of the
19 jury can see.

20 A These are just randomly drawn, and these are not -- these
21 are real vessels that you can reproduce, you know, established
22 vessels. These are all what I call collateral. Like he said
23 yesterday, they connect. The veins, also, they're random. These
24 pictures are drawn by somebody who's a nonmedical person, so
25 yesterday they showed ones that only had blood vessels on the

1 side. Well, that's not how it works. That's not how the human
2 body works.

3 So you can see here that even if you block this blood
4 flow -- and, again, I'll show a thing in a minute -- this is not
5 a two-dimensional structure, it's three-dimensions, so it has
6 width, length, but it also has depth. So the fact that there's a
7 scar in a superficial layer does not affect the deeper tissue.

8 Q First, I think you're using some big terms. The scar in the
9 superficial layer, what does that mean?

10 A That's what you can see on the skin, the actual scar.

11 Q So that's on the surface of the skin?

12 A Yes. Any incision in a human, outside of the uterine,
13 actually makes a scar. We don't know why that it is not in the
14 uterine.

15 So my point is that, even if there's no blood flow coming
16 here, you can see from that picture, in real anatomy, that
17 there's collateralization all over, going around this, and below.
18 So that's just not -- what he shows in the diagram, I'll show you
19 in real pictures.

20 Q All right. Thank you. Just for the record, when you were
21 referring to plaintiff's diagram, that was Exhibit 22, correct?

22 A Me?

23 Q Yes.

24 A I believe so, yes.

25 Q Okay. There were some other photographs that you provided

1 us, I believe, of a surgery that's not Ms. Turisk.

2 A Yes, sir.

3 Q Would those help you explain kind of how the process of
4 blood flow is maintained and how a pedicle is moved?

5 A Yes. It demonstrates the pedicle, and it also demonstrates
6 the procedure of like he was talking about, why I didn't pick
7 that procedure.

8 Q Okay. We'll get a few more here that I want you to be able
9 to use to explain your testimony. To be clear, these are not
10 Ms. Turisk and this is not from her surgery, correct?

11 A It is not her and it is not from her surgery.

12 Q Tell us what these photographs demonstrate and how they're
13 related to this case, please.

14 A Another patient who had a previous mastopexy and wanted a
15 lift --

16 Q Let me see if I can hold that up for you. Is that better?

17 A Here I've taken a, what we call, cookie cutter, but it's a
18 surgical circle basically outlining her new nipple. And you can
19 see that she has scar completely around this, 360 degrees, and
20 completely down. Here I've gone and taken that skin off. And
21 you can see where there was scar, veins, and vessels growing
22 across that tissue. You can see this scar here on the outside,
23 there's normal, vascularized tissue underneath.

24 JUROR: Tilt it this way. There's a glare.

25 ATTORNEY SMYTH: Sorry. I'm not very good at being a banner

1 [ph]. I'm sorry.

2 BY ATTORNEY SMYTH:

3 Q And can you show the jury that may not have their bearings
4 straight yet in terms of what is a vessel, what were you pointing
5 to? Show the vessels.

6 A The purple things here are clearly veins, and the red are
7 arteries. Well, they're collateral flow. Again, they're not
8 main vessels. But when you cut something, tissue realigns again
9 and it begins to basically grow across in a random fashion.

10 The other thing that cutting this does, ironically it
11 actually makes the rest of the blood flow stronger, so it
12 actually increases collateralization. So when you go back -- and
13 that's partly what Dr. Hultman was saying yesterday. The reason
14 that he was saying that he would stage this, which honestly isn't
15 a reasonable in-practice technique, you're committing the patient
16 to two surgeries for sure. And the reason to stage something,
17 when you do the first stage, you let it heal; and then you go
18 back and do the second stage. So that, by definition, is doing
19 exactly what this is, healing. And especially over a 25-year-old
20 period, it just isn't physiologically factual. And you can see
21 that from the picture.

22 This is a little bit more. So this is actually, again,
23 another patient where we outlined how we were going to do the
24 surgery and why this patient ended up getting a superior-medial
25 pedicle, which is what he talked about.

1 You can see, this nipple is moving from here to here, a few
2 centimeters, probably 2, 2 1/2, 3 centimeters. With this, we go
3 and remove the lower chunk of tissue here to reduce the volume,
4 and then we deepithelialize all this.

5 Q Meaning?

6 A Take the skin off. I'm sorry.

7 Q That's okay.

8 A And again, you can see the bleeding across the scar. This
9 nipple is alive, clearly pink and viable. And then you can go
10 ahead and take that down.

11 And here -- I'm sorry for the graphics, but I thought it was
12 kind of necessary. So now this patient is having a
13 superior-medial pedicle. The pedicle --

14 Q That's approach that Dr. Hultman recommended?

15 A Yes. For this patient, it's indicated and correct. This is
16 the tissue and pedicle. Remember, this is all scar. There's a
17 vertical scar. This is completely relying on tissue that's
18 healed.

19 This is an implant and capsule that he was talking about.
20 We do not take the capsule out. I can't tell for sure from that
21 picture. I'm not quite sure how he could. But, I generally do
22 take some of the capsule out laterally, but not where the pedicle
23 is.

24 And as you can see, this is just wispy scar tissue. There's
25 not a huge amount of vascularization in something like this. Of

1 course, if you can save it in patients around the pedicle, we do.

2 And then this shows you the three-dimensional. So here I've
3 taken this piece and picked it up with finger, and you can see it
4 has a thickness. So again, on a two-dimensional drawing it looks
5 like a scar and you thinking, Oh, nothing is going to flow across
6 that, but there's all tissue underneath that re-vascularizes.

7 So this patient had, again, a 360 degree scar, a vertical
8 scar, and is solely dependent on tissue medial to those scars.
9 And this is -- the reason that I did this in this patient, again,
10 was the small amount of lift.

11 Ms. Turisk, unfortunately, had heavy, pendulous breasts. So
12 you can imagine if this nipple is down here, this tissue is
13 stretched, and it has to rotate vertically. And it's virtually
14 impossible to insect that in somebody that has heavy, dense
15 breasts.

16 Q And in that scenario, is there a risk, using the superior
17 pedicle technique, that you might actually have the problem that
18 we're here about this week?

19 A Yeah. The other thing -- and I'll just say this now, I
20 guess, about the standard of care. It's very interesting. It's
21 like, you know, if you go -- apply the term to mechanics, apply
22 the term to contractors -- you know, it's based on the doctor's
23 experience and what they do every day and what they're
24 comfortable doing, and so standard of care doesn't mean that you
25 have everybody out there that is against you and says that was

1 the wrong procedure. Of course, you know, plaintiffs find one
2 person that's against it; we find one that's for it.

3 But the fact is that, what I did is extremely acceptable for
4 people. I do breast surgery on higher risk patients, and there's
5 a whole -- you know, we have a local plastic surgeon who fully
6 supports that.

7 Absolutely should not be doing this your first year in
8 training. Absolutely not. Should you do it if you just dabble
9 in breast surgery? Absolutely not. You know.

10 She had real symptoms. My goal was to help her with those
11 symptoms. I feel terribly that it went the way it did but, you
12 know, that's why this was done. It's solid medical --

13 Q And in terms of the risk that you say is there for the
14 superior pedicle technique that Dr. Hultman recommended, what
15 happens to the blood supply when you've got to take a really long
16 pedicle and remove it?

17 A Yeah. So the way that we close this, this tissue goes up
18 under so that this goes to that, and then we close it in that
19 vertical "T" which we showed in one of these pictures over here.
20 Well, you can see it her picture, too. It's an inverted-T.

21 The problem with somebody like Ms. Turisk, unfortunately, in
22 this pedicle, it's big, it's heavy, and it's stretched. You can
23 see her breasts. It's just pulling. That has to be rotated and
24 stuck up like that in order to close it, and then you close
25 tissue over it, so the likelihood of squishing that is higher.

1 With the inferior pedicle, which I drew earlier, the tissue
2 just slides vertically and it easily closes over, and so it's the
3 right surgery for what she had. Unfortunately, she didn't get
4 the outcome that neither her or I wanted, but it wasn't because
5 the surgery wasn't the right surgery.

6 Q Thank you, Doctor. During the course of the surgery that
7 you performed, is there a way to check to see whether you're
8 getting adequate blood flow to this nipple-areolar complex?

9 A Yes.

10 Q All right. How do you do that?

11 A Well, first, like I was showing in the pictures, I mean,
12 visually we all know what sort of pinkish, you know, healthy
13 tissue looks like, but the way that we traditionally do it is by
14 capillary refill testing.

15 Q And did you provide a video to us kind of showing what you
16 do to test that?

17 A I did. Again, this is not Ms. Turisk, but it's what we do
18 at the end of every surgery and what we basically dictate in our
19 note, is -- if you want to go ahead and play it, I guess. I'm
20 not sure you can see -- can you see it better up there?

21 And you can actually do it on your own hand. When you push
22 on that -- for some reason it's whited out. But, if you push on
23 it somewhere on your body, you can see it goes blanching and then
24 it goes pink.

25 And so if there's too much blood coming in, meaning blood's

1 coming in faster than it's going out, that means that it's venous
2 congested. So it's not that all of the blood flow has been cut
3 off; it's actually that something's compressing or affecting the
4 blood flow leaving the nipple, which then leads to purple, black,
5 eschar, and, you know, tissue death.

6 The opposite of that is, if I had cut off all the blood
7 flow, it would be pale, white, and cold, and it doesn't blanch.

8 Both of those scenarios are troublesome, but both have
9 ability to address them. So if you close this completely, suture
10 it all closed -- is there any way, Allie, not to make it so
11 bleached out?

12 (Off-the-record discussion.)

13 THE WITNESS: I think it's important to see, because it's a
14 real valid way to look at this.

15 ATTORNEY SMYTH: Is it all right if we play the video? It's
16 just not projecting well on the screen. You want to see it
17 first?

18 THE COURT: Sure.

19 ATTORNEY TANENBAUM: Subject to our objection, Your Honor.

20 THE COURT: Yes, sir. Same ruling.

21 ATTORNEY SMYTH: Permission to publish that video to the
22 jury?

23 THE COURT: Yes, sir.

24 THE WITNESS: May I go demonstrate?

25 THE COURT: Yes, sir. If you want to stand in front.

1 ATTORNEY SMYTH: Is it easier here?

2 THE COURT: Yes. That way they can all see it.

3 BY ATTORNEY SMYTH:

4 Q Why don't you come this way, Doctor. That way everybody can
5 see.

6 A To give you kind of orientation, this is the armpit, the
7 head is up here, the feet are down here, so it's basically
8 somebody like in this position.

9 So this nipple's been -- all of that's been done that I
10 showed you. It's been rotated in. It's temporarily closed, and
11 we're starting to close everything. So at this point ... So here
12 I take the --

13 ATTORNEY TANENBAUM: Excuse me a second.

14 (Counsel confer off the record.)

15 THE WITNESS: So can everyone see it? So when I push with
16 the clamp -- so we take this and push and watch. It goes white,
17 and then refills, and so that should be one to three seconds,
18 would be normal. If there's significant venous injury, it's
19 bright purple, and as soon as you let go it's bright and it
20 progresses over time. If it's not, if there's not enough blood
21 flow, it doesn't blanch at all, and it looks white like a piece
22 of paper.

23 And the reason that we do that is, at that point if it is
24 purple, or dark, we do things like leave the sutures out, we
25 leave it loosely closed, put Vaseline on it and let it heal for a

1 couple days, and usually the venous system accommodates and you
2 can come back and close it.

3 If we've already closed it and somebody's gone home and they
4 come back in, we can take a needle, an 18-gauge larger needle,
5 and poke it every two to four hours, releasing that blood flow,
6 and over time those vessels with accommodate.

7 And then there's even, I'm sure you might have heard,
8 leeches, the use of leeches, medical leeches. You can get those
9 air-mailed within 6 to 12 hours. And you put those on a
10 venous-congested area, and the leeches actually remove the blood
11 and conjoin a hyaluronidase, which helps lyse some of it, clot.

12 So if it's arterial, it's actually a much harder problem.
13 So if you have no blood flow to that tissue, believe it or not,
14 the treatment is to remove the nipple and do a free nipple graft,
15 meaning if you take the nipple completely off devascularized
16 tissue and then put it back down, it grows through inhibition,
17 just like a normal skin graft. So that's the importance of doing
18 that at the end of that procedure.

19 BY ATTORNEY SMYTH:

20 Q And let's look at your operative note for a second.

21 Following the procedure, did you create a note that details how
22 you performed the surgery?

23 A Yes.

24 Q And is that found on pages 4 through 6 of your chart?

25 A Yes.

1 Q And we've got it on the screen here. Is this the operative
2 note that you prepared for Ms. Turisk's surgery?

3 A Yes, sir.

4 Q And kind of take us through what you've got there in terms
5 of the opening paragraph and what you're explaining there.

6 A Basically just talking about what we're doing, and having
7 discussed it. The patient's then consent -- or, obtained
8 confirmation. We mark the patients in preoperative holding to
9 make sure that they're still conscious and know. I make them
10 tell me in their own words what they're having done. And then
11 this just highlights kind of the numbers and the diameters and
12 measurements that we use so that we have a recollection of it.

13 Q Okay. And then going over to the second page of your note,
14 is this the body of the note where you describe how you did the
15 surgery?

16 A Yes.

17 Q And is there any reference in your note to having checked to
18 make sure that Ms. Turisk's breasts, nipple-areolar complex, were
19 getting adequate blood supply during the surgery?

20 A Yes, I believe there is.

21 Q And what did you say about that specifically?

22 A The bottom part, at the conclusion, the nipple-areolar
23 complex appeared intact and viable.

24 Q That's at the end of the case. Did you also talk about
25 having done that test in the video that we just showed the jury?

1 A Yes.

2 Q And did you note any problems with the blood flow to either
3 of Ms. Turisk's breasts during the surgery?

4 A No.

5 Q And I think you spoke to this, perhaps, a minute ago, but if
6 you had seen something that was unusual or not right --

7 A Yeah.

8 Q -- with the blood flow, would you have addressed that during
9 surgery?

10 A Yes, sir.

11 Q The treatment that you would give for that, does that change
12 whether it's an arterial issue or a venous issue?

13 A It does. Yeah.

14 Q And I think just for clarification for the jury, this
15 illustration that we talked about that has the blood-flow supply,
16 it's got veins in the left breast and arteries in the right
17 breast. Is that accurate?

18 A No.

19 Q All right. How is that in real life?

20 A Most of them run almost in parallel, or some degree of
21 parallel, so they would be interspersed throughout each other.

22 Q And so you would have both arteries and veins in each
23 breast?

24 A Yes, sir.

25 Q And in this case did you do anything to cut off the blood

1 flow into the nipple-areolar complex as has been suggested?

2 A No.

3 Q Do you think the problem that Ms. Turisk experienced was
4 something different than that?

5 A Well, I know for sure based on clinical scenario afterwards
6 that formation of an eschar and having the bruising, that it was
7 a venous-outflow issue of some sort.

8 Q Does that run against the theory that the surgical technique
9 that you chose somehow cut off all the blood supply to her
10 nipple?

11 A Yes.

12 Q If it was suggested in this courtroom yesterday that your
13 surgery you planned to use, the inferior pedicle technique, was
14 essentially doomed to fail or certain to fail, do you agree with
15 that?

16 A No. I disagree.

17 Q And why is that?

18 A For the reasons that we stated earlier. I do both
19 techniques. I have no vested interest personally in which one I
20 do on somebody. I have the ability and the choice to do either
21 one. And I've shown, I think, when, in a clinical scenario, one
22 works well and when it doesn't, and shown there are patients that
23 have far greater scarring and vascularity can be maintained.

24 Q And prior to surgery did you do anything to help control the
25 risk of infection?

1 A Well, being accredited, we have to follow the guidelines
2 that our accreditation and our handbook outlines.

3 Q And give the jury an idea of what that includes with a
4 patient like Ms. Turisk with this surgery.

5 A Yes, sure. So, you know, evaluation, when she's brought it.
6 Obviously all the instruments go through a sterile process. They
7 have indicators on them to ensure that their sterility is
8 maintained. The patient, themselves, are prepped with
9 Chlorhexidine or Betadine, or one of those things, and they're
10 draped with sterile drapes to prevent, as much as possible, local
11 contamination either from the surgeons, or nurses, or from the
12 patient's own skin.

13 Q And do they receive antibiotics during the surgery?

14 A They do. In a case like this they get, ideally, about, you
15 know, within a timeframe perioperatively, 30 minutes or so,
16 somewhere around that.

17 Q And was Ms. Turisk given an interoperative antibiotic?

18 A She was.

19 Q Which one was that?

20 A I think she got Ancef. That's correct.

21 Q And in your experience, does that practice that you follow
22 comply with the standard of care in terms of trying to minimize
23 the risk of infection?

24 A Yes. There's been large studies out of the VA system about
25 perioperative antibiotic use before surgery and after, and her

1 case was considered a clean case. They are categorized by clean,
2 clean dirty, contaminated, those kind of things. So the amount
3 of antibiotic therapy that you get is based on that. And the
4 data is very clear for someone like Ms. Turisk, it's just that
5 perioperative dose at the time of surgery.

6 Q You talked a little bit about venous congestion and why you
7 think that was the source of the issue in this case. Was there
8 any evidence when Ms. Turisk left the operating room or you
9 finished the procedure that she had any type of blood-flow issue
10 either in through the arteries or out through the veins?

11 A No, sir.

12 Q Did you have any reason to anticipate that she was going to
13 experience a complication after you finished that surgery?

14 A No.

15 Q Can this venous-congestion problem occur in the
16 postoperative period?

17 A Yes, uh-huh.

18 Q Tell the jury how that happens, in your experience.

19 A Probably the most common thing would be a hematoma, where
20 you get accumulation of blood in a closed space. And because
21 veins are very low pressure, they're not like arteries, so when
22 you feel your wrist or feel your neck you can't feel venous
23 pressure but you can feel arterial because of the discrepancy in
24 pressure, so veins are very suspect to compression, whether it's
25 internal or external.

1 And again, I'm not accusing Ms. Turisk of anything or that
2 she did anything wrong, but the common things that happen with
3 venous congestion are the hematoma, the closure's too tight which
4 you would see at the time of the closure, or certainly before
5 they left.

6 External compression can be people go home and kind of fall
7 asleep in a weird way and the bra twists or the bra tightens and
8 pulls across, and that can be enough to put pressure on that
9 tissue.

10 And then just, really, some folks just have a massive amount
11 of swelling that's inter-tissue, if you will, so it's not fluid
12 and it's not from the outside. It's just within, you know, like
13 I showed you, it has a thickness. Some tissue just expands. And
14 that can be compressive.

15 Q Is there any way for you to control the amount of swelling a
16 patient has?

17 A No.

18 Q Is that an individualized response to the surgery?

19 A It is, and no way of knowing who's going to do that or not.

20 Q In a case where you're concerned about venous congestion
21 like this one, is there a certain time period when you have to be
22 able to act in order to do something to preserve the tissue?

23 A Yes. And it depends on the degree of congestion. So in
24 somebody that is extremely congested immediately obviously has a
25 very shorter timeframe, but generally somewhere in that 12 to 36

1 hour, you know, 48-hour period, depending on what the cause is,
2 too.

3 Now, if somebody comes in and is compressed and it's from
4 our closure, we cut out the sutures. The tissue kind of bulges
5 out. We leave it open for a couple days, and then close it in a
6 delayed fashion.

7 And then, like I said, you can stick it with a needle every
8 four hours. You know, if you don't feel it, there's no pain, and
9 that allows the blood out. And leeches, and other things.

10 Q And so after you finished the surgery and Ms. Turisk goes
11 home, what was your next communication with her and her
12 caregivers?

13 A I spoke with her caregiver multiple times that night and the
14 next day. She was having some blood-pressure issues. I actually
15 called an anesthetist to make sure that she had gotten
16 Solu-Medrol and all of that, because I wanted to make sure we
17 hadn't missed any of that, and she had. Yeah, I spoke to them
18 multiple times.

19 Q In any of those conversations, was it ever reported to you
20 that there was a concern about the appearance of her breasts or
21 her nipple-areolar complex?

22 A No. I asked how things looked, because hematoma is a
23 concern, and I was told that it looked okay; it looked normal.

24 Q And did you have any understanding as to whether they had
25 taken down the dressings to actually look?

1 A I assume they had when I asked them how it looked, but I
2 don't have confirmation of that.

3 Q Did you get any pictures in the first three or four days
4 after the postoperative procedure?

5 A No.

6 Q Did you ask Ms. Turisk to come in and be seen?

7 A With her blood pressure, I asked her caregiver if she would
8 come either to the office or to an urgent care facility. It's
9 kind of a toss-up. If it's a blood-pressure issue, it's harder
10 for us to do that in the office. I mean, we can't run labs or
11 anything. But if it's just somebody that needs some hydration, a
12 couple liters of fluid, we will see patients back, hook them up
13 to IV, and most people respond well.

14 The combination of not eating and drinking for several
15 hours, and then surgery, you know, people become dehydrated
16 pretty quickly.

17 Q And did you have any more conversations with Ms. Turisk or
18 any of her caregivers after the first night?

19 A I did. I checked on the second and, I believe, the third
20 day. But, yeah.

21 Q Did the information you receive from those conversations
22 cause you any concern or think that she might be having a
23 complication of this nature?

24 A No. She was doing better by 48 hours or so. I mean, she
25 still was certainly not her normal self, but she was not

1 regressing and heading in the right direction.

2 Q And we have seen the postoperative pictures that were
3 discussed yesterday.

4 A Yes.

5 Q I think those were taken on November the 6th. Is the time
6 when those pictures taken still within the window where you could
7 do something about a venous-congestion problem?

8 A No. Unfortunately, the venous congestion, a lot of times,
9 is worse than arterial insufficiency because it's like a clogged
10 drain or whatever, if you will. It just backs up, and it causes
11 the tissue to swell and the cells to lyse, or open, and basically
12 break down, and so there's no real way for those cells to
13 regenerate or survive.

14 Q What does that lead to?

15 A Tissue death. Those cells that are dramatically affected
16 die. They lyse. The fat becomes a liquid, which is called
17 liquefied necrosis, which generally is referred to as fat
18 necrosis.

19 And so at first fat necrosis is not necessarily hard; it's
20 more liquified. It's a drainage. It's often confused with
21 purulence, or pus that everybody refers to, because it's whitish
22 yellow. But it's not -- there's no organism or cells, or
23 anything like that.

24 Q And there was reference in Ms. Turisk's testimony, I
25 believe, yesterday that she was experiencing some of the drainage

1 and some of the changes in color in her tissue. What do you
2 believe that was due to?

3 A Congestion and injury to the tissue.

4 Q Did Ms. Turisk return to your office for follow-up visits?

5 A She did.

6 Q Did she see staff members at your office?

7 A She did.

8 Q What was your understanding of what her condition was during
9 those visits?

10 A She seemed to be, overall, improving with her activity level
11 and feeling better, as reported. She did -- was noted to have
12 significant bruising of her nipple-areolar complex, right
13 significantly more than the left.

14 Q Were you concerned that she was having an infection at all
15 during those postoperative visits?

16 A No, I was not.

17 Q And I believe you were sent photos of her breasts following
18 one of those visits?

19 A I was, yeah.

20 Q Did you also see Ms. Turisk yourself during the
21 postoperative period?

22 A I did.

23 Q And what were your findings at that time? You're welcome to
24 refer to your notes, if you'd like.

25 A I don't know where that would be. She had obvious venous

1 issues. The interesting thing with that, aside from the note, is
2 that the tissue can often act as a biological dressing, so at the
3 eschar, it shows you what's going on at the very top layer, but
4 you don't know necessarily what's going on deeper.

5 The human body is resilient at demarcating tissue, so
6 something that we look at as a surgeon -- you can look and think
7 That's got to come out -- a lot of the times you can decrease the
8 amount of tissue that needs to be removed by letting the body
9 kind of demarcate it itself.

10 And so that's -- My feeling at that point was there was
11 clearly tissue injury, but to the extent, we, at two weeks, don't
12 know at that point.

13 Q Let's look at your note of November the 15th. That's on
14 page 36 of the notebook there.

15 ATTORNEY SMYTH: Permission to publish, Your Honor?

16 THE COURT: Yes, sir.

17 BY ATTORNEY SMYTH:

18 Q So what we've got on the screen here is page 36 of the
19 chart. Can you tell us what that is?

20 A A follow-up note.

21 Q And what's the date?

22 A Fifteenth of November 2016.

23 Q So you're now about two weeks postoperative?

24 A Yes.

25 Q And was there someone seeing the patient with you?

1 A Yes.

2 Q Who is that?

3 A Physician Assistant Rebecca Johnson.

4 Q And at the bottom there it says DKS did see as well. What
5 does that mean?

6 A My initials.

7 Q So that's an indication that you saw this patient at this
8 visit as well?

9 A Yes.

10 Q And what were the findings contained in this note in terms
11 of the appearance of Ms. Turisk's breasts two weeks after
12 surgery?

13 A That her right areolar-nipple complex is very bruised and
14 had eschar forming. The remainder of the incisions were clean
15 and intact without erythema, warmth, or discharge. There were no
16 palpable seromas to the breasts or abdomen.

17 Q I'm going to get you to interpret that for us --

18 A Sure.

19 Q -- so that we understand the medial significance of that.

20 A Yeah. Basically, there was nothing that was alarming to us
21 in terms of her incisions or the tissue itself aside from her
22 nipple, which we noted, and that she had no fluid.

23 Seroma is like a fluid collection that occurs under the skin
24 and on top of muscle, and that's why we put drains in, to try to
25 alleviate that risk.

1 Q And are the bruising and the eschar, is that related to the
2 venous congestion that you talked about?

3 A The eschar is. The bruising is not. The bruising is
4 outside of the incisions, in the native tissue.

5 Q All right. I'm going to show you a picture of what I
6 believe we've seen already here. And can you tell us what's
7 depicted here?

8 A It's an extremely magnified picture. That black area is
9 probably 3 centimeters in size. So now, that it's as contracted.
10 It's extremely -- and you can see intricacies of very tiny veins
11 and stuff.

12 But there's an eschar present out over the nipple-areolar
13 complex. That tissue is damaged, if not dead, to some degree.
14 There is pink tissue around the outside edge of the wound, which
15 is granulation tissue, which is healthy. That pink tissue grows
16 in, and then skin follows it. And there's fat behind it that has
17 liquid present that appears yellowish brown below the
18 nipple-areolar complex.

19 Q The eschar being there, that black area in the middle where
20 the nipple is, is that a good thing or a bad thing in terms of
21 the healing process?

22 A Well, it's not a great thing, obviously, because we don't
23 want any tissue damaged. This is what you hear people say dry
24 gangrene. A lot of time you may see people have it on their feet
25 and stuff like that. You know, folks can walk around for years

1 with dry gangrene. When it becomes a wet gangrene is when people
2 become sick from it.

3 So what we're doing at this point is, that injury has
4 occurred. There is nothing I can do to stop that or fix that
5 from happening. My hope at this point is that the tissue
6 demarcates well underneath it, and eventually we'll remove that.

7 If she were to become, you know, extremely not well and have
8 to be hospitalized, at this point we would do something more
9 aggressive, but we did not have to do that.

10 Q And I believe in the note that we were just looking at
11 there's an indication in there that the incisions were clean and
12 intact.

13 A You can put it back. The nipple area, you can see
14 underneath, that they are closed. There is some sloughing of
15 skin underneath of the inverted-T, which is extremely common in
16 breast-reduction surgery.

17 It is open in areas, so I don't think it's necessarily
18 accurate to say it's completely intact, but I think, in general,
19 the shape and form of the breast is being maintained by the
20 closure.

21 Q And it was suggested yesterday by Dr. Hultman that you may
22 have missed an infection at this point, or sooner, based on this
23 picture that was taken in your office, I believe it was, on
24 November 28th.

25 ATTORNEY TANENBAUM: Objection, Your Honor. I don't think

1 Dr. Hultman said he missed an infection.

2 BY ATTORNEY SMYTH:

3 Q There may have been a missed infection. How about that?

4 A I believe, to a patient like Ms. Turisk, again, which I feel
5 terrible -- obviously seeing this on your body, it's terrible --
6 and you haven't seen it before, and everyone assumes that every
7 open wound or thing that looks like this is an infection, the
8 reality is it's not, it's not an infection. It's tissue that's
9 been injured, and some of it dead.

10 But, you know, what's interesting with that is we have to
11 see how much of that tissue's going to survive. And tissue
12 that's not perfused doesn't benefit from, you know, antibiotic
13 therapy anyway. So, to some degree, we're watching this to see
14 what happens, and if she doesn't clinically become unwell, then
15 we'll watch this for a good bit of time before we're forced or
16 decide to do something.

17 Q You said something there I want to follow up on. Why
18 wouldn't antibiotics be helpful in this scenario?

19 A Well, I don't believe that there's an actual infection. And
20 the tissue's been damaged. There's no blood flow going into that
21 nipple at this moment, so all of the IV antibiotics in the world
22 are not going to get into that because antibiotics are carried
23 through blood.

24 So that's one of the big problems, and that's why, in
25 plastic surgery, we move tissue around, because if you have a

1 wound somewhere that's not well-vascularized, you can put
2 somebody on all the antibiotics in the world but they're not
3 addressing the site, and so we move vascularized tissue there
4 that then is perfused with antibiotics.

5 Q And it was suggested yesterday that a topical antibiotic
6 cream would have made a difference and preserve breast tissue
7 even. Do you agree with that?

8 A I categorically disagree, but that's my -- he has his
9 opinion; I have mine. In 20, whatever, 18 years of practice, I
10 do not routinely do that. And, in fact, it causes -- if you put
11 antibiotic cream on skin for an exposed period of time, meaning
12 multiple days or weeks in a row, you can get a hypersensitivity
13 to it, so you start to get redness that actually can be confused
14 with infection.

15 It's been well-documented in the literature that surgical
16 sites treated with water and soap is by far the most effective
17 treatment.

18 Q There was some testimony, I believe, yesterday from
19 Ms. Turisk that she used a different method to try to treat those
20 wounds which, I think, involved hydrogen peroxide. Is that
21 something you would have ever recommended to Ms. Turisk?

22 A No.

23 Q Why not?

24 A That's also -- I know a lot of our generations grew up with
25 grandmothers putting hydrogen peroxide on everything, but

1 hydrogen peroxide is very effective at killing everything. So
2 when you have growth or healing, it's done by regeneration of
3 tissue, and that involves inflammatory response in cells that
4 have to -- neutrophils, macrophages, all these different cells.
5 Unfortunately, hydrogen peroxide, especially in large volumes, is
6 extremely toxic to tissue and cells.

7 Q Could it make things worse?

8 A It could, but I -- I mean, obviously I'm not blaming her,
9 but that's not something, had we been asked, that we would
10 recommend today. But I know it is commonly done by people.

11 Q All right. You can take that down. Did you have an
12 occasion to see Ms. Turisk again?

13 A Yes.

14 Q Let's look at page 42 of your record.

15 ATTORNEY SMYTH: Permission to publish?

16 BY ATTORNEY SMYTH:

17 Q Do you recognize this note?

18 A I do.

19 Q Can you tell us what it is, please.

20 A A follow-up appointment note.

21 Q And what's the date of that?

22 A November 30th, 2016.

23 Q And this ended up being the last time you actually had a
24 patient interaction with Ms. Turisk?

25 A Yes. I saw her that date. I believe this was on a

1 Wednesday. We were planning to follow up on Friday again. She
2 had been seen Monday. But, yes, this is the last time I saw her.

3 Q And I think you had a note chronologically in time before
4 this.

5 A I did.

6 Q And when was that date?

7 A Twenty-eighth, I believe.

8 Q The 28th?

9 A Yes.

10 Q In reviewing for this case and going back, did you notice
11 any discrepancy in the date that you recorded that note?

12 A Yes. I'm honestly not sure. I'm confused myself, because
13 she went to two different facilities and a second plastic
14 surgeon, and I received phone calls from the places when she'd
15 go. A couple of them were at night. And so I think she went to
16 an urgent care center first on the 27th, I believe, came in on
17 the 28th, and then on the 29th went to Summerville Medical Center
18 or another hospital.

19 And so I wrote a generalized note that I think I had one day
20 later or earlier than she had actually gone to one of them.

21 Q Setting the dates aside for a second, what was your general
22 understanding of how her condition had changed at this point
23 since you had last seen her on the 15th?

24 A There was definitely more concern, it sounded like, from the
25 incision, and at least in general and, as very common with

1 patients, as time goes on they become less patient and more
2 worried, rightfully so.

3 Again, obviously they don't see this every day and they
4 don't see the long term, but I think she was beginning to have
5 more anxiety. I know her caregiver was becoming more, I don't
6 know, just more forceful in kind of what he felt the approach
7 should be, so she was seen at outside facilities.

8 Q And on this visit of the 30th when you saw Ms. Turisk, what
9 treatment did you provide to her?

10 A At that point, on the 30th, that black area was removed.
11 It's basically tangentially removed. Takes probably three
12 seconds to do that, or two seconds. And a dressing was placed.
13 And she had been started on Bactrim, I believe, since Monday.

14 Q And what is Bactrim?

15 A Generalized skin antibiotic that works well for MRSA and
16 most generalized gram-positive skin bacteria.

17 Q And who was that ordered by?

18 A I believe that was started by Jordan, one of our caregivers.
19 I believe it was Jordan on Monday. Oh, yes. It says Monday.
20 Yeah.

21 Q So she had already been on antibiotics by the time you saw
22 her?

23 A She was, yes.

24 Q And do you believe those were the appropriate antibiotics
25 for what was going on with her at that time?

1 A No. Well, that was. I think she was started on another
2 antibiotic by an outside facility, which they started Keflex,
3 which is also a gram-positive but it's a more, not quite as
4 aggressive and doesn't cover MRSA the same, which is a
5 community-declared staph which everybody talks about at schools
6 and hospitals.

7 Q We talked a little bit about the actual bacteria that were
8 found on the cultures. Did you get culture results sent to you
9 on wound cultures for Ms. Turisk?

10 A We did. I don't know when we received them.

11 Q Let's look at page 62 of your record, please.

12 A Yeah.

13 Q We may need to zoom in. All right. Is this the wound
14 culture report that you received that was taken from Ms. Turisk's
15 breast wound?

16 A Yes.

17 Q And it looks like it's dated November 29th; is that right?

18 A Yes.

19 Q And then if we could go down a little bit. What were the
20 results of the wound culture that were performed on her?

21 A Staph aureus and enterococcus faecalis.

22 Q And are you familiar with those bacteria?

23 A Yes.

24 Q What are they? Give the jury an understanding.

25 A Sure. Staph is the common, most common, form of bacteria

1 that's on all of our skin. No matter how much you wash your
2 hands, no matter how much you scrub your hands, there's no way --
3 It's a natural occurring bacteria, which the human body has tons
4 of natural occurring bacteria throughout skin, organs, GI tract,
5 and most infections that people get come from themselves a lot of
6 the times.

7 Q And then it looks like there was also noted to be a second
8 organism present?

9 A Yes.

10 Q What's your understanding of what enterococcus faecalis is
11 associated with?

12 A It's a gastrointestinal origin.

13 Q And in your experience, have you had patients that have
14 encountered this type of bacterial infection?

15 A I have. It's not extremely commonly cultured. At least in
16 my practice, I haven't seen a lot of it, but ...

17 Q Based on the report that you were given here -- let's scroll
18 down a little bit more. There at the bottom there's something
19 that says susceptibility procedures.

20 A Uh-huh.

21 Q What is that telling us?

22 A Just the antibiotics that would work for what they believe
23 is growing.

24 Q So there's a list of different antibiotics, starting with
25 clindamycin and going down to vancomycin. Are all those

1 antibiotics that would work against the two bacteria that they
2 found in the cultures?

3 A They believe so, in this culture. Yeah.

4 Q Do you treat, routinely, wound cultures that come back with
5 bacteria in them?

6 A We don't. And, you know, part of what Hultman said
7 yesterday, I agree with him. He said these bacteria are
8 everywhere, everywhere you go, so we can't go starting every
9 patient that has a positive culture on an antibiotic. We already
10 have tremendous problems with resistance in antibiotic therapy,
11 and certainly antiviral therapy, so -- And there's a whole bunch
12 of things that go into taking a culture, and the accuracy is
13 dependent on who's doing it and how careful they are. If you
14 bump the native skin in doing it, if you touch the outside of a
15 container when you're putting a swab in.

16 So we generally, especially in surgical practice, don't
17 start people on an antibiotic course based solely on a culture.

18 Q Going back to the office notes. So we're looking, again, at
19 the note of November 30th. There in the bottom part of that
20 note, maybe we can blow that up where it says medications.

21 A Yes.

22 Q There's something there called Dakin's solution. What is
23 that?

24 A It's taking saline, a gallon, usually a gallon of saline,
25 and mixing it with a cup, like a cap, of Clorox or bleach.

1 Q And why is that used?

2 A It's very effective at odors that can come out of tissue,
3 whether it's fat necrosis or if it's infection, or whatever it
4 may be. We basically take a dressing, dab it in that, and then
5 put the dressing in the wound. And as the dressing dries, when
6 we remove it, it removes kind of nonviable tissue that you don't
7 want, and it also will help, for patients who are experiencing --
8 you know, oftentimes the smell that a patient smells, they become
9 very sensitive to it and it becomes bothersome. And usually once
10 they're debrided and stuff, most people around them don't smell
11 it, but it's a constant source of reminder and agitation, and it
12 makes people upset. So Dakin's often, after two or three days of
13 doing that, will alleviate that smell, or cut it down
14 dramatically.

15 But, it's a very dilute form of, you know, that Clorox being
16 mixed with saline. And it's not in the pharmacies.

17 Q Before I forget, the photographs that you've used to
18 demonstrate the various procedures today -- and these are four
19 posters -- do those fairly and accurately represent the concepts
20 that you've discussed here today?

21 A Yes, solely to show why -- why I choose one procedure vers
22 another, and my rational for that.

23 ATTORNEY SMYTH: At this time, Your Honor, we would offer
24 those into evidence as well.

25 THE COURT: Any objection?

1 ATTORNEY TANENBAUM: No objection, Your Honor.

2 THE COURT: All right, sir. They're in.

3 (Defendant's Exhibits 7, 8, 9, and 10 are marked for
4 identification.)

5 (Defendant's Exhibits 7, 8, 9, and 10 are received in the
6 record.)

7 BY ATTORNEY SMYTH:

8 Q Just about finished here, Dr. Schimpf. I know everybody
9 will be glad to probably have a break shortly.

10 But, going back to the infection, was it your understanding
11 that Ms. Turisk antibiotic -- excuse me, that her concerns with
12 those bacteria were being treated with the appropriate
13 antibiotics?

14 A Yeah. Yes, sir.

15 Q And what was your plan at the end of that visit on
16 November 30th?

17 A We were going to see her back in two days, Friday, before
18 the weekend. I was going to see how the tissue had continued to
19 demarcate with the nipple-areolar complex being removed and, you
20 know, continue to monitor that and see her on a regular basis and
21 do dressing care.

22 Q At any point during your postoperative interactions with
23 Ms. Turisk did she ever tell you that she was upset with you or
24 blamed you for any of the problems that were going on?

25 A I don't believe so.

1 Q Did she ever tell you that she was not going to come back to
2 you for the next follow-up appointment that you scheduled?

3 A I don't believe so.

4 Q You referenced this a time or two, but do you feel badly
5 that Ms. Turisk had a complication?

6 A Well, I feel badly every time somebody has a complication.
7 I certainly feel badly for her, you know, for her reason for
8 doing it was correct, she had a good intention and was realistic.
9 But unfortunately that's, you know -- it's the hard part about
10 doing surgery that we take extremely personal, and it's the stuff
11 you lay in bed at night thinking about.

12 But I do -- you know, I do now, probably, 800 surgeries or
13 700-or-some procedures/surgeries a year. It's just the nature of
14 it. And, you know, we try to learn from each experience.
15 Exercises like this are actually good in some ways. You go
16 through it in detail to see what could have been done
17 differently.

18 I hate the outcome that she had, but I would have done the
19 same surgery.

20 Q Do you believe you did anything that was outside of the
21 standard of care for a plastic surgeon in treating Ms. Turisk?

22 A No. And I think that -- you know, you have to be careful
23 because, again, we bring one person, they bring one person and
24 they say you absolutely shouldn't do this. Well, there's 80,000
25 plastic surgeons in the country, and there is nowhere in the

1 literature that this procedure has said this is not the standard
2 of care and you shouldn't do this.

3 So again, you know, we all practice different specialties
4 within plastic surgery and, as I alluded to, you wouldn't want me
5 doing your burn surgery. I did a lot of it, I'm knowledgeable
6 about it, but I'm not up to date on it and I wouldn't testify to
7 being an expert in it.

8 A lot of medicine you learn, you know, the basics in school,
9 and then you go out and practice and it takes years of practice
10 to become comfortable in doing certain things. And, you know,
11 this is a complex surgery, so I think this is something that
12 people that do it a lot need to be doing.

13 Q There was reference, I think, in your earlier testimony, to
14 the fact that the inferior pedicle is widely used. Can you give
15 the jury an understanding of what that means?

16 A Yes. So Dr. Hultman did a very good diagram of showing you
17 there's at least seven -- there's probably more than that --
18 techniques. Only two of them, really, are used 95-plus percent
19 of the time, and that's inferior pedicle and the superior medial.
20 The most common performed in the United States, in North America,
21 and worldwide, is the inferior pedicle.

22 In Europe and areas like that, the superior-medial pedicle
23 is used more than the U.S., but the inferior pedicle is still the
24 number one, widely used, most commonly taught breast-reduction
25 technique in the world.

1 Q It was suggested that just based on Ms. Turisk's scar that
2 the inferior pedicle technique was contraindicated for her
3 surgery. Do you agree with that?

4 A No. And as I demonstrated, I think in real life it's one
5 thing to put up a poster and say this isn't going to work, but
6 it's just not common practice. As in most professions, what's in
7 a book and in a diagram is not what you do in day-to-day life.

8 Q And do you believe you performed the surgery on Ms. Turisk
9 correctly and within the accepted standard of care?

10 A Absolutely.

11 Q Do you believe that you gave her good care in the
12 postoperative period?

13 A Yes.

14 Q Was there ever any time where she reached out to you, either
15 by phone or some other method, where you didn't respond to her?

16 A No, not that I'm aware of.

17 Q Did you ever refuse to see her?

18 A No.

19 Q Did you miss any infections?

20 A I don't believe so.

21 Q Were you ready, willing, and able to take care of her with
22 those complications?

23 A I was.

24 Q We heard a lot of testimony on the first day about some of
25 the procedures that she has undergone to help reconstruct the

1 tissue that was lost. Are those procedures that you do?

2 A Yes, uh-huh.

3 Q Are they procedures that you could have done for Ms. Turisk
4 had she decided to stay with you?

5 A Yes.

6 Q Would you have charged her for those procedures?

7 A No. No.

8 Q So we could have avoided all of the bills we've been talking
9 about in this case had she stayed with you?

10 A Yes. We tend to not charge people for stuff where they
11 don't get an outcome. And we may charge for a small amount of,
12 like, anesthesia or equipment fees, but it's minimal.

13 Q And would you have done the same thing for Ms. Turisk that
14 you would have done for any other patient?

15 A Yes, uh-huh.

16 Q Doctor, do you hold all the opinions that you've expressed
17 here today to a reasonable degree of medically certainty as a
18 board-certified plastic surgeon?

19 A I do.

20 Q Those all my questions. Thank you, Doctor. Please answer
21 any questions opposing counsel may have.

22 A Thank you.

23 THE COURT: Ladies and gentlemen, it might be a good time
24 for us to take a brief comfort break, so we'll take about a
25 10-minute break. We'll be right back with you.

1 Please remember my previous discussion not to discuss the
2 case amongst yourselves or with anyone else.

3 (Jury escorted out of the courtroom at 11:17 a.m.)

4 THE COURT: Doctor, you can step down during the break.

5 THE WITNESS: Thank you, ma'am.

6 THE COURT: Remember not to discuss your testimony. I'll
7 see everybody in about 10 minutes.

8 (Court recessed at 11:18 a.m. and reconvened at 11:32 a.m.,
9 without the jury present.)

10 THE COURT: Everyone ready to proceed?

11 ATTORNEY TANENBAUM: Ready to proceed, Your Honor.

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

13 (Jury seated in the courtroom at 11:34 a.m.)

14 THE BAILIFF: All the jurors are present, Your Honor.

15 THE COURT: Thank you.

16 ATTORNEY TANENBAUM: May it please the Court.

17 THE COURT: Welcome back, ladies and gentlemen of the jury.
18 We're ready to proceed. You may proceed with your
19 cross-examination.

20 ATTORNEY TANENBAUM: Thank you very much, Your Honor.

21 **CROSS-EXAMINATION**

22 BY ATTORNEY TANENBAUM:

23 Q Dr. Schimpf, good morning still.

24 A Good morning, sir.

25 Q So I want to get a few things out of the way just to sort of

1 be certain that I hear you correctly. You agree that Rebecca did
2 not do anything herself to cause this outcome; is that correct?

3 A I'm unaware of anything. That's correct.

4 Q She didn't tell you she had been sleeping on her chest, or
5 that she slept improperly? In fact, I think you heard her
6 testimony she was having a hard time sleeping; is that correct?

7 A That is correct.

8 Q She told you all of the comorbidities that she was
9 experiencing before she had this surgery, because your lawyer
10 asked her about them --

11 A Yes.

12 Q And you agree that the results she got occurred after your
13 surgery, correct?

14 A Yes.

15 Q And as a loss of the blood supply, correct?

16 A No.

17 Q Not as a loss of a blood supply?

18 A No. There's plenty of blood going in. It was a
19 venous-congestion issue, not arterial.

20 Q So your expert, Dr. Lefkowitz, talked about the lack of
21 blood supply, correct?

22 A I didn't see his testimony. I read it a long time ago, but
23 I can't speak to what he testified about.

24 Q So if your expert from instate --

25 ATTORNEY SMYTH: Your Honor, pitting.

1 THE COURT: Sustained.

2 ATTORNEY TANENBAUM: I'm sorry?

3 THE COURT: Sustained.

4 ATTORNEY TANENBAUM: I didn't hear his objection.

5 THE COURT: It was pitting the witnesses.

6 ATTORNEY TANENBAUM: Oh. Yes, Your Honor.

7 BY ATTORNEY TANENBAUM:

8 Q But Dr. Lefkowitz will be here, correct?

9 A He will, sir.

10 Q As will Dr. Joseph, coming all the way from California?

11 A Yes. I believe that's his name.

12 Q Now, your testimony, however, today is that she had too much
13 blood, in essence, what we call, what I think of it as, a
14 compartment syndrome; is that correct?

15 A Not correct, no.

16 Q Not correct, okay. Tell me --

17 A Compartment syndrome is where muscle swells after
18 reperfusion. It's trapped by fascia, and has had nothing do with
19 this.

20 Q Well, it had nothing to do with this, but my point is that
21 she was getting so much blood --

22 A No. It's not that she was getting so much blood. She was
23 getting arterial inflow, and something at some point compromised
24 the outflow. And it wasn't the pedicle construction; it was --
25 which normally is not, but venous congestion happens after,

1 usually.

2 Q And so what happens when you get venous congestion?

3 A The blood that enters the tissue cannot leave.

4 Q And that causes swelling. You talked about swelling,
5 correct?

6 A Yes.

7 Q And the swelling chokes off the blood supply and the cells?

8 A No. The cells become hyperemic and basically lyse. They
9 swell.

10 Q They swell?

11 A Yes.

12 Q But as a result of that, you can't -- the cells inside, so
13 to speak, don't get sufficient oxygen from the blood coming in --

14 A No.

15 Q -- because of the swelling?

16 A The causative action is the inflow of arterial blood. The
17 outflow on the other side is either slowed or, you know,
18 obstructed. The arterial pressure is higher than venous outflow,
19 so the blood continues to flow in until it basically occludes
20 that tissue.

21 Q And when you say occludes the tissue, what do you mean?

22 A Blocks.

23 Q The blood supply?

24 A Right, but it's not from the lack of blood supply.

25 Q And then you don't have sufficient blood supply?

1 A Well, any tissue that dies, you don't have a blood flow.
2 Yeah.

3 Q Exactly. Exactly. And to us laypeople, that's sort of like
4 a compartment syndrome? The breast is a compartment.

5 A No, it's a socket --

6 Q Let me finish my question. Please, sir.

7 A Sorry. I apologize.

8 Q I know you're eager to --

9 A My fault. I apologize.

10 Q That's okay. I promise not to interrupt you, all right.

11 A And I won't interrupt you. I'm sorry.

12 Q The breast is like a compartment, correct?

13 A Yes. It's a --

14 Q I'm sorry. And it becomes closed off?

15 ATTORNEY SMYTH: Your Honor, can he finish his answer,
16 please?

17 THE COURT: All right, gentlemen. One party asks the
18 question; the other party fully answers before the next question.

19 ATTORNEY TANENBAUM: I did apologize.

20 THE COURT: Yes, sir. You both apologized, so be mindful
21 and just take turns.

22 BY ATTORNEY TANENBAUM:

23 Q So the breast is a compartment, correct?

24 A Yes.

25 Q And once the blood enters, it causes swelling?

1 A Yes.

2 Q Correct? And you used the term "massive" swelling, I think?

3 A Yes, it can be.

4 Q And then as a result of the veins not allowing it to
5 drain -- correct?

6 A Correct.

7 Q It swells, and the blood is no longer able to get in?

8 A Yes.

9 Q I just wanted to be sure.

10 A Yes.

11 Q And that all occurred as a result of the surgery?

12 A No.

13 Q Okay. Why did it occur?

14 A Well, because at the conclusion of the surgery she had
15 adequate inflow and outflow of blood. The huge difference in a
16 breast and compartment syndrome is that compartment syndrome
17 happens under fascia, which is a very sticky substance that has
18 very little give, so the minimal amount of swelling in a
19 compartment can cause detrimental effects where it will obstruct
20 arterial flow.

21 A breast is very compliant. You can put a couple liters of
22 fluid into a breast as it swells and gets bigger. So they are
23 different anatomically and functionally.

24 Q But eventually they both fill with too much and don't empty?

25 A The certain part of the tissue within the breast tissue can

1 be affected by the inability for an outflow, but I have to say
2 that comparisons are not anatomically similar. But we can agree
3 to disagree. That's all right.

4 Q No, no, no. Just as a layperson, it feels like a
5 compartment syndrome.

6 A But it's not.

7 Q All right. However, whatever occurred, the blood was no
8 longer able to flow in because it wasn't able to flow out?

9 A That's correct. Yes.

10 Q At whatever point, the tissue filled enough in that
11 compartment, correct?

12 A No, in the actual vessel.

13 Q In the vessel.

14 A Yes.

15 Q But it led to the death of the nipple?

16 A The tissue. Yes.

17 Q And so did you ever tell Rebecca that she had venous
18 insufficiency?

19 A She didn't have venous insufficiency.

20 Q She didn't?

21 A No, because she had adequate venous outflow at the
22 conclusion of the procedure.

23 Q I understand, but by the time you saw the eschar -- you saw
24 that photograph on November the 6th, correct?

25 A Yes.

1 Q That had eschar?

2 A That had bruising and deep changes to the tissue, which we
3 refer to as bruising because we generally don't know the extent
4 of how it's going to demarcate.

5 Q And at that point you could tell there was venous
6 insufficiency?

7 A No. There's arterial inflow and no venous outflow where the
8 fat tissues are.

9 Q I'm sorry.

10 A Yeah.

11 Q But she already had developed the problem that was going to
12 lead to the loss of that nipple?

13 A At that point we don't know if she's going to lose her whole
14 nipple or partial nipple. Because if you look at the other side
15 where the exact same procedure was done, she may have looked very
16 ugly at certain points but in the end it actually healed with
17 probably 85 percent, you know, survival.

18 So the left side speaks very well to why we let the body
19 demarcate.

20 Q And the ladies and gentlemen of the jury will have that
21 exhibit in evidence that shows the difference between the left
22 and the right.

23 A I would believe so. Yes.

24 Q And I think there's some pinkness on the medial side, but
25 the lateral side shows eschar?

1 A I believe you're correct. Yes.

2 Q I'm learning a few medical terms here.

3 A Yes, sir.

4 Q And on that side she had some blood flow that goes to that
5 breast and, in turn --

6 A Which side? I'm sorry.

7 Q On the left side.

8 A Yeah. She had blood flow in both breasts. Yes.

9 Q No. I'm not talking about November the 1st.

10 A Oh.

11 Q I'm talking about November the 6th. That photograph, I'm
12 talking about.

13 A Yes.

14 Q But didn't have blood flow on the right side?

15 A Well, she had blood flow still to the tissue to some degree
16 but, again, that's -- the wound is clinically still closed, and
17 the extent of the tissue damage, we don't know. So I don't know
18 the degree of flow underneath.

19 Q And did you tell her on November the 8th that she was going
20 to lose, or in danger of losing, her right nipple?

21 A I don't remember what we told her.

22 Q If she says you didn't tell her, can you disagree with her?

23 A I don't remember.

24 Q Okay. And when you saw her on November the 15th -- did you
25 see her on the 15th?

1 A I believe so. I'd have to look in the chart.

2 Q I think so.

3 A Do you know the page of the note?

4 Q And did you tell her then that she was in danger of losing
5 that nipple?

6 A I don't recall.

7 Q And you didn't put that in your chart either, did you?

8 A I don't believe so.

9 Q And you didn't put it in the chart on the 8th either?

10 A No.

11 Q And when you saw her on November the 28th did you tell her
12 then that she was going to lose that nipple?

13 A I had spoke with her caregiver at that point. We had
14 discussed -- and that's why we talked about a debridement at some
15 point -- I had explained a biological dressing and the idea of
16 having an eschar and why, because obviously they're looking at it
17 every day and wondering, you know, What's going on?

18 And her previous partner was very in tune with stuff and
19 asked a lot of questions, and he told me he was on Google all the
20 time. So we talked about it, and I explained the reasoning for
21 needing a -- the term we use is -- "biological dressing."

22 Q And that's a term you used, "biological dressing"?

23 A Uh-huh; yes, sir.

24 Q And biological dressing means? I don't know what that
25 means.

1 A As opposed to a piece of gauze that we put over a wound,
2 it's your own tissue that's functioning as a barrier. And we're
3 giving that tissue every opportunity to demarcate and maintain as
4 much healthy tissue as we can.

5 Q But did you tell him or her that she was going to lose that
6 right nipple?

7 A The 28th, we had talked about -- I don't know if it was the
8 28th or 30th when I actually debrided it, because she was, I
9 believe, worn out by the process, understandably, and it had been
10 four weeks so at that point there's not a lot of benefit to
11 leaving that tissue any further.

12 Q But my question is -- and I'm sorry, sir -- did you tell
13 either of them that, on the 28th, she was going to lose that
14 nipple?

15 A I don't recall the day.

16 Q So it wasn't until the 30th that you do recall that you told
17 her that that nipple had to come off?

18 A Well, I performed the debridement that day, so.

19 Q You had to tell her, right?

20 A I believe so, sir.

21 Q I assume you discussed that with her?

22 A Yes.

23 Q And did you tell her why she lost that nipple?

24 A She was pretty upset. I believe I talked with her caregiver
25 prior to that about why it was blue or dark and black and all of

1 those types of circumstances, but I can't testify to what
2 specifically we talked about six years ago.

3 Q Well, today I think I heard you say that she had venous
4 insufficiency in her breast; that she wasn't draining properly
5 through her veins?

6 A Outflow. Yeah. Insufficiency is different than outflow.
7 You may, as a nonmedical person, use them interchangeably, but
8 they're not.

9 Venous insufficiency usually has to do with venous valvular
10 disease in veins that have valves when they become incompetent.
11 And that's different than what we're dealing with here.

12 Q Well, can you tell us why her veins weren't able to take the
13 blood out?

14 A At the conclusion of the surgery, they were able to. I
15 don't know what happened after that, so I cannot tell you that.

16 Q I think you gave us several reasons why that could occur.

17 A Yes. And those are theoretical. I'm not blaming her.

18 Q I know you're not blaming her, all right. That would not
19 be -- I understand that. But you talked about wearing a garment
20 that was too tight.

21 A Yes.

22 Q And she was wearing what I think your office suggested, a
23 sports bra?

24 A Yes. Usually it can become twisted or it can become, you
25 know -- it may not be tight when it's put on, but six hours or

1 eight hours, after there's swelling, it becomes tight.

2 Q And were you shown the photograph taken on November the 6th?

3 A I believe so. Yes.

4 Q And did anybody call her back and tell her, Hey, change the
5 position you're sleeping in so --

6 A No, because that -- I'm sorry.

7 Q You and I both want to be in control.

8 A I'll just sit back. We both want to talk a lot. I'm sorry.

9 Q We both want to take control.

10 A I've been sitting there so many days, I can't wait to talk.
11 I'm sorry.

12 Q So -- I had forgotten the question I was asking. Did you or
13 anyone call her back and say, Hey, watch the way you're sleeping;
14 loosen your support, your bra, anything like that?

15 A I don't believe so. The damage is usually done in the first
16 48 hours, so at that point it's conservative management.

17 Q And yet no one told her then, Hey, the damage is done;
18 you're going to -- you're at risk for losing this breast?

19 A So generally in post-op management we have the ability
20 standing here today to look in hindsight of the outcome.

21 Obviously in realtime treating somebody, you don't know that.

22 I've seen dozens of eschars and tissue throughout my career that
23 tissue turned out like the left side, where if we had gone in
24 aggressively debrided that, she would have lost a large portion
25 of her left nipple.

1 So we manage the patient day to day. And we don't know down
2 the line how much of it's going to be lost. I find that me
3 telling patients worse-outcome hypotheticals a week or two after
4 practice -- a week or two after surgery is probably not in
5 anyone's best interest.

6 Q Telling them is not going to change the outcome?

7 A Not at that point, sir.

8 Q Preparing them for that --

9 A As time goes on, I have a clearer understanding at four
10 weeks that we need to do this now, and what we're doing. I
11 think, while four weeks is long time, in a post-op course, I
12 believe it's reasonable to not commit to outcomes at that point.

13 Q And do you think -- would you agree that a patient not
14 knowing that this was going to happen to her and that she was
15 going to end up with, I think y'all call it, fatty tissue?

16 A Fat necrosis.

17 Q Fat necrosis.

18 A Yes.

19 Q Right. Knowing that she was going to end up with fat
20 necrosis, that she should be told that?

21 A At that point I don't know for sure what's going to happen
22 to the tissue. We don't know how much damage is done underneath.

23 We transfer tissues. I mean, early on in my career when I
24 was doing breast reconstruction, I'd take tissue off people's
25 bodies, move it and completely sever the blood supply, and

1 whether they had ischemia time of a few seconds or minutes or an
2 hour or two, didn't correlate to how much fat necroses they got.

3 We did extensive research on fat necrosis, and it's a very
4 poorly understood phenomena. It probably has somebody to do with
5 what's referred to as apoptotic cellular death, meaning once that
6 blood flow is changed, something inside those cells happen that
7 we don't understand.

8 So I don't like to tell people things that I don't know are
9 going to happen to them, especially that are going to upset them.

10 Q And certainly in the risks that you do warn a patient about,
11 you don't mention that particular phenomenon of not being able to
12 drain properly and the loss of tissue?

13 A I believe it does list loss of tissue in our consent.

14 Q I'm sorry?

15 A I do believe it lists loss of tissue in our consent.

16 Q Well, I know loss of tissue, but the reason for it. As a
17 result of this surgery, you can have venous insufficiency, or a
18 failure of the veins to drain properly, and because of the manner
19 in which the surgery's done, for example, and you may lose that
20 breast? You don't tell them that, do you?

21 A We told them that you can lose the nipple. I guess, in my
22 opinion, I'm not sure that the physiology of it is important to a
23 layperson who -- if a surgeon's wife is having surgery and they
24 want to talk about stuff that is medical, then I'd be happy to
25 answer that, but I don't -- I don't know -- we don't do that.

1 I can't find the consent, so I actually don't know what's
2 listed, but I know tissue loss and blood-flow issues are
3 mentioned.

4 Q And some people then deserve a clearer statement of what's
5 going to happen than others. Is that what you're telling the
6 ladies and gentlemen of the jury?

7 A No. I'm telling you that some people ask more in-depth
8 questions, which I answer, but ...

9 Q Now, the needling, I think, you talked about, --

10 A Yes.

11 Q -- what does that do?

12 A It causes a vascular release of venous blood. So it's
13 commonly used in free-flap surgeries, again, what I did hundreds
14 of at one point. When you -- a lot of times, moving free flaps,
15 taking tissue off the body and using it to reconstruct the
16 breast, venous outflow is a problem in those cases.

17 And so we will take an 18 gauge, which is a little bit
18 larger of a needle, and just poke little holes in the skin, and
19 the blood evacuates that way. You do that for 24 to 48 hours,
20 and the veins that remain underneath accommodate, what's referred
21 to as accommodate, meaning they become more efficient in venous
22 outflow, and eventually stop poking the skin. The tissue doesn't
23 hurt. It doesn't hurt the patient. There's no sensation. It's
24 a well-known way in microsurgery and tissue-transfer procedures.

25 Q And I think the terms that you used, venous congestion,

1 venous system not open, were never mentioned in your deposition,
2 correct?

3 A I didn't -- I don't know. I don't have it in front of me.
4 I don't believe I did. I don't believe I was asked about it.

5 Q I asked you then if you had an opinion as to why this
6 occurred, correct?

7 A I don't have -- I'm sure you did. I don't have the
8 document.

9 Q And I'm going to give you a clean copy of your deposition,
10 because if I took your deposition, without asking -- tell us what
11 a deposition is.

12 A You meet with an attorney and they ask you questions under
13 oath.

14 Q Under oath, with a court reporter present?

15 A Court reporter present, yes.

16 Q And your lawyer present?

17 A Yes.

18 THE COURT: Is it sealed?

19 ATTORNEY TANENBAUM: It is sealed.

20 (The Court unseals a transcript.)

21 BY ATTORNEY TANENBAUM:

22 Q There's usually a word index in these. There you go. If
23 your eyes are better than mine, you can see that.

24 A Sure.

25 Q See if you can find -- that's the easiest way to find if you

1 talked about venous or veins.

2 ATTORNEY SMYTH: Your Honor, I would object. I don't think
3 this is proper impeachment. He hasn't given an inconsistent
4 statement as of yet, and I don't believe that showing him a site
5 in the deposition to refer to --

6 THE COURT: How about, Mr. Tanenbaum, ask him a specific
7 question as to whether or not you asked him something.

8 ATTORNEY TANENBAUM: Sure. I'm sorry.

9 BY ATTORNEY TANENBAUM:

10 Q Were you asked in your deposition what the cause of the loss
11 of her nipple was?

12 A I believe I was. I mean, I'm sure I was. Yeah.

13 Q And did you use the term "venous" -- well, did you use the
14 term "venous" or "vein" at any point in your deposition to
15 explain your answer?

16 A I don't know, to be honest with you.

17 Q Thank you. I just want you to be honest with me.

18 A Yeah. I don't know.

19 Q You don't believe you did?

20 A I don't know.

21 Q Well, that's why you have your deposition there.

22 A Okay.

23 THE COURT: Counsel, if you could point him to the specific
24 page as to where the question was asked, that would be helpful.

25

1 ATTORNEY SMYTH: Your Honor, could we approach?

2 THE COURT: Yes, sir.

3 ATTORNEY TANENBAUM: Sure.

4 (Sidebar discussion off the record.)

5 THE COURT: All right, counsel. You may proceed.

6 BY ATTORNEY TANENBAUM:

7 Q So without digging down through the index, do you recall,
8 the best you can recall, I did ask you for your reasons why you
9 believed that the surgery failed, so to speak?

10 A I don't remember, so I can't tell you what I said.

11 Q And at any point during your deposition you also don't
12 remember using the word "vein" or "venous," correct?

13 A That was a couple years ago. I don't remember how I used it
14 or when or if I did.

15 Q And when was it that you decided that failure for the veins
16 to allow outflow caused this problem?

17 A When I read your expert's testimony, cause he -- can
18 I explain? I'm not --

19 THE COURT: You can explain.

20 THE WITNESS: So he repeatedly kept saying blood flow was
21 cut off, choked off, wasn't enough blood getting to it. And,
22 really, general surgery entry-level training, when somebody looks
23 at that tissue knows that that was an outflow issue, not an
24 inflow. And when I was preparing for this trial and actually
25 looking at the documents, it became clear.

1 BY ATTORNEY TANENBAUM:

2 Q And, Doctor, did you discuss your theory of causes of
3 failure with your experts?

4 A The only expert we have is Lefkowitz, who --

5 Q Yes.

6 A -- the first time I spoke to him was yesterday, so I just --
7 I didn't speak about much.

8 Q And you say you know for sure it's a problem with venous
9 outflow, is what you've --

10 A That's my clinical assessment.

11 Q So when I use the term "venous outflow," that does mean
12 something to you?

13 A I'm sorry?

14 Q The term "venous outflow," you used that already today?

15 A Yeah. Venous outflow is the blood leaving a given area
16 after it's converted from arterial.

17 Q And the video that you used to demonstrate what was going --
18 I think -- tell me what that was for. What was that about?

19 A It's the assessment that's noted in the "op" report, or the
20 assessment that we do on a regular basis to assess viability of
21 tissue after moving it.

22 Q So the venous-outflow problem began after the surgery?

23 A Yes.

24 Q And I think you used the term "massive swelling."

25 A That's a hypothetical for a cause of venous outflow.

1 Q And is swelling, in Rebecca Turisk's breasts, ever described
2 in your chart as being more than minimal or moderate?

3 A Anything that I saw was not. That swelling would have been
4 immediately postop, but I did not see anything described in
5 there. And I was offering that, again, not as her case but as a
6 possibility.

7 Q Well, then you're asking us to conjecture that it was venous
8 outflow?

9 A It's venous outflow based on the photographs that you
10 supplied. It's black and blue tissue that's congested and
11 forming an eschar. That is, by definition, venous congestion.

12 Q And caused by the lack of the ability to get fresh,
13 oxygenated blood to that area?

14 A The cause is the inability of the blood to leave the tissue,
15 which then obstructs inflow.

16 Q So in any case it's the blood flow is interrupted?

17 A The outflow. The outflow is obstructed, which leads to a
18 backup, and blood can no longer go into the tissue that's
19 obstructed.

20 Q Your lawyers sent us a video that they plan to use. Have
21 you reviewed that video that shows this particular procedure?
22 Not Rebecca's.

23 A I haven't seen a video that I didn't see today yet. No.

24 Q Can you describe for us the depth of the scar that is caused
25 by the implant placement?

1 A The depth?

2 Q Yes.

3 A Any tissue that you divide through would have part of a
4 scar -- or, part of healing is scar formation. Scars form,
5 initially become hyperinflated. So initially if you see somebody
6 that has a fresh scar, it's bright red, pink, it's raised, it
7 looks bad. Right.

8 Q And so to create the pocket for the implant --

9 A Yep.

10 Q -- you open up here at the bottom of the areola --

11 A You do.

12 Q -- and you create a pocket?

13 A You actually dissect through that tissue directly, and then
14 create --

15 Q Okay.

16 A A pocket -- a pocket is insinuating that there's underlying
17 of tissue, which is different.

18 Q All right. So, just so I understand, if you're cutting your
19 way through that disrupted tissue and you're going down to --

20 A Pectoralis major muscle. Pectoralis major muscle, the chest
21 muscle.

22 Q The chest muscle?

23 A Yes, sir.

24 Q And were her implants above or below that muscle?

25 A I believe they were initially completely under, or

1 submuscular. But over time, you can see in that picture -- the
2 pec muscle contracts and pushed the implants down, and it's very
3 common, for 25 years later, that they're no longer in the same
4 position.

5 Q And that incision to cut in there and place that implant
6 below the muscle would then go deep over the muscle?

7 A It goes to the level of the pectoralis muscle, the inferior
8 border, and then there's actually an avascular plane, meaning
9 there's no blood vessels between the pectoralis minor and chest
10 wall and the pec major. And that's where the implant goes.

11 Q And the scarring that takes place then goes down that far as
12 well?

13 A The vertical scar, yes.

14 Q And just so I understand, the vertical scar means it goes
15 down that way?

16 A Yeah. Not perpendicular to the chest wall.

17 Q Yeah. I just get those things confused sometimes.

18 A Sure.

19 Q All right. And you believe that collaterals had grown
20 through there to supply the nipple and that breast tissue?

21 A Collaterals don't grow through the scar. Angiogenesis, the
22 new blood vessel growth, occurs through the scar. But for that
23 temporary period, meaning a couple of weeks to a couple of
24 months, when you cut through that tissue it puts more burden on
25 the vessels that are collateral like Dr. Hultman put up. And

1 those vessels accommodate, which is making up for the loss of the
2 -- if there is a loss. But -- go ahead.

3 Q I'm sorry.

4 A That's all right.

5 Q And so the collaterals they we're talking about are the
6 collaterals coming in from lateral and medial and superior?

7 A Yeah, along the pedicle that's dissected. Yes.

8 Q I think you testified that Rebecca was asked if she wanted
9 to come in to see you on the evening of the 2nd? 1st or 2nd.

10 A She did not. I spoke with her caregivers.

11 Q You didn't insist they come in or insist that they go to the
12 emergency room?

13 A I did not.

14 Q And did you --

15 A I offered to see them, but I didn't insist.

16 Q And did you recommend that she drink some Gatorade, I think?

17 A Yeah. Her main issue after surgery was she was very
18 lethargic, so -- and she was laying, as described to me, in a
19 position on a bed or a couch-type position. And the options for
20 hydration, obviously, are oral or IV, and so if she's not coming
21 in, it's oral intake.

22 Q And then I want to go to the 6th. During your testimony did
23 you not testify that by November the 6th postoperatively it was
24 too late to fix the venous congestion?

25 A Yes. Five days would be too long.

1 Q And so you knew that at that point?

2 A I knew that there was injury. We don't know the extent at
3 that point.

4 Q And do you tell patients not to use hydrogen peroxide?

5 A I don't. People often ask, but I don't go out of my way to
6 say it.

7 Q I'm sorry?

8 A People often ask, but it's nowhere in the instructions not
9 to use it.

10 Q And I've got that she was in the November 6th, 18th, 8th,
11 15th, 28th and 30th?

12 A Correct.

13 Q And you saw her on the 30th?

14 A I saw her earlier than that, too. On the 15th, I believe.
15 Yeah.

16 Q Now, you talked about the culture results. Certainly you
17 don't blame Rebecca for any of the bacteria that we all come in
18 contact with, correct?

19 A Correct.

20 Q And staph aureus and enterococcus faecalis, if you walk in
21 the restroom, probably are on the door handle or something like
22 that --

23 A Well, --

24 Q Let me finish my question. All right. And the third --
25 there was a third organism, as well, correct?