

ORIGINAL

IN THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM RICHLAND COUNTY
HONORABLE GEORGE C. JAMES, JR., CIRCUIT COURT JUDGE
C/A NO. 2010-CP-40-5705

Doris F. Atkinson and William E. Atkinson, Jr.,

Appellants,

v.

James A. Williams, Jr., M.D., and South Carolina Oncology Associates,

Respondents.

RECORD ON APPEAL
(Volume 1 of 3; Pages 1 - 400)

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STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND) FIFTH JUDICIAL CIRCUIT
10-CP-40-5705

Doris F. Atkinson and William E.)
Atkinson, Jr.,)

Plaintiffs,)

vs)

James A. Williams, Jr., M.D. and)
South Carolina Oncology Associates,)

Defendants,)
_____)

ORDER

The court has carefully considered the plaintiffs' motion for new trial and judgment notwithstanding the jury's verdict. For the following reasons, the motions are denied.

THIRTEENTH JUROR

This court would be permitted to effectively veto the jury's verdict if it concluded that justice has not prevailed. Worrell v S.C. Power Co. 186 S.C. 306, 195 S.E. 638 (1938); Todd v Owen Industrial Products, 315 S.C. 34, 431 S.E. 2nd 596 (Ct. App. 1993).

Even though other juries hearing the same evidence could easily return a verdict for the plaintiffs, other juries could likewise easily return verdicts for the defendants. The jury heard conflicting testimony from many witnesses as to whether Dr. Williams violated the standard of care, and it obviously concluded he had not. Though this court could grant a new trial based on its own view of the fact without even stating a reason, the court declines to do so. In so concluding, the court has considered each of the seventeen points noted by the plaintiff.



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2012 DEC 11 PM 2:43
JEANETTE M. BRIDGEMAN
C.C.P. & G.

SPOILIATION OF EVIDENCE AND ADVERSE INFERENCE CHARGE

The plaintiffs requested a jury charge concerning the whereabouts of the “feet of bowel” removed by Dr. Williams. This court declined to give a spoliation and adverse inference charge because the only evidence presented was that Dr. Williams had removed the “feet of bowel” and promptly, within the operating room, transferred it to an operating room nurse for delivery to the pathology laboratory. Dr. Williams continued with the operation. The bowel was either never delivered to the lab, or if it was delivered, it was never examined and reported upon by the lab.

The nurse in question was an employee of the hospital, Palmetto Health Richland, where the operation took place. Neither she nor any other person in the operating room, except for Dr. Williams, testified. There is absolutely no evidence that Dr. Williams was responsible for what happened to the bowel after he removed it and transferred it to the nurse. It should also be noted that the hospital is not a party to this action. The only evidence is that either the hospital operating room personnel or the hospital laboratory personnel failed to preserve this evidence.

The plaintiffs requested the following charge:

When a party fails to preserve material evidence for trial, it is for you to determine whether the party has offered a satisfactory explanation for that failure. If you find the explanation unsatisfactory, you are permitted – but not required – to draw the inference that the evidence would have been unfavorable to the party’s claim.

Stokes v Spartanburg Regional Medical Center, 368 S.C. 515, 629 S.E. 2nd 675 (Ct. App. 2006) (emphasis added).

In Stokes, the spoliation issue concerned missing blood test results and a missing nurse’s chart detailing the decedent’s vital signs on the evening of his death. In Stokes,



the hospital was a party, and the issue was whether the jury could draw a negative inference from the hospital's failure to preserve critical evidence.

The Stokes charge is indeed warranted where there is evidence that a party has failed to preserve evidence. However, in the instant case, there is no evidence that would allow even the inference that Dr. Williams is the party who failed to preserve it. Giving the Stokes charge to the jury would have (1) allowed the jury to improperly conclude that the nurse's or laboratory's actions were imputable to Dr. Williams, or (2) led the jury to erroneously believe that Dr. Williams had the duty to personally transfer the bowel to the laboratory, or (3) allowed the jury to speculatively conclude that Dr. Williams was even responsible for the loss of the specimen between the operating room and the laboratory.

A Stokes charge is warranted when there is evidence that a party has failed to preserve material evidence. Here, there is evidence only that a non-party, Palmetto Health Richland, failed to preserve it. The plaintiffs' motion on this ground is denied.

PART III NEW TRIAL AND JNOV MOTIONS

The court respectfully concludes that the motions for new trial and jnov under Part III of the plaintiff's motions are without merit and must be denied.

Based upon the foregoing, all post-trial motions are denied.

AND IT IS SO ORDERED.

December 7, 2012


George C. James, Jr., Presiding Judge



STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
CASE NO. 2010-CP-40-_____

Doris F. Atkinson and
William E. Atkinson, Jr.,

Plaintiffs,

v.

James A. Williams, Jr., M.D., and
South Carolina Oncology Associates,

Defendants.

COMPLAINT
(Jury Trial Demanded)

1. Medical Negligence
2. Loss of Consortium

FILED
2010 AUG 23 AM 9:31
JEANETTE W. McBRIDE
C.C.P. & G.S.
RICHLAND COUNTY

**TO: DEFENDANTS JAMES A. WILLIAMS, M.D., JR., AND SOUTH CAROLINA
ONCOLOGY ASSOCIATES**

The Plaintiffs, complaining of the Defendants herein, would respectfully allege and
show unto the Court as follows:

FOR A FIRST CAUSE OF ACTION
(Professional Negligence/Medical Malpractice)

1. Plaintiffs Doris F. Atkinson ("Doris Atkinson") and William E. Atkinson, Jr. ("William Atkinson"), are citizens and residents of Darlington County, South Carolina. During all times relevant herein, Plaintiffs Doris Atkinson and William Atkinson have been and remain wife and husband.

2. The Plaintiffs believe Defendant James A. Williams, Jr., M.D. ("Williams"), is a physician who currently resides and practices medicine in Richland County, South Carolina. During all times herein relevant, Defendant Williams resided and practiced medicine in Richland County, South Carolina. In addition, the medical care and treatment

about which the Plaintiffs complain occurred in Richland County, South Carolina. Accordingly, this Court is the appropriate forum within which to resolve the parties' dispute.

3. The Plaintiffs believe South Carolina Oncology Associates is a medical practice located in Richland County, South Carolina. The Plaintiffs believe Defendant Williams had an ownership interest and/or employee relationship with Defendant South Carolina Oncology Associates while providing medical care and treatment to Plaintiff Doris Atkinson in Richland County. Further, the Plaintiffs believe Defendant Williams was acting individually, as well as on behalf of Defendant South Carolina Oncology Associates, while providing medical care and treatment to Plaintiff Doris Atkinson. The Plaintiffs believe Defendant South Carolina Oncology Associates is legally responsible for the conduct of Defendant Williams involving his medical care and treatment of Plaintiff Doris Atkinson in this matter.

4. On or about April 25, 2007, Defendant Williams performed an "extensive adhesiolysis" and "small bowel resection" surgical procedures upon Plaintiff Doris Atkinson at Palmetto Health Richland ("Palmetto Richland"). During the April 25, 2007, surgical procedure at Palmetto Richland, Defendant Williams negligently perforated Plaintiff Doris Atkinson's small bowel and failed to timely recognize and promptly treat her small bowel injury. Defendant Williams' injury of Plaintiff Doris Atkinson's small bowel and failure to identify and treat the problem in a timely manner constitute medical malpractice and deviations from the requisite standards of care applicable to him.

5. As a proximate result and consequence of Defendant Williams' negligence,

Plaintiff Doris Atkinson incurred several serious medical complications, including a post-operative small bowel obstruction, respiratory failure that required ventilator assistance, peritonitis, an incisional hernia, and other related medical complications. In addition, Plaintiff Doris required multiple corrective surgical procedures and a surgical resection of her bowel due to Defendant Williams' negligence.

6. The Defendants were negligent and careless in one (1) or more of the following particulars:

AS TO DEFENDANT WILLIAMS

(individually and on behalf of Defendant South Carolina Oncology Associates)

- a. In a careless and negligent manner, Defendant Williams failed to attain Plaintiff Doris Atkinson's "informed consent" involving the April 25, 2007, surgical procedure in violation of standards of care applicable to him;
- b. In a careless and negligent manner, Defendant Williams failed to properly evaluate, diagnose, and treat Plaintiff Doris Atkinson's medical condition in a timely manner in violation of standards of care applicable to him;
- c. In a careless and negligent manner, Defendant Williams failed to properly recognize and surgically correct a full-thickness injury (perforation) or significant partial-thickness injury (delayed perforation) of the small bowel he caused during Plaintiff Doris Atkinson's surgery;
- d. In a careless and negligent manner, Defendant Williams failed to have a general surgeon consult and/or assist him during Mrs. Atkinson's surgery;
- e. In a careless and negligent manner, Defendant Williams failed to consult and attain a general surgeon to correct Mrs. Atkinson's small bowel perforation in a timely manner;
- f. In a careless and negligent manner, Defendant Williams failed

to properly perform the April 25, 2007, surgical procedure upon Plaintiff Doris Atkinson in violation of standards of care applicable to him;

- g. In a careless and negligent manner, Defendant Williams failed to properly and timely recognize and diagnose Plaintiff Doris Atkinson's medical complications involving the April 25, 2007, surgery in violation of standards of care applicable to him;
- h. In a careless and negligent manner, Defendant Williams failed to properly treat Plaintiff Doris Atkinson's bowel injury involving the April 25, 2007, surgery in violation of standards of care applicable to him;
- i. In a careless and negligent manner, Defendant Williams failed to consult with appropriate medical professionals in a timely manner involving Plaintiff Doris Atkinson's bowel injury and surgical complications in violation of standards of care applicable to him;
- j. In a careless and negligent manner, failed to order and/or interpret appropriate diagnostic, radiographic, and/or laboratory examinations, tests, and/or studies to diagnose and properly treat Plaintiff Doris Atkinson's bowel injury in violation of standards of care applicable to him; and/or
- k. In a careless and negligent manner, Defendant Williams failed to provide appropriate follow-up medical care and treatment to Plaintiff Doris Atkinson after the April 25, 2007, surgical procedure in violation of standards of care applicable to him.

AS TO DEFENDANT SOUTH CAROLINA ONCOLOGY ASSOCIATES

- l. In a careless and negligent manner, Defendant South Carolina Oncology Associates failed to properly hire, train, monitor, and/or supervise Defendant Williams involving his medical care and treatment of Plaintiff Doris Atkinson; and
- m. Defendant Williams was acting individually and as an agent, employee, and/or representative of Defendant South Carolina Oncology Associates while providing medical care and treatment to Plaintiff Doris Atkinson. Accordingly, Defendant

South Carolina Oncology Associates is legally responsible for Plaintiff Doris Atkinson's damages arising from Defendant Williams' misconduct.

7. As a proximate result and consequence of the negligence and carelessness of Defendants Williams and South Carolina Oncology Associates, Plaintiff Doris Atkinson has incurred and will continue to suffer from substantial physical, medical, emotional, financial, occupational, and psychological harms and damages.

8. Due to the grossly careless, reckless, indifferent, wanton, willful, and/or intentional misconduct of Defendants Williams and South Carolina Oncology Associates, Plaintiff Doris Atkinson is entitled to a reasonable sum of punitive damages in this matter.

WHEREFORE, Plaintiff Doris F. Atkinson respectfully prays the Court enter a judgment against Defendants James A. Williams, Jr., M.D., and South Carolina Oncology Associates, jointly and severally, for actual damages in a sum to be determined by a jury; grant her a reasonable sum of punitive damages in a sum to be determined by a jury; and award her other and further relief as the Court deems just and proper.

FOR A SECOND CAUSE OF ACTION
(Loss of Consortium on behalf of Plaintiff William Atkinson)

8. Plaintiff William Atkinson reavers each and every allegation above as if repeated verbatim herein; and, furthermore, he alleges as follows:

9. Plaintiff William Atkinson realleges averments under the First Cause of Action involving the Defendants' negligence against Plaintiff Doris Atkinson.

10. As a proximate result and consequence of the Defendants' negligence committed against Plaintiff Doris Atkinson, Plaintiff William Atkinson has incurred and will

continue to suffer from substantial "loss of consortium" harms and damages, including, but not limited to, loss of companionship, love and affection, society, financial support, guidance, and other compensable harms and damages.

WHEREFORE, Plaintiff William E. Atkinson, Jr., respectfully prays the Court enter a judgment against Defendants James A. Williams, Jr., M.D., and South Carolina Oncology Associates, jointly and severally, for actual damages in an amount to be determined by a jury and award him other and further relief as the Court deems just and proper.

RESPECTFULLY SUBMITTED,

CORBIN LAW FIRM

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Post Office Box 447

Florence, SC 29503

(843)667-6119

BY: 

DARYL J. CORBIN

Attorney for Plaintiffs

Florence, South Carolina

August 18, 2010

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FIFTH JUDICIAL DISTRICT
COUNTY OF RICHLAND	)	
	)	
Doris F. Atkinson and William E. Atkinson, Jr.,	)	Civil Action No: 2010-CP-40-5705
	)	
Plaintiffs,	)	
	)	ANSWER OF DEFENDANTS JAMES
vs.	)	A. WILLIAMS, JR., MD AND SOUTH
	)	CAROLINA ONCOLOGY ASSOCIATES
James A. Williams, Jr., MD and South Carolina Oncology Associates	)	
	)	
Defendants.	)	

Now come the Defendants, answering the Complaint, herein allege:

FOR A FIRST DEFENSE

1. The Defendants deny each and every allegation of the Complaint not hereinafter specifically admitted.
2. The Defendants admit the allegations of Paragraphs 1, 2, and 3.
3. With respect to the allegations of Paragraph 4, the Defendants admit so much as allege that on or about April 25, 2007 Dr. Williams performed, in part, an "extensive adhesiolysis" and "small bowel resection" surgical procedure upon Doris Atkinson at Palmetto Health Richland and the Defendants crave reference to the Operative Report for further description of the procedure, as well as the potential testimony of Dr. Williams in that regard, but the remaining allegations are denied. By way of further answer thereto, the Defendants would affirmatively allege that Dr. Williams acted in accordance with generally acceptable standards of care at all times.

4. The Defendants deny the allegations of Paragraphs 5, 6, 7, 8, second paragraph 8, 9, 10 and deny any and all subparts and prayers for relief.

FOR A SECOND DEFENSE

5. That at all times relevant to the matters set forth herein, the Defendants rendered care to the Plaintiff Doris Atkinson in accordance with generally accepted standards of care applicable to physicians treating patients for the same or similar condition, under the same or similar circumstances, and as a result thereof, the Defendants are in no way liable to the Plaintiffs for the matters set forth in the Complaint.

FOR A THIRD DEFENSE

6. That the injuries and damages to the Plaintiffs alleged in the Complaint were due to and caused by her underlying medical problems and health care condition, and did not result from any departure of generally accepted standards of care on the part of the Defendants, and as a result the Defendants are in no way liable to the Plaintiffs for the matters set forth in the Complaint.

FOR A FOURTH DEFENSE

7. The Defendants plead lack of proximate cause as a complete bar to this action.

FOR A FIFTH DEFENSE

8. The Complaint fails to state a cause of action upon which relief can be granted.

FOR A SIXTH DEFENSE

9. That if any injury or damage was sustained as alleged in the Complaint, the Plaintiffs were fully informed of the risks arising out of and connected with the operative procedures, which risk was assumed by the Plaintiffs and for which the Defendants are not liable and the Defendants plead assumption of risk as a bar to this action.

FOR A SEVENTH DEFENSE

10. That the causes of action asserted in the Complaint are barred by the South Carolina Statute of Limitations in such cases, and that the Defendants plead such Statute as an affirmative defense and complete bar to this action.

FOR AN EIGHTH DEFENSE

11. To the extent applicable, the Defendants plead the statutory caps on damages as set forth in the Medical Malpractice Tort Reform Act.

FOR A NINTH DEFENSE

12. That any claim for punitive or exemplary damages as set forth in the Complaint against the Defendants would violate the Defendants' constitutional rights under the due process clause in the Fifth and Fourteenth Amendments to the Constitution of the United States of America, Excessive Fines Clause in the Eighth Amendment to the Constitution of the United States of America, the Double Jeopardy Clause in the Fifth Amendment to the Constitution of the State of South Carolina and/or the common law and public policies of the State of South Carolina, and/or applicable statutes and court rules, and the Defendants

raise these defenses as a complete bar to the imposition of punitive or exemplary damage against them.

WHEREFORE, having answered the Plaintiffs' Complaint, the Defendants demand that the same be dismissed, with costs. The Defendants further demand a trial by jury.

#4
By: 
William C. McDow

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Phone: (803) 771-4400
Attorneys for Defendants
James A. Williams, Jr., MD and
South Carolina Oncology Associates

September 9, 2010

CERTIFICATE OF SERVICE

I, the undersigned, an employee of RICHARDSON PLOWDEN & ROBINSON, PA, attorneys for the Defendants, James A. Williams, Jr., MD and South Carolina Oncology Associates, do hereby certify that I have this date served the foregoing Answer of Defendants James A. Williams, Jr., MD and South Carolina Oncology Associates on the below-listed individuals by depositing a copy of same into the United States Mail, first-class, postage pre-paid, addressed to:

Daryl J. Corbin
Corbin Law Firm
P.O. Box 447
Florence, SC 29503-0447



Martha Boynton, Legal Assistant to
William C. McDow

September 9, 2010

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
CASE NO. 2010-CP-40-5705

Doris F. Atkinson and)
William E. Atkinson, Jr.,)

Plaintiffs,)

v.)

James A. Williams, Jr., M.D., and)
South Carolina Oncology Associates,)

Defendants.)
_____)

**PLAINTIFFS' MOTIONS FOR
NEW TRIAL AND JNOV**

The Plaintiffs respectfully ask the Trial Court to consider the following reasons for granting them a new trial and a judgment notwithstanding the verdict in this case.

I. THE "THIRTEENTH JUROR DOCTRINE"

- A. What authority and duty does the Trial Court have to grant new trials under the Thirteenth Juror Doctrine?

Traditionally, South Carolina trial judges have the authority to grant a new trial upon the trial judge's finding that justice has not prevailed. Todd v. Owen Indus. Prods., Inc., 315 S.C. 34, 431 S.E.2d 596 (Ct.App. 1993). Trial judges as thirteenth jurors are charged with the duty of seeing that justice is done. Graham v. Whitaker, 282 S.C. 393, 321 S.E.2d 40 (1984). South Carolina trial judges have the authority and duty under the dictates of justice to promote justice and grant a new trial following a jury verdict under the Thirteenth Juror Doctrine.

In short, the Thirteenth Juror Doctrine entitles the judge (a) to sit as the thirteenth juror when he finds the evidence does not justify the verdict, and (b) to grant a new trial

based solely upon his evaluation of a fair preponderance of the facts. Norton v. Norfolk Southern Railway Co., 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002), citing Folkens v. Hunt, 300 S.C. 251, 387 S.E.2d 265 (1990). Under the Thirteenth Juror Doctrine,

[The] trial court may grant a new trial if the judge determines the jury's verdict is contrary to the fair preponderance of the evidence.

R.C. McEntire v. Mooregard Exterminating Servs., Inc., 353 S.C. 629, 633, 578 S.E.2d 746, 748 (2003) (emphasis supplied).

Accordingly, the evidentiary standard under which trial courts can properly grant a new trial under the Thirteenth Juror Doctrine is "a fair preponderance of the evidence."

The Thirteenth Juror Doctrine is well-established in South Carolina as the standard for granting a new trial. Norton, 350 S.C. at 477, 567 S.E.2d at 854. On numerous occasions, South Carolina appellate courts have reviewed and refused to abolish or even weaken the Thirteenth Juror Doctrine. Id. at 478, 567 S.E.2d at 854. See also Sorin Equipment Co., Inc. v. The Firm, Inc., 323 S.C. 359, 474 S.E.2d 819 (Ct.App. 1996). The Supreme Court of South Carolina provided trial courts with a comprehensive review of the Thirteenth Juror Doctrine in Folkens as follows:

This Court has had an opportunity to reconsider the Thirteenth Juror Doctrine on several occasions. Each time we have refused to abolish the doctrine. **We have also refused to require trial judges to explain the reasons for the ruling. The Thirteenth Juror Doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict.** This ruling has also been termed granting a new trial upon the facts.

The effect is the same as if the jury failed to reach a verdict. The judge as the thirteenth juror "hangs" the jury. 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. A trial judge's order granting or denying a new trial upon the facts will not be disturbed unless his decision is wholly unsupported by the evidence or the conclusion reached was controlled by an error of law. When an order granting a new trial is before this Court, our review is limited to the consideration of whether evidence exists to support the trial court's order.

Folkens, 300 S.C. at 254 - 255, 387 S.E.2d at 267 (citations omitted) (emphasis supplied).

Moreover, the trial court's discretion to grant or deny a new trial as the thirteenth juror extends to the "Nth degree."

As has often been said, the trial judge is the thirteenth juror, possessing the veto power to the Nth degree . . .

Worrell v. S.C. Power Co., 186 S.C. 306, 313 - 314, 195 S.E. 638, 641 (1938) (emphasis supplied).

A trial judge's order granting or denying a new trial upon the facts will not be disturbed unless his decision is wholly unsupported by the evidence or the conclusion was controlled by an error of law. Folkens, 300 S.C. at 254 - 255; 387 S.E.2d at 267. The Thirteenth Juror Doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict. Id.

South Carolina appellate courts will uphold a trial judge's order granting a new trial under the Thirteenth Juror Doctrine unless the ruling is wholly unsupported by the evidence or the conclusion reached was controlled by an error of law. Norton, 350 S.C. at 478, 567 S.E.2d at 854. As long as there is some conflicting evidence, the appellate courts will not disturb the trial judge's discretionary decision to grant a new trial. Id. The Trial Court in the Atkinson case ought to exercise his Thirteenth Juror Doctrine authority

and grant the Plaintiffs a new trial if he believes the preponderance of the evidence weighed in favor of a Plaintiffs' verdict.

- B. Why should the Trial Court in the Atkinson case exercise his authority and grant the Plaintiffs a new trial under the Thirteenth Juror Doctrine?

Although the Trial Court cannot be required to state reasons for granting a new trial under the Thirteenth Juror Doctrine, ample and compelling reasons exist to prompt the Trial Court to exercise his authority under the dictates of justice to grant the Plaintiffs a new trial in this case. Although the Trial Court certainly can consider other compelling evidence, the Plaintiffs would respectfully accentuate some compelling trial testimony and evidence as follows:

- (1) Mrs. Atkinson's had a CT scan taken of her small bowel at Byerly Hospital (now Carolina Pines Medical Center) in Hartsville on March 30, 2007, two (2) weeks before her initial visit with Dr. Williams in his Columbia office on April 13, 2007.
- (2) Mrs. Atkinson testified at trial she had two (2) small bowel resections at Byerly Hospital during the 1995 hospitalization which resulted in removal of ten (10) inches of her small bowel the first time and another small portion of her small bowel the second time. No one, including Dr. Williams, ever contradicted Mrs. Atkinson's testimony in this area. There was absolutely no evidence upon which a jury could factually conclude Mrs. Atkinson had several feet of small bowel removed at Byerly Hospital in 1995.
- (3) The 1995 Byerly Hospital records of Mrs. Atkinson's small bowel resections were no longer available at the time of trial.
- (4) William P. Irvin, M.D. ("Dr. Irvin"), the Plaintiffs' board-certified Gynecological Oncologist from Virginia, reviewed Mrs. Atkinson's March 30, 2007, CT scan and testified at trial to a reasonable degree of medical certainty that her small bowel appeared to have a normal length of sixteen (16) to eighteen (18) feet within two (2) weeks before her first visit with Dr. Williams. Dr. Irvin testified that the type of resection which Mrs. Atkinson had during 1995 would not cause her to have a small bowel

length significantly shorter than the average length for a woman of her size. No one, including Dr. Williams, ever contradicted this area of Dr. Irvin's trial testimony. The uncontroverted proof at trial was that Mrs. Atkinson had approximately sixteen (16) to eighteen (18) feet of small bowel at the time she became Dr. Williams' patient.

- (5) According to Mrs. Atkinson's trial testimony and the 1995 - 2007 medical records in evidence of her family physician in Hartsville, Susan Reynolds, M.D. ("Dr. Reynolds"), Mrs. Atkinson had absolutely no symptoms of abdominal adhesions or small bowel problems after the 1995 small bowel resections at Byerly Hospital and before her initial surgery performed by Dr. Williams at Palmetto Health Richland on April 24, 2007. No one, including Dr. Williams, ever contradicted the trial testimony or documentary evidence involving this subject.
- (6) Dr. Williams' April 24, 2007, operative report failed to indicate both (a) how much small bowel he actually removed from Mrs. Atkinson during his first surgery, and (b) how he reattached her small bowel after removing an unknown portion of it. Matthew F. Kohler, M.D. ("Dr. Kohler"), a board-certified Gynecological Oncology defense expert witness, considered the lack of an indication of the amount of small bowel Dr. Williams removed and the failure to describe the repair technique to be significant "5 star" problems. In fact, Dr. Kohler testified during cross-examination about his hand-written notes listing several significant problems involving Dr. Williams' treatment of Mrs. Atkinson. See copy of trial exhibit attached hereto as Exhibit A. In Dr. Kohler's notes, he specifically referenced the need to "pin down" and get answers from Dr. Williams involving several problem areas. However, Dr. Kohler testified he never got answers from Dr. Williams or anyone else about the problem areas he raised in his notes.
- (7) Dr. Williams testified at trial that he did not know the length of the small bowel segment he removed from Mrs. Atkinson during the April 24, 2007, surgery other than "feet." In addition, Dr. Williams did not know how many holes he caused in Mrs. Atkinson's small bowel other than "multiple." No one, including Dr. Williams, testified for the defense to even attempt to quantify how much small bowel Dr. Williams actually removed from Mrs. Atkinson or how many perforations or holes he caused during the first operation.
- (8) The Palmetto Health Richland pathology records account for a combined total of seventy-one (71) centimeters or approximately twenty-eight (28) inches of small bowel removed from Mrs. Atkinson during Dr. Williams' second operation and two (2) subsequent resections performed by Harris H.

Parker, M.D. ("Dr. Parker"). Accordingly, the total amount of Mrs. Atkinson's small bowel removed during the entire Palmetto Health Richland hospital stay was approximately twenty-eight (28) inches or slightly more than two (2) feet. No one, including Dr. Williams, ever contradicted the accuracy of Mrs. Atkinson's pathology reports. See Exhibit B which is copy of a summary of the pathology records introduced at trial indicating the total amount of "accounted for" small bowel removed from Mrs. Atkinson during the entire Palmetto Health Richland hospitalization was approximately twenty-eight (28) inches.

- (9) The only portion of Mrs. Atkinson's small bowel not accounted for at Palmetto Health Richland was the unknown "feet" which Dr. Williams removed during his first operation. No one, including Dr. Williams, ever contradicted this area of trial testimony.
- (10) T. Bright Williamson, M.D. ("Dr. Williamson"), Mrs. Atkinson's current treating gastroenterologist from Camden, testified at trial without contradiction that Mrs. Atkinson suffers from permanent Short Bowel Syndrome. Dr. Williamson showed and explained to the jury an abdominal CT scan taken of Mrs. Atkinson's small bowel after her release from Palmetto Health Richland hospital. Dr. Williamson testified to a reasonable degree of medical certainty that Mrs. Atkinson currently has just twenty (20) inches of small bowel.

Dr. Williamson also showed the jury an abdominal CT scan of a normal appearing bowel for comparison purposes. There was a substantial and visually obvious difference in the CT scan film appearances of the normal bowel and Mrs. Atkinson's remaining twenty (20) inch small bowel: the normal abdominal CT scan showed an abdominal cavity packed with small bowel, Mrs. Atkinson's CT scan showed an essentially empty abdominal cavity with some small bowel dangling down along the left side of her abdomen.

Dr. Williamson testified he had treated some patients over his career who were victims of automobile wrecks or other trauma with a viable small bowel just as short as Mrs. Atkinson's remaining small bowel; however, Dr. Williamson testified those other patients with extremely short small bowels like Mrs. Atkinson would normally be sewed up and then they would soon die. Dr. Williamson testified Mrs. Atkinson's life expectancy was shortened by approximately ten (10) years due to her Short Bowel Syndrome. No one, including Dr. Williams, ever contradicted Dr. Williamson's trial testimony.

- (11) Dr. Parker was Mrs. Atkinson's subsequent treating surgeon after Dr. Williams' second surgery. Dr. Parker had to do four (4) surgeries on Mrs. Atkinson to address the surgical complications arising from Dr. Williams' prior surgeries. Dr. Parker testified he "ran the bowel" and physically inspected the condition and length of Mrs. Atkinson's remaining small bowel during his first operation on June 3, 2007. Before Dr. Parker removed any of Mrs. Atkinson's bowel during his first surgery (her third surgery), he determined Mrs. Atkinson had approximately seventy (70) to eighty (80) centimeters or between twenty-eight (28) inches and thirty-two (32) inches of total small bowel left after Dr. Williams' prior surgeries. In other words, the amount of small bowel Dr. Williams removed during his two (2) surgeries left Mrs. Atkinson with approximately thirty (30) inches of small bowel. No one, including Dr. Williams, ever contradicted Dr. Parker's trial testimony.
- (12) The Palmetto Health Richland pathology reports indicating twenty-eight (28) inches of small bowel removal (not counting Dr. Williams' first surgery) and Dr. Williamson's testimony that Mrs. Atkinson currently has twenty (20) inches of small bowel mathematically account for approximately forty-eight (48) inches or four (4) feet of small bowel. Everyone agreed at trial that Mrs. Atkinson would normally have between sixteen (16) and eighteen (18) feet of small bowel absent any resections.

The only other two (2) events which could possibly account for any additional small bowel loss would necessarily have to be Mrs. Atkinson's 1995 Byerly Hospital resections and Dr. Williams' first surgery. In short, the remaining twelve (12) feet to fourteen (14) feet of Mrs. Atkinson's "unaccounted for" small bowel must involve a combination of the 1995 Byerly Hospital resections and Dr. Williams' April 24, 2007, removal of an unknown length of feet of small bowel at Palmetto Health Richland. No one, including Dr. Williams, ever contradicted these facts at trial.

- (13) During cross-examination, Dr. Williams admitted that, if a surgeon were to remove ten (10) feet or more of Mrs. Atkinson's small bowel during the April 25, 2007, operation, it would be a gross violation of the standard of care. No one disputed Dr. Williams' trial testimony in this area.
- (14) No one contradicted at trial the fact that Mrs. Atkinson lost an unknown amount of feet of small bowel during Dr. Williams' first operation. Dr. Williams and none of the physicians who testified for the defense at trial knew the length of Mrs. Atkinson's small bowel segment that was removed and lost involving the April 25, 2007, surgery.

(15) What evidence at trial was introduced indicating that Dr. Williams removed approximately ten (10) feet or more of Mrs. Atkinson's small bowel during the first surgery?

- Mrs. Atkinson's March 30, 2007, Byerly Hospital abdominal CT scan introduced into evidence showing a normal appearing small bowel of approximately sixteen (16) to eighteen (18) feet in length.
- Dr. Irvin's expert testimony about Mrs. Atkinson's March 30, 2007, CT scan and her normal small bowel length of approximately sixteen (16) to eighteen (18) feet before the initial office visit with Dr. Williams in Columbia just two (2) weeks later.
- Dr. Williamson's testimony that (a) Mrs. Atkinson's current small bowel as proven by a recent CT scan is twenty (20) inches long; (b) she has Short Bowel Syndrome; and (c) her life expectancy has been reduced by ten (10) years due to Short Bowel Syndrome.
- Dr. Parker's testimony that Dr. Williams removed all but about seventy (70) centimeters to eighty (80) centimeters [approximately thirty (30) inches] of Mrs. Atkinson's small bowel before Dr. Parker's initial surgery.
- The Palmetto Health Richland pathology reports account for all portions of Mrs. Atkinson's small bowel removed during the Palmetto Health Richland hospitalization . . . other than the unknown and unaccounted for number of "feet" Dr. Williams removed during Mrs. Atkinson's first surgery on April 25, 2007. The only plausible explanation based upon the evidence is that Dr. Williams removed at least ten (10) feet of Mrs. Atkinson's small bowel during the April 25, 2007, surgery. Dr. Williams admits removal of ten (10) feet of Mrs. Atkinson's small bowel during his first operation would constitute a deviation from the standard of care. If Dr. Williams did not remove that much small bowel during the first surgery, what happened to it?

(16) An important issue in this case was whether Dr. Williams' violation of the standards of care caused Mrs. Atkinson to suffer from Short Bowel Syndrome. Dr. Williams testified that removal of ten (10) feet of Mrs. Atkinson's bowel would constitute a violation of the standard of care. There is no dispute that the best way to prove how much small bowel Mrs. Atkinson lost during Dr. Williams first surgery would be a pathology examination of the actual bowel he removed, but the specimen is missing.

What is the significance of ten (10) feet or more of unaccounted for small bowel surgically removed from Mrs. Atkinson's body? The only documentation in the Palmetto Health Richland records indicates Dr. Williams removed and had possession of Mrs. Atkinson's small bowel in the operating room. There is no documentation in Mrs., Atkinson's hospital chart that Dr. Williams ever relinquished control of the small bowel specimen to anyone. The only proof that Dr. Williams sent the bowel specimen to pathology is his uncorroborated testimony and absolutely nothing else.

Dr. Williams testified at trial that he sent feet of Mrs. Atkinson's small bowel to pathology for analysis; however, the hospital records indicate the specimen was never sent to pathology. According to the hospital records which are supposedly contemporaneous and accurate, Dr. Williams only sent Mrs. Atkinson's ovaries, fallopian tubes, and ovarian cysts to pathology for analysis without any mention of feet of small bowel. Dr. Williams testified at trial he did nothing to follow-up on his patient's feet of missing bowel. A jury could reasonably conclude (a) Dr. Williams never relinquished control of the bowel specimen to anyone, (b) Dr. Williams never actually sent the small bowel specimen to pathology, (c) Dr. Williams did not want independent, incontrovertible scientific proof that he removed ten (10) feet or more of small bowel - which he admits would be a violation of the standard of care, and (d) Dr. Williams did not want independent, incontrovertible scientific proof that his deviation from the standard of care - removing ten (10) feet of small bowel - caused Mrs. Atkinson to suffer from Short Bowel Syndrome.

What would a pathology examination prove? According to testimony of the physicians at trial, the normal pathology examination would have proven how much of Mrs. Atkinson's small bowel Dr. Williams removed during the first surgery (which is critical since he testified he did not even know). In addition, a pathology examination of the feet of Mrs. Atkinson's missing small bowel portion would scientifically prove what injuries Dr. Williams caused to her small bowel. For example, the pathology examination would have provided the jury with independent, incontrovertible scientific proof involving the following material issues:

- How many perforations did Dr. Williams cause during the first operation since he says he does not know and the operative report does not say?

- How large were the perforations Dr. Williams caused during the first surgery since he says he does not know and the operative report he prepared does not say?
 - Could the perforations Dr. Williams caused during the first surgery have been fixed by a bowel-preserving oversew technique instead of a more radical resection of feet of small bowel placing Mrs. Atkinson at risk for Short Bowel Syndrome? If not, why not? Were there too many holes and were the holes too massive to fix without cutting out several feet of small bowel?
- (17) The Trial Court refused to provide the jury with a spoliation of evidence charge as requested by Plaintiffs' counsel. Without a spoliation charge, the jury really had no guidance from the Trial Court about the legal significance of missing evidence important to the Plaintiffs in proving their case. Since the jury charge was void of any reference to missing evidence, it would be reasonable to assume the jury had the belief that the missing bowel really had no legal significance at all and was not worthy of jury deliberation. In effect, the absence of a spoliation jury charge effectively emasculated some of the Plaintiffs most important arguments in proving Dr. Williams violated the standards of care:
- Dr. Williams never sent the several feet of small bowel to pathology.
 - There was no record Dr. Williams sent Mrs. Atkinson's small bowel specimen to pathology involving the first surgery.
 - There was no record pathology ever got Mrs. Atkinson's small bowel specimen Dr. Williams removed during the first surgery.
 - Dr. Williams got a pathology report back involving Mrs. Atkinson's ovaries and cysts which he actually sent to pathology with absolutely no mention of feet of small bowel.
 - Dr. Williams never documented anywhere or complained to anyone about the feet of missing bowel segment.
 - There is absolutely nothing anywhere in the hospital records or even evidence introduced at trial indicating Dr. Williams did anything to follow-up on Mrs. Atkinson's "missing" feet of bowel.

The Plaintiffs believe Dr. Williams elected not to do any follow-up or documentation of the missing bowel specimen because he knew it was not really missing; he never sent it to pathology (consistent with all the records); and pathology never got Mrs. Atkinson's small bowel specimen (consistent with the records).

- No one should expect the jury to understand the significance of missing evidence without some guidance from the Trial Court and an adverse inference charge.
- If a party is entitled to an adverse inference jury charge which the trial judge refuses to give, the automatic appellate remedy is reversal with another trial.

II. SPOILIATION OF EVIDENCE AND ADVERSE INFERENCE CHARGE

A trial court is required to charge the current and correct law. Burroughs v. Worsham, 352 S.C. 382, 392, 574 S.E.2d 215,220 (Ct.App. 2002). In Kershaw County Bd. of Educ. v. U.S. Gypsum Co., 302 S.C. 390, 396 S.E.2d 369 (1990), the Supreme Court of South Carolina upheld a jury charge as follows:

[W]hen evidence is lost or destroyed by a party, an inference may be drawn by the jury that the evidence which was lost or destroyed by that party would have been adverse to that party.

Id. at 394; 372

In the Atkinson case, the Trial Court refused the Plaintiffs' request to charge the jury on the law of spoliation. In fact, Plaintiffs' counsel requested that the Trial Court use the specific verbatim spoliation charge approved by the Supreme Court of South Carolina in the case of Stokes v. Spartanburg Regional Medical Center, 368 S.C. 515 (Ct.App. 2006). The Trial Court reviewed the Stokes opinion and refused to give the jury charge on spoliation of evidence.

The Supreme Court of South Carolina approved the spoliation of evidence charge in Stokes as follows:

I charge you that when a party fails to preserve material evidence for trial, it is for you to determine whether the party has offered a satisfactory explanation for that failure. If you find the explanation unsatisfactory, you are permitted - but not required - to draw the inference that the evidence would have been unfavorable to the party's claim.

Id. at 522.

The facts in the Stokes case are similar to the facts in the Atkinson case. For example, in the Stokes case, two (2) pieces of medical evidence were missing from the Plaintiff's hospital records: (a) results from a blood test, and (b) a nurse's chart detailing the patient's vital signs on the evening of his death. The defendant rebutted evidence of the missing records suggesting that the blood drawn from the patient's artery on the night of his death may never have been sent to the laboratory for testing. As for the missing nursing chart, the defendant suggested it may have been lost during the confusion of the patient's code. Similarly, in the Atkinson trial, the Plaintiffs proved "feet" of Mrs. Atkinson's small bowel removed by Dr. Williams were missing. The hospital records indicated Dr. Williams never sent the bowel specimen to pathology for examination. Dr. Williams speculated on the witness stand that perhaps a nurse failed to deliver the feet of bowel to the pathology laboratory. The Plaintiffs in Atkinson believe Dr. Williams' explanation, while relevant, was implausible (a) given no hospital records support his claim, (b) the pathology records indicate only ovaries, fallopian tubes, and cysts were actually sent to the laboratory, and (c) Dr. Williams never followed-up or complained to anyone about feet of missing bowel.

The Stokes opinion, in relevant part, states as follows:

While the jury may well have accepted the hospital's explanations, it was also in its province to draw a negative inference from the hospital's failure to produce those pieces of evidence.

Id. at 521 (emphasis supplied).

Was it within the province of the Atkinson jury to draw a negative inference from Dr. Williams' failure to produce feet of Mrs. Atkinson's small bowel he surgically removed during the first operation?

In Stokes, the appellant requested that the trial court provide the jury with the following spoliation of evidence and negative inference charge under the law:

I charge you that when a party fails to preserve material evidence for trial, it is for you to determine whether the party has offered a satisfactory explanation for that failure. If you find the explanation unsatisfactory, you are permitted — but not required — to draw the inference that the evidence would have been unfavorable to the party's claim.

Id. at 522.

The South Carolina Supreme Court's opinion in Stokes further states:

[T]his language reflects the law of South Carolina and should have been charged based on the evidence presented in this case. While we recognize that no exact language is required, the **charge as given made no mention of missing evidence at all.**

Id. at 522 (emphasis supplied).

The Trial Court's jury charge in the Atkinson case was totally silent on the issue of missing evidence.

The Stokes opinion continues as follows:

In addition to being erroneous, we find the failure to charge on "spoliation of evidence" was prejudicial to Appellant. Appellant's malpractice claim

against the Hospital hinged on the jury believing Stokes died from lack of oxygen rather than from a sudden and unexpected heart attack. Both pieces of evidence the Appellant alleges are missing would have helped determine how Stokes died. Thus, it was crucial to Appellant's case that the jury know it could draw a negative inference from the Hospital's failure to produce those important pieces of evidence. We therefore find the Appellant was prejudiced by the trial court's failure to instruct the jury on "spoliation of evidence." See, e.g., Baker v. Weaver, 279 S.C. 479, 309 S.E.2d 770 (Ct.App.1983) (finding trial court's erroneous jury charge prejudicial where requested instruction involved a substantial feature of the case).

Id. at 522.

In short, a trial court is required to charge the current and correct law. Burroughs v. Worsham, 352 S.C. 382, 392, 574 S.E.2d 215,220 (Ct.App. 2002). Would a jury charge on the law of spoliation have made a difference in the jury verdict in the Atkinson case? Would it have made a difference to the jury knowing the law allowed it to infer that an unknown quantity of feet of Mrs. Atkinson's small bowel segment was missing and not available for pathology testing by Palmetto Health Richland or the Plaintiffs' expert witnesses because Dr. Williams knew its preservation and production could cause him harm? Instead of emasculating the portion of the Plaintiffs' case about feet of missing, unaccounted for bowel, a standard spoliation of evidence jury charge would have given an important part of the Plaintiffs' case legal significance.

However, the appellate issue is not whether the spoliation charge would have persuaded the jury to rule in favor of Mrs. Atkinson. The dispositive issues are much less complex and do not even involve having to predict how a jury would have ruled if given the spoliation charge. The sole issues involving spoliation on appeal are as follows:

- Whether the missing bowel was a material part of the Plaintiffs' case?

- Whether the Plaintiffs were entitled to a spoliation of evidence charge?
- If there was any reasonable evidence introduced at trial indicating the Plaintiffs were entitled to a spoliation of evidence charge, the Trial Court's refusal to give the spoliation charge absolutely constitutes reversible error.

Under the Thirteenth Juror Doctrine, the Plaintiffs respectfully request that the Trial Court grant them a new trial. The "preponderance of the evidence" favored the Plaintiffs' case that Dr. Williams' removal of all but seventy (70) centimeters to eighty (80) centimeters or approximately thirty (30) inches of small bowel was a violation of the standard of care. Even Dr. Williams admitted during cross-examination that removal of ten (10) feet of small bowel during Mrs. Atkinson's first surgery (if done by another surgeon) would violate the standard of care. There was no evidence refuting the amount of bowel Dr. Williams removed and the length of the segment he left after Mrs. Atkinson's first surgery. Without question, the defense merely said: "We don't know."

If the Trial Court upon reflection agrees that the Plaintiffs were entitled to a spoliation of evidence charge, the Thirteenth Juror Doctrine provides the Trial Court with an efficient and just way to correct the error. The Trial Court has discretion to the "Nth degree" to determine the facts in accordance with his assessment of the evidence introduced at trial. If the Trial Court believes the "preponderance of the evidence" favored the Plaintiffs, his exercise of the Thirteenth Juror Doctrine would be appropriate. On the other hand, if the Trial Court believes he should have given the Stokes spoliation charge to the jury as requested by the Plaintiffs, the Thirteenth Juror Doctrine provides the Trial Court with an efficient and just method to correct the error.

The trial judge sitting as the thirteenth juror (is) charged with the duty of seeing that justice is done . . .

Graham v. Whitaker, 282 S.C. 393, 321 S.E.2d 40 (1984) (emphasis supplied).

Justice has not prevailed in the Atkinson case. The Plaintiffs respectfully ask the Trial Court to exercise his authority and grant them a new trial.

III. MOTIONS FOR A NEW TRIAL AND JNOV

In short, the Plaintiffs believe the Trial Court erred in denying their Motion for a Directed Verdict. When evidence presented at trial yields only one conclusion concerning liability, a trial court may properly grant a motion for directed verdict. See Ecclesiastes Prod. Ministries v. Outparcel Assocs., LLC, 374 S.C. 483, 490, 649 S.E.2d 494, 497 (Ct.App. 2007) (citing Carolina Home Builders, Inc. v. Armstrong Furnace Co., 259 S.C. 346, 358, 191 S.E.2d 774, 779 (1972)). See also Swinton Creek Nursery v. Edisto Farm Credit, ACA, 334 S.C. 469, 476-77, 514 S.E.2d 126, 130 (1999) ("When the evidence yields only one inference, a directed verdict in favor of the moving party is proper."). In considering a motion for directed verdict, the trial court must view the evidence and inferences that can be drawn from it in the light most favorable to the non-moving party. Doe v. ATC, Inc., 367 S.C. 199, 204, 624 S.E.2d 447, 449 (Ct.App. 2005); (citing Sabb v. S.C. State Univ., 350 S.C. 416, 427, 567 S.E.2d 231, 236 (2002)). So long as no more than one inference is created from the evidence presented, a jury issue is not created, and the trial court is proper in directing a verdict. Henson v. Int'l Paper Co., 358 S.C. 133, 147, 594 S.E.2d 499, 506 (Ct.App. 2004) (holding where the evidence is

susceptible of more than one reasonable inference, a jury issue is created and the court may not grant a directed verdict).

In addition to the Thirteenth Juror Doctrine and the spoliation charge issue, the Plaintiffs would respectfully petition the Trial Court to grant them a new trial or issue a judgment notwithstanding the verdict for the following reasons:

- (1) The Plaintiffs made a Motion for a Directed Verdict at the close of the defense case on the ground there was no factual dispute about Dr. Williams' failure to satisfy the dictates of "Informed Consent" involving Mrs. Atkinson's second surgery on May 28, 2007. Everyone agreed at trial that the second surgery was "elective" and even more inherently dangerous and technically challenging than the first surgery. Dr. Williams never denied the existence of treatment options available to Mrs. Atkinson other than surgery. In fact, Dr. Williams' senior medical partner, S. Terrell Smith, M.D. ("Dr. Smith"), testified at trial through deposition publication parts that Mrs. Atkinson had three (3) treatment options which the standard of care required Dr. Williams to explain to her as follows:

Q. On Post-Operative Day 33, the day before the surgery, assume you were there instead of Dr. Williams. We know that you would recommend TPN. What would you do if the reason for doing surgery is to get Mrs. Atkinson out of this horrible nausea and vomiting? What would you recommend to treat that?

A. Had I been there then, we would've had a discussion regarding several options. One option would be to put an NG tube in, continue the TPN, and see how we did. Another option would be to put the NG tube in. If we got better, then to consider a gastrostomy tube if it could be placed and TPN. And the third option would be to go to the operating room, with all of its intended complications.

(Dr. Smith's Deposition, p. 120, l. 22 – p. 121, l. 13)

- (2) Without question, the law of Informed Consent required Dr. Williams to disclose and explain to Mrs. Atkinson all treatment options available to her at the time of the second surgery, including the option to reject the second

operation, especially given Dr. Williams and all defense witnesses agree the May 28th surgical procedure was "elective".

For example, the Supreme Court of South Carolina has defined the obligations of physicians to attain the patient's informed consent as follows:

Under the doctrine of informed consent, **a physician has a duty to disclose** (1) the diagnosis, (2) the general nature of the contemplated procedure, (3) the material risks involved in the procedure, (4) **the probability of success associated with the procedure**, (5) **the prognosis if the procedure is not carried out**, and (6) **the existence of any alternatives to the procedure**.

Hook v. Rothstein, 281 S.C. 541, 547, 316 S.E.2d 690, 694-95 (Ct. App. 1984) (emphasis supplied).

There was no evidence introduced at trial by anyone that Dr. Williams satisfied the Hook requirements under (4), (5), or (6) above. As a matter of law, the Trial Court should have granted the Plaintiffs a directed verdict as to Dr. Williams' liability under the law of Informed Consent.

- (3) Dr. Williams admitted during his trial testimony that he did not tell Mrs. Atkinson at the time of the second surgery any options available to her, even the option to refuse surgery in accordance with Hook. Dr. Williams violated the standard of care and failed to honor Mrs. Atkinson's right to Informed Consent by at least not explaining to her the consequences of refusing to submit to the dangerous second surgery. Dr. Williams' own testimony clearly proved he violated Mrs. Atkinson's most basic right as a patient to be fully informed of all treatment options involving the second surgery.
- (4) The hospital records are clear that Mrs. Atkinson received NG tube decompression for the first time the day before Dr. Williams' planned surgery scheduled for the next day. According to the hospital records introduced at trial, the NG tube decompression was successful in relieving Mrs. Atkinson's persistent abdominal distention, nausea and vomiting, and pain. In addition, Mrs. Atkinson testified at trial that her complaints were relieved by the NG tube decompression the day before the second surgery. There was no dispute from anyone that the second surgery was "elective" and more dangerous than repeated the NG tube decompression treatment if necessary and continuation of the TPN which had been instituted weeks

before the second operation. Mrs. Atkinson should have been afforded her fundamental right to "elect" or reject the second surgery under the law of Informed Consent.

- (5) There is no dispute that Dr. Williams failed to give Mrs. Atkinson at least the information required under the law of Informed Consent under Hook about the risks and benefits of "refusing the second surgery."

Under the circumstances, the Trial Court should have granted the Plaintiffs a limited directed verdict on the sole issue of Dr. Williams' failure to satisfy his requirement to properly offer and explain to Mrs. Atkinson the option she had to refuse the second surgery. Given the Trial Court's refusal to grant the Plaintiffs' their Motion for Directed Verdict, the Trial Court should grant the Plaintiffs a new trial or JNOV and order a new trial in this matter.

III. CONCLUSION

The Plaintiffs respectfully petition the Trial Court to grant them a new trial under the Thirteenth Juror Doctrine and for the other reasons stated in this document involving the spoliation of evidence jury charge under Stokes and the law of Informed Consent under Hooks.

RESPECTFULLY SUBMITTED,

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BY: 

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Attorney for Plaintiffs

Florence, South Carolina
October 22, 2012

EXHIBIT A

59% prior Hgt - 1973
~~ovarian cyst~~
 H/O Borel rsn 3/07 CEA 2.7
 HCG 1.7
 CA 125 4.2
 Any other BS
 CBC, Metabolites ok
 Lym 29
 Hydronephrosis
 u/s

Atkinson Case

7/26/10 12:15pm to 1:15pm - 1 hr

20P
 Radiology

Office u/s "Women's Care of Hartsville" 4/3/07
 mostly cystic masses 12cm x 9.4 x 9.7 cm
 some internal debris, one small firm septation

CXR 3/07 - COPD = hyperinflation

CT ABD 3/30/07 - Carolina Pines Med Center
 / priors

tiny @ renal stone
 12.8 x 9 mm @ appendix
 "worrisome for ovarian carcinoma"

CT head = normal
 Mammogram = negative

preop Hx

4/13/2007 CC: @ flank pain

pm Hx "H/O laparoscopy for Borel rsn / 'gangrenous bowel' 1995
 1995 → repeat laparoscopy for SBO to adhesions

? date
 ? circumstances
 ? old of notes

Px 128165 "large ventral midline skin incision"

pm → @ solid midline mass 14 cm

Williams Dx: ① Cystic mass of the pelvis
 ② Laparotomy x 3 (Actually 4?)

"Risks of surgery include anesthetic causes & ... Visceral injury
 to bowel, bladder + ureter - even complications
 that could result in major problems or death were
 discussed - This was discussed - pt, her husband
 + daughter"

Op Note: 4/25/07

extreme adhesion 2 1/2 hrs adhesiolysis out of 3 1/2 hrs case

"massive adhesions"

"An enterotomy was encountered"

**** ① problem = No description of Bowel reanastomosis

Also ② why not simply over-close enterotomy as opposed to resecting

"The Bowel was run from the Ligament of Treitz to the terminal ileum + was excellent + normal"

"The small Bowel resection + anastomosis site was clear"

Separation placed

**** problem — Bowel resection where's the Bowel

NOT on PTH report

Only ovaries = serous epitheliomas

Postop course

POD # 8

Radiology

~~Barium~~ Barium UGI/SBE 5/2/07 Indication = N/V
Findings = SBO vs ileus

APD CT 5/4/07 - partial SBO (POD # 10)

CXR 5/7/07 (POD # 13) Indication = 02 sat

Consultations

POD # 27

5/21/07 Dr Harris Parker (? gen surgery ??) ***

pt Agelinde, APD mody tender & peritoneal signs ***

pt interest in maximal medical management"

TPN option

???

~~gastrografin~~ enema 5/21/07 - ~~no~~ obt & leak

5/28/07 (POD # 34)

Williams re-explors

Find, massive adhesiolysis x 4 hrs
SB resection & PA
cystostomy

How were these
multiple enterostomies
closed ???

? dye extravasation ??
enterostomy - multiple

? how many ?? ***

"jejunum ileal reanastomosis"

→ only 1 cm of terminal ileum salvaged

"enterostomy noted proximal to reanastomosis oversewn
2 layers of silk *** ok ok."

48 cms of small bowel on port right.

POB # 40 overruled (POB # 6 from 2nd laparotomy)

Lap III 6/3/07

Lap #3 this hospitalization
Drs. Parker + Prickett — gen surgery
"Requesting MD = Ferry Smith ??? ~~xxxxxx~~ was Smith
on call??
"Specimens from drains, ~~leucocytes~~
leucocytosis + thrombocytosis"
2 SB perforators → high prox jejunum,
just distal to Lij of Treitz
2 liters succo anterior → distal SB → just prox to
perforators.

Lap IV 6/5/07

peritonitis SB laceration, ileocolic vein
perforation 10-15 cm prox to staple line
Gastrostomy, jejunostomy
"prox jejunum ok" ~~xxxxxx~~

Lap V 6/7/07

Ileocecal coloproctomy

~~overrule~~ Admitted 4/25/07
Discharged 4/8/07 (POB #45)

Lap VI 6/11/07

Washout + Mesh

Readmitted 7/6/07 → outcome??

Was original surgery indicated: Yes

Deviation From standard of care: No

Why?

Easy
to
prove

Opn oncologists are both trained &
qualified to perform a bowel Adhesolysis
and bowel resection

Gen Surgeon agreed in his ement that
a surgical re-exploration would likely
be indicated.

~~was~~ It was already at high risk

- * prior Bowel surgery for ? SBO
- * massive adhesions described at
initial laparotomy
- * malnutrition & ~~if~~ ~~more~~ ~~or~~
poor PO intake

Initial Surgery was indicated

She was known to be at high risk for complications
(Williams acknowledged that in his notes)

- She appears to have been appropriately counseled 1st go
round

- ~~the~~ When it obstructed & didn't get better, gen surgery
ement was obtained, who acknowledged it would need
reoperation.

- Bowel perforation postop is NOT necessarily an indication
that Bowel injury at preceding surgery went unrecognized.

To wit = it perforated even after general surgeon reoperated.

Issues (1) Review of consents, particularly pertaining to surgeries #1 AND #2 (i.e. Williams)

(2) What happened to Bowel resected at surgery #1
→ it never appears on post report of Williams

doesn't mention re-anastomosis per se — Nightmare Scenario → he ~~forgot to re-connect~~ he got distracted

4 didn't finish resection (re-anastomosis) →

~~not~~ Need to pin Williams down on this and for review of scan to look for stable liver

(3) What was conversation between (A) Williams & pt

and (B) Williams + Harris (gen surgeon) prior to Williams 2nd surgery is why didn't gen surgeon do the case

Need to find out what Harris' testimony is going to be in this regard

(4) What was pt's Nutritional status ~~at~~ just before 2nd surgery — Albumen, pre-albumen was low on TPN — was thought given to prolonged TPN instead of reoperation? Why did Williams choose reoperation?

(5) How many opportunistic Bowel surgeries had Williams done previously as compared to the surgeon whom he consulted with

EXHIBIT B

DORIS FAYE ATKINSON'S BOWEL REMOVED
DURING THE APRIL 25, 2007, HOSPITALIZATION

<u>DATE OF SURGERY</u>	<u>SURGEON</u>	<u>BOWEL REMOVED</u>
APRIL 25, 2007	JAMES WILLIAMS, JR., M.D.	UNKNOWN
MAY 28, 2007	JAMES WILLIAMS, JR., M.D.	48.7 CM (SMALL BOWEL) 2.3 CM (SMALL BOWEL) TOTAL: 51.0 CM (SMALL BOWEL)
JUNE 3, 2007	HARRIS PARKER, M.D.	15.5 CM (SMALL BOWEL) 6.7 CM. (COLON)
JUNE 6, 2007	HARRIS PARKER, M.D.	NONE
JUNE 7, 2007	HARRIS PARKER, M.D.	4.5 CM (SMALL BOWEL & COLON)
JUNE 11, 2007	HARRIS PARKER, M.D.	NONE

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

) IN THE COURT OF COMMON PLEAS
) FIFTH JUDICIAL CIRCUIT
) CASE NO. 2010-CP-40-5705

Doris F. Atkinson and
William E. Atkinson, Jr.,

)
)
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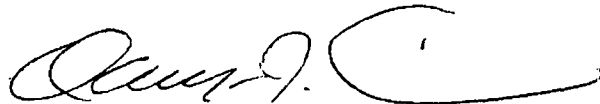
James A. Williams, Jr., M.D., and
South Carolina Oncology Associates,

)
)
) Defendants.
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CERTIFICATE OF SERVICE

I, Daryl J. Corbin, Esquire, attorney for the Plaintiffs, do hereby certify that I served a copy of the foregoing **Plaintiffs' Motions for New Trial and JNOV** via hand-delivery and email transmission on October 22, 2012, addressed to the attorney as indicated below.

William C. McDow, Esquire
Richardson Plowden
1900 Barnwell Street
Columbia, SC 29201
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Daryl J. Corbin, Esquire

Florence, South Carolina

1 that I have described to you earlier. After the plaintiffs
2 rest -- and I don't know when that will be -- this case
3 will take a fair amount of the week to try, if not all
4 week. After the defendant, excuse me, the plaintiffs rest,
5 the defendants will have the opportunity to present
6 evidence as well. After that, the plaintiffs may, under
7 the rules, if the rules permit, present reply evidence and
8 then they will give closing arguments, I will give you the
9 charge on the law, and you will be released to deliberate.

10 Now, any objections to those remarks Mr. Corbin?

11 **MR. CORBIN:** None, Your Honor.

12 **THE COURT:** Mr. McDow?

13 **MR. MCDOW:** No, sir.

14 **THE COURT:** All right. Ladies and gentlemen, Mr.
15 Corbin will now give his opening statement.

16 **OPENING STATEMENTS**

17 **MR. CORBIN:** Thank you, Judge.

18 Rules, rules, rules. We all have rules. The judge
19 is absolutely correct. Attorneys have rules. We're
20 supposed to abide by the rules to properly present the
21 evidence to you. The judge has rules. If a judge does not
22 follow the rules and commits errors, the Supreme Court
23 corrects it. Attorneys are held accountable, even the
24 judge is held accountable. Rules are good. Many
25 situations people are required to abide by the rules. For

1 example, in the workplace. Companies are expected to
2 follow certain safety rules. If the company violates
3 safety rules and exposes its employees to harm, ought we
4 not hold that company accountable for hurting its
5 employees?

6 Imagine someone driving down the highway. Pretty
7 good driver. He's going down the highway. Could pay more
8 attention, kind of distracted that day. He sees ahead a
9 sign, Warning, construction workers ahead. Keeps driving
10 doesn't slow down. Next sign says reduce speed. Orange
11 cones all over the place. Lanes merging ahead. Let 'em
12 work, let 'em live. A construction worker is hit. The
13 driver's a pretty good guy. Should we hold him responsible
14 for being careless at that particular moment in time? We
15 all have rules.

16 Gosh, even lawyers have rules. I mean, even
17 doctors have rules. The rules that govern how a doctor is
18 supposed to treat his patients is what medicine and the law
19 calls standards of care. These basically are just rules of
20 what the doctor is supposed to do in a particular
21 circumstance. The standard of care requires a doctor to
22 act like a reasonably competent doctor is supposed to act
23 and treat a patient in the certain circumstance.

24 What is a basic rule that governs how the doctors
25 are supposed to treat patients? Ladies and gentlemen, we

1 have an absolute right as competent adults to pick and
2 choose what happens to our bodies. It's called informed
3 consent. A doctor or a surgeon is required if you go see
4 him, to examine you, figure out what conditions might you
5 have; take what treatments are available -- and oh, no, a
6 doctor cannot choose which one he wants. You choose what
7 happens to your body. That's rule number one, informed
8 consent.

9 After a surgical procedure, sometimes patients have
10 complications. Some patients have complications with
11 cesareans. If a surgeon does not recognize a patient's red
12 flags and orange cones after surgery, that I am in trouble,
13 and he misdiagnoses the condition or treats something else
14 and the patient is hurt, we have to hold that doctor
15 accountable. That's another rule in medicine under the
16 standard of care.

17 A basic rule in medicine is that a surgeon must
18 investigate a patient's indications of complications after
19 surgery and must rule out the most dangerous conditions
20 first. Rule out the worst first. If a patient, after
21 surgery, has complications -- for example nausea and
22 vomiting, distended abdomen, fevers, sore belly, the
23 doctor's supposed to figure out what could this be. It's
24 called a differential diagnosis. It could be something
25 serious or it could be something not so serious. But you

1 do not pick the least serious complication and treat that
2 and ignore conditions that could kill or cause you
3 permanent damage. For example, a patient goes to the
4 emergency room with chest pains. Could be a heart attack
5 or it could be indigestion. A doctor is supposed to rule
6 out the condition that could cause you the most harm first,
7 not wait 30 some days after all these warning signs and red
8 flags when it's too late.

9 What is this case about? This case is about a
10 surgeon who was absolutely convinced he was right; who had
11 a patient after a surgery, a very difficult surgery, had to
12 remove part of the bowel. But he was so convinced that he
13 was right, but in fact he was wrong and the patient was
14 hurt. The doctor in this case is Dr. Williams, sitting in
15 this courtroom. The patient is Ms. Faye Atkinson. Faye is
16 sitting at the table over here.

17 Let me take you back to April, 2007. Faye, who
18 lives in Hartsville with her husband, Bucky, was referred
19 to Dr. Williams in Columbia. Dr. Williams is what you call
20 a gynecological oncologist who practices surgery. He will
21 tell you on the witness stand, the standards of care or the
22 rules that apply to a surgeon also apply to me because I do
23 lots of surgery.

24 Faye had an ovarian mass. She was referred to Dr.
25 Williams. Dr. Williams was aware of certain studies and

1 tests that indicated, the mass probably isn't cancer.
2 CA-125 test or an ultrasound test, looked on the inside of
3 her body and it came back, probably this is not cancer.
4 Dr. Williams decided to do an operation on Faye here in
5 town at Palmetto Health Richland Hospital. Dr. Williams --
6 because Faye, twelve years earlier had some abdominal
7 troubles and she had what's called a resection where she
8 had a bowel obstruction 12 years ago and the doctors had to
9 remove a small portion of her bowel and sew it back
10 together. A normal person has 18 or 20 feet of small
11 intestines, small bowel. If you don't have enough small
12 bowel, you can have lots of digestive issues.

13 Dr. Williams knew, because 12 years earlier Faye
14 had had an a surgical resection, she was at a high risk to
15 have what are called adhesions or scars on the inside of
16 her abdomen. When you have adhesions on the inside of your
17 abdomen, it makes surgery more difficult and more dangerous
18 and causes situations where you more likely would have
19 holes in your bowel from the procedure called perforations.

20 Dr. Williams, instead of deciding, Faye, you've got
21 this mass. You've never had it before. I don't know if
22 it's getting bigger or smaller. Why don't we do an
23 ultrasound in 90 days and let's see what's going on with
24 you. You're post-menopausal. Post-menopausal women are
25 least likely to have cancerous masses, let's wait. She

1 didn't have that chance. He did the surgery. Dr. Williams
2 goes inside Faye's stomach. He -- sure enough, he found
3 what he thought he would find, adhesions. Another rule in
4 surgery -- and you will hear expert testimony from three or
5 four different people in this case -- but a rule of surgery
6 is if I have a patient with adhesions on the inside, but
7 she needs surgery, in the first place you try to avoid it.
8 But if she needs surgery, you only address the least amount
9 of adhesions that you can to get access to what you want to
10 take out. If you go inside somebody's belly, there are a
11 couple of ways that you can address adhesions if you need
12 to. You can take your fingers and pull them off the organs
13 on the inside, you can gently pull apart the adhesions from
14 the intestines, or you can use scissors and you can cut the
15 adhesions away from these organs. That's when the danger
16 comes in.

17 Dr. Williams did his procedure and low and behold
18 he found adhesions. But what he did was, he violated the
19 rule. You only address those adhesions that are necessary
20 because if you mess with them, you're exposing your patient
21 to perforations in the bowel, number one. And all surgeons
22 know if you mess with adhesions and cut them or pull them
23 apart, they're coming back again, maybe worse than before.
24 If you had no troubles in 12 years with adhesions, leave
25 them alone.

1 He decides he's going to do what the doctors call a
2 complete adhesionology (phonetic) or a complete lysis
3 procedure, he went searching for adhesions on the inside of
4 the body. Up here, up here, down here, down here. He was
5 trying to get access to the pelvis, to the ovaries. Well,
6 sure enough, just as he anticipated, it was a complicated,
7 difficult surgery and he caused a couple of perforations in
8 her bowel. He had no business removing those adhesions
9 that he did. By the way, he also perforated her bladder.

10 A couple of ways you can fix that. If you go in
11 there and you have a surgical complication, a little
12 mishap, holes in the bowel, there are a couple of ways you
13 can fix it. Number one is, you can take and you can sew
14 the hole shut, assuming it's a relatively small hole, you
15 take, prep, and you sew sutures and you sew the hole shut.
16 What that does is, it preserves the bowel. Another way you
17 can address the hole in the bowel is you resect it. You
18 cut it out. You go a little bit on one side of the hole
19 that you caused, then you go a little bit on the other side
20 of the hole that you caused and you cut it out. That's
21 called a resection. Resections hurt patients because it
22 removes the bowel.

23 Dr. Williams did the resection. Well, how much
24 bowel did he take out? He ought to know. Don't you think
25 pathology or somebody at the hospital will know, we're

1 taking out part of a lady's bowel. Normal procedure is
2 when you cut something out of a patient's body, you just
3 don't throw it away. Especially what you cut out what you
4 now state are feet of bowel, you cut it out, you send it to
5 a pathology lab, to those experts; they examine it with a
6 microscope; they check it for disease, they check it for
7 holes, and they report back to the doctor.

8 We have a missing bowel in this case. We have Dr.
9 Williams' testimony about how much he took out. He says he
10 sent it to pathology, Gosh, they must have lost a feet of
11 bowel. And we'll get more into that during this case.

12 What happened after that difficult, rough surgery?
13 It's our position it was extensive surgery. He didn't mean
14 to expose perforations, but he did. He didn't need to cut
15 her bowel out, he could have sewed it, unless it was a
16 large hole, unless there were lots of holes in that bowel,
17 which is missing, there's really no need is resect. That's
18 a last-ditch effort. You can't stop the leak.

19 Dr. Williams will testify or else I'll read part of
20 his deposition to you, that he knew after this surgery, the
21 risk -- there would be a leak from where he connected the
22 remainder of Faye's bowel together, the risk of a leak
23 there was as high as 50 percent. Flip a coin. Flip a
24 coin. Bowel leaks where you have stool content dumping
25 into your body is an extremely, extremely dangerous

1 situation that can kill you. He knew coin flipping, bowel
2 leak.

3 Let's get into the red flags that I was talking
4 about a while ago. We hold drivers accountable. But the
5 next 33 days, we're talking 33 days, coin flip or the bowel
6 leak. There were over a hundred red flags, over a hundred.
7 What happens if there's a bowel leak? You get abdominal
8 distension. Your belly gets firm and big and hard because
9 it's filling up with fluids on the inside. What's going in
10 is leaking out of your bowel into your abdomen. That's a
11 red flag. Faye, during those 32 or 33 days, had 30 days of
12 abdominal distension, 27 days in a row.

13 What's another red flag? That a patient could be
14 suffering from what you knew was a coin flip, nausea and
15 vomiting. During those 30 days -- and we'll get into to
16 records in a minute -- Faye had 60 -- more than 60
17 episodes. Doctors call it a nice word called emesis. It's
18 vomit. Faye vomited sometimes as much as half a Coca-Cola
19 bottle, 900 cc's of vomit. Large amounts of vomit, brown.
20 The nurses -- I mean you're going to hear what nurses say
21 in this case -- and trust me, it's not going to be on
22 Faye's side of the table.

23 Nurses were talking about foul smelling, what the
24 doctor's call fecula, the vomit from Faye. Now know what
25 that is? Fecula, vomiting, it's stool like content.

1 Instead of coming out your anus, you throw it up. Those
2 red flags were waiving pretty hard. He ignored them.

3 More red flags. This is a case of many, many,
4 times just ignoring what you're supposed to do. Another
5 red flag: Wouldn't you think if you just cut somebody's
6 belly open, you just took out feet of bowel and sewed it
7 back together, there's a coin flip; there could have been a
8 bowel leak. Wouldn't you take heed of large amounts of
9 yellow pus, foul-smelling yellow pus, foul-smelling yellow
10 pus coming out of the wound? Would that get someone's
11 attention? Not Dr. Williams. During those 30 something
12 days, during 18 or 20 or 25, we'll tell you the exact
13 amounts in a while, why in the world wouldn't Dr. Williams
14 culture? I mean our common experience tells us -- I'm not
15 a physician -- you've got a lady that you just took out a
16 big chunk of her bowel and sewed it back together. She's
17 throwing up feculent material. Her belly is firm and hard
18 and you've got yellow pus rolling out of the wound, I think
19 I would be looking inside.

20 What is the best way in the world -- and Dr. Bailey
21 from Florida, he's one of our surgical experts, he will
22 tell you that the medical literature will tell you -- if
23 you're not a doctor, you can resort to the medical
24 literature -- but the medical literature will tell you to
25 rule out a coin flip in Ms. Atkinson's situation. The way

1 you do it is a CT scan. CT scan. We've probably all heard
2 about those. There's going to be testimony that doctor's
3 like Dr. Williams, they do CT scans by the wheelbarrels
4 full. During these 32 or 33 days, with those red flags and
5 orange cones, he failed to do a single CT scan. He failed
6 to do the device, noninvasive device that could have looked
7 inside her body and could have identified with 3-D exactly
8 where that perforation was. Red flag.

9 Dr. Bailey will tell you, surgeons -- and this is
10 another one -- post-surgery patient like Ms. Atkinson, like
11 Faye, if you start seeing green stuff, thick green stuff,
12 so much you have to have a bag to collect it, coming out of
13 that surgical wound, coming from the deep pelvis, that
14 green stuff, that's bowel content. That is a red flag.
15 That's first year medical school. You'd go in, you look
16 around and you see what's going on, or do a CT scan. Dr.
17 Williams chose for those 32 days to do what are called
18 KUB's. KUB is nothing but what the doctor's call plain
19 films. Plain films. And they don't do hardly anything to
20 rule out the condition that could kill a patient like Faye.

21 Remember we talked about rule out the worst first?
22 Rule out the perforation that can kill you first, you do
23 that with CT scan, not a plain KUB imprecise film.

24 Well, another red flag: Even decides -- who knows
25 why you don't do a CT scan, but you decide to do KUB's five

1 or six of them. Then you get notice from the radiologist
2 because you're asking him to check the persistent nausea
3 and vomiting. Radiology record says, Gosh, you've got some
4 barium -- we're going to talk about barium in a minute --
5 in Faye's intestines and it looks like some of it's coming
6 out of her intestines. There's something strange going on
7 in her intestines. It's angular down there. It could be
8 extravasation of barium, a leak of barium. Everybody will
9 tell you that the only way barium leaks out of Faye's
10 intestine is because there was a perforation, a hole.

11 Dr. Williams, he was convinced he was right, but in
12 fact, he was wrong. He was treating a small bowel
13 obstruction, something that won't kill you. He didn't do
14 what he had to do to rule out the perforation. The
15 perforation, the hole in her intestine went on for 32 or 33
16 days that caused another horrible condition called a
17 fistula. A fistula is a fancy medical term that means the
18 perforation has been there a long time and the whole
19 contents are coming out of the holes in the skin.

20 What could have been done during those 32 days
21 between rough surgery and eventually a second surgery?
22 What should have been done? Dr. Bailey will tell you
23 surgeons know that in a patient like Faye, she had a
24 resection twelve years ago, now she had a very complicated
25 surgical condition, another bowel removal of feet.

1 Surgeons know that you need to closely watch your patient.
2 You need to pay attention to your patient and if you see
3 signs and symptoms that give you indications there could be
4 a bowel leak, you either do a CT scan or it's okay for
5 surgeons, especially when you see green content coming out
6 of the wound, you've got a surgical mishap, you go in. You
7 open up the wound, you see what you have, you fix it. You
8 don't let what the doctors call intestinal juices delay and
9 dump inside her body for the next 32 days. You don't do
10 that.

11 If you wait beyond a couple of weeks -- there's no
12 magical date, but surgeons know, these adhesions are coming
13 back. You know we talked about initial adhesions, they're
14 coming back worse than ever now. And when you don't --
15 when intestinal juices are inside the abdomen, they're
16 coming back worse than ever. So surgeons know, if we have
17 to do surgery, we better do it. Look at about two weeks or
18 15 days or so because if you wait longer than that and you
19 ignore the warning signs and the flags and the cones and
20 you go in after 15 or 16 or 17 days, you're really going to
21 encounter a mess because those adhesions, they start out
22 failing where you pull them apart with your fingers. Then
23 they start getting hard, they start getting festered and
24 blood inside. They start getting thick and stubborn and
25 that happens after a couple of weeks. If you decide to do

1 surgery on a patient like that, you're really asking for
2 troubles. Most surgeons -- all surgeons avoid that as much
3 as they possibly can.

4 So Dr. Williams, number one, he should have done --
5 he should have been warned by the yellow stuff and the
6 green stuff. He should have done exploratory on day 2 or 3
7 or 4. He should have done a CT scan which would have
8 proven the perforation. He could have addressed it. He
9 could have had an interventional radiologist drain it
10 without major surgical complications. He didn't do that.
11 He let her fester for 30 some days and then he does the
12 second surgery.

13 You know, one reason I postponed it was because
14 Faye was scared of another surgery. Could you blame her?
15 The first one went terribly bad. Faye was anxious. She
16 did not want more surgery. Fix what is bothering me, Dr.
17 Williams. Fix this fecular vomit. Throwing up in her bed
18 at nighttime, 4 or 5 or 6 times a day. Fix it. Fix my
19 abdominal pain. Please fix it. Fix my fullness in my
20 belly. She didn't call it distension, she said I got a
21 fullness. Fix it.

22 Well, Dr. Williams says, the way you fix that, you
23 wait a couple more days just to see. No, no, the way you
24 fix it is NG tube down your nose. Doctors -- even Dr.
25 Williams' partner will testify, NG tube down your nose, it

1 immediately gets rid of distension. It immediately avoids
2 you throwing up the fecular material because it comes out
3 into a bag. It immediately relieves your pain. Rather
4 rudimentary, simple stuff. It's really sad in this case.
5 Even if Ms. Atkinson had a small bowel obstruction, it's
6 important to remember, obstructions can be caused by
7 perforations.

8 Anything that obstructs the intestines is
9 considered a small bowel obstruction. Perforations can
10 cause it, which is in fact what she had. Abscesses can
11 cause it, which is, in fact, what she had. A horrible
12 condition called peritonitis can cause it, which is what,
13 in fact, she had. He diagnosed her as having a small bowel
14 obstruction. Well, when you look at that, Dr. Williams
15 really didn't even treat a small bowel obstruction problem.
16 And if he would have done that, even though he misdiagnosed
17 the condition, if he would have used an NG tube, which is
18 the proper treatment for obstruction -- Dr. Williams was
19 wrong, but if he would have done the right thing for the
20 wrong diagnosis, we wouldn't be here because the right
21 thing is sticking a tube down her nose, the NG tube.

22 Why is that important? The distension is causing
23 pressure, kind of like a garden hose. I think you can stop
24 a garden hose. You put a garden hose together and you've
25 got pressure there. And if you let that pressure build and

1 build and build, you're inclined to get a leak. If you
2 relieve that pressure, your chances of having a leak are
3 less. Dr. Williams did not properly treat a small bowel
4 obstruction, NG tube. If he would have, we wouldn't be
5 here.

6 The second operation -- finally we get around to
7 the second operation -- 32 days of misery without a CT
8 scan, didn't send a culture for that pus coming out of the
9 wounds. Nurses said, Doctor, she's got pus coming out of
10 her wounds. His testimony is, Well, nurses, they don't
11 know. They can't diagnose an acute abdomen, can they? I'm
12 a doctor. The nurses were right. Thirty-three days he
13 speaks with Faye. I don't want surgery. Can't you do
14 something. I don't want surgery.

15 He tells her the option is surgery. He violated
16 her rights. He violated her rights in a gross sense
17 because even he testifies he knew in that hostile
18 abdomen -- that's what they call it after 15 days -- well
19 it gets real dangerous. Opening that patient up, opening
20 Faye up and going into that hostile abdomen, it's extremely
21 dangerous. You think he told Faye that before he opened
22 her up a second time? You think he told Faye, NG tube,
23 Faye. I know you're scared to death. NG tube, we can
24 avoid this dangerous surgery. Let's give it a try. The NG
25 tube might make you better. If it doesn't, we've got to

1 wait about 90 days or so. You're on a feeding tube, you're
2 not going to starve to death. The distension, if I do it
3 will get rid of your complaints. Let's wait 90 days until
4 it's safer, don't make me operate in a dangerous abdomen.
5 But he didn't do that. He violated her rights. He said,
6 You need surgery. He wheeled her into the operating room.

7 Wouldn't you think that a surgeon knowing what he
8 could have done the first time, taking out a foot of bowel,
9 knowing all those horrible conditions and red flags and 32
10 or 33 days, knowing the condition is going to be even worse
11 the second time than the first one, wouldn't he get
12 somebody to assist him that was a qualified surgeon, an
13 experienced surgeon? I mean, I would want the doctor to
14 pick a qualified experienced surgeon to assist him. He
15 picked a resident. He picked a resident to assist him.

16 The second operation was horrible. You think the
17 first one was a nightmare, the second one was even worse.
18 He opens her up and he doesn't have to. If he would have
19 given Faye the right, she would have said don't you dare
20 open me up. I'm scared to death. He opens her up. Again
21 he encounters adhesions. Worse than before. What does he
22 do now? He starts that lysis procedure again. I guess
23 when you're a carpenter, you can solve everything by doing
24 one thing. He decided to do this lysis procedure again.
25 He starts messing with those adhesions. Starts messing

1 with them. You know he did take a CT scan before he went
2 in there which would have told him what was in there. Now,
3 why he didn't do that? I don't know. I would want to know
4 what's in there. Doesn't do a CT scan. He opens her up,
5 sees these adhesions, he starts cutting them out.

6 Well, just like the first time, except even worse.
7 This time he caused so many holes in the bowel that he
8 didn't count them. He didn't count his patient's holes in
9 her bowels that he caused. He describes it as multiple.
10 Well, can't you do a little bit better than that? Tell me
11 what multiple means. Well, just a lot. Could be ten.
12 What he did was he violated another rule. He went into the
13 abdomen and he started causing perforations. How many do
14 you need to cause before you say to yourself, I'm hurting
15 my patient. I'm not going to cause -- two or three or four
16 or five or six. I'm not going to do this.

17 Even his partner will testify, the option Dr.
18 Williams had, if you're going to go in there and -- my
19 experts on this side say you don't go in there. You don't
20 do it. But even Dr. Smith, Dr. Williams' senior partner,
21 will testify he would not have gone in there. He wouldn't
22 have done it; NG tube for the senior partner. But if you
23 go in there, according to Dr. Smith, you start causing
24 these perforations, you don't keep ongoing. You stop. You
25 have the option to stop, Doctor. Especially when you

1 didn't get your patient's permission. But he didn't. He
2 encountered what seemed like a ball of glue. He's causing
3 up to ten enterotomies or holes. He goes back to what he
4 did the first time. Instead of fixing, let's cut it out.

5 Well, this time he took out another big portion of
6 Faye's bowel. The first time feet, the second time a ball
7 of glue. He took her bowel out, sewed her back up. When
8 you read his post-operative records about how Faye was
9 doing 3 or 4 days after this, before he was going on
10 vacation, looking good. Going well. Looking good. Goes
11 on vacation. Dr. Smith covers for him. Dr. Smith, sees
12 something horribly wrong: Stuff coming out of the wound.
13 Faye was not doing well at all. You know you read the
14 reference twelve hours earlier, Dr. Williams says she's
15 doing good.

16 Dr. Smith did the correct thing. He got a surgeon
17 involved. He didn't mess with it. He got a surgeon
18 involved. It took four additional surgeries to correct the
19 snowballing effect that Dr. Williams put her on. The
20 second surgery opened her up and found two perforations.
21 He found two liters of bowel content in her belly. He
22 diagnosed her with that fistula, you know I talked about a
23 fistula.

24 Fistula is a whole other condition. It's a long,
25 long standing perforation. Been there a long time. Dr.

1 Williams missed that too. Second surgeon, Dr. Parker,
2 whose friends with Dr. Williams, close friends, and he'll
3 probably testify. But what did Dr. Parker do? He found a
4 mass. He did the honorable thing and told the family, I
5 don't know if you're going to make it, Faye, but if you
6 make it, I've got to go in. It's sort of like a ball game.
7 I can't get a home run if -- I mean, I'm going to go in
8 there, I've got to do a little bit. I can see what's
9 there. I know it's there. I can open you up and I'm going
10 to keep your belly open because I'm coming back in 48 hours
11 for a second look to avoid that surgical trauma. And then
12 I'm coming back again and I'm not going to stop until I
13 find all these perforations and fix everything and drain
14 out the pus; and that's what he did. Faye will tell you he
15 is a God send. He saved her life.

16 I want to talk a little bit about Dr. Parker and
17 his relationship with Dr. Williams. And the judge just
18 told you, you can consider a lot of things to see if
19 someone's going to kind of shade their testimony a little
20 bit. They worked in the same hospital, refer patients to
21 each other. Just remember that. What damage did Dr.
22 Williams cause? This is a medical malpractice case. Dr.
23 Williams violated the rules. He hurt his patient. He
24 needs to be held accountable.

25 We have brought this case on behalf of Faye and

1 also her husband. Her husband's name is Bucky. They've
2 been married between 40 and 50 years. Three years ago when
3 this case was brought, Bucky was doing okay. The judge has
4 allowed me to tell you -- and this is it, Bucky is not here
5 because the medical condition he has does not allow him to
6 come here and you cannot hold that against him, like he
7 doesn't give a tahoots about his wife's case or he doesn't
8 give a tahoots about his claim too. Don't hold it against
9 him. His condition has nothing to do with Dr. Williams.
10 Faye's condition has everything to do with Dr. Williams.
11 But do not hold anything against Bucky because medically he
12 cannot be here. But it has nothing to do with Dr. Williams
13 and we are not here for sympathy because some people might
14 be concerned that we're asking for sympathy, I've just
15 explained why Bucky's not here. Don't hold it against
16 Faye, don't hold it against Bucky. He's not here.

17 Faye has almost \$600,000 in medical bills. Should
18 have been a relatively simple procedure to remove an
19 ovarian mass, send her home in 3 to 5 days; \$570,000 in
20 medical bills. She had six operations. She has what she's
21 going to describe to you as a nightmare. It's a horrible
22 thing and I don't relish having to tell anybody those
23 horrible things, but this is her one chance in court to
24 tell you what's going on with her, what Dr. Williams did to
25 her. She has what's called short bowel syndrome. You

1 know, a woman her size, 5 foot 2, she used to weigh like
2 125 pounds. Dr. Williams will say that a normal person
3 like that would have 18, 20 feet of bowel, 14, 16 feet,
4 something like that. When Dr. Williams finished with his
5 patient, she has about 20 inches, 20 inches of bowel left;
6 short bowel syndrome, uncontrollable diarrhea, pretty bad,
7 up to 60 or 70 times a day until her anus is raw. No fix
8 for her.

9 Dr. Williams will tell you he fixed her. His two
10 surgeries, he'll tell you, I fixed the problem. When she
11 was released from the hospital after 62 days going home,
12 that was some of her worse times. Bucky would find her
13 laying in the floor in her own feces, electrolytes down.
14 The digestive system -- I mean everybody knows when you got
15 a rough-feeling belly it's difficult. If you don't have
16 enough small intestines to properly digest your food and
17 slow it down and do what the bowel needs to do, it's going
18 to race through your body. If you eat something, won't be
19 long, won't take four hours, it might take a few minutes,
20 but it's coming out. If you drink something, it's coming
21 out.

22 That's Faye's nightmare. She has horrible
23 scarring. And I'm telling you this not to have anybody
24 feel sorry for her, but at the end of this case, I am going
25 to ask you to return a verdict that Dr. Williams violated

1 the rules. He committed medical malpractice numerous times
2 and he caused Faye damages. Part of those damages are the
3 horrible scars that she has and you'll see photographs of
4 the scarring. The embarrassment that she has.

5 The testimony that we have in this case, you can
6 have testimony live or the rules allow us to take sworn
7 statements from witnesses and read parts of that testimony
8 to you. I took Dr. Smith's deposition testimony and we're
9 going to read a large chunk of his deposition testimony to
10 you. We might read Bucky's deposition testimony to you.
11 We appreciate your patience in the case. You're going to
12 hear a lot of terms that don't make a whole lot of sense to
13 regular people, like adhesions and bowel obstructions; and
14 we're doing our best to bring to you an expert witness who
15 can explain what's going on. You'll soon see things on the
16 monitor about the location of her ovaries and why Dr.
17 Williams did not need to cut perforations at the top of her
18 abdomen.

19 We appreciate your time. Your decision in this
20 case may come Thursday or Friday. Your decision in this
21 case affects more than just the people in this courtroom
22 because you're going to decide -- you're going to set the
23 standard for grandmothers, grandparents, parents, children,
24 loved ones, what is a surgeon required to do in a situation
25 like Faye's? You're going to decide that. You'll decide

1 whether or not this community has a lax standard of care or
2 one that fully protects patients. So when you make your
3 decision it's going to go well beyond this courtroom.

4 Thank you.

5 THE COURT: Mr. McDow?

6 MR. MCDOW: Thank you, may it please the Court?

7 THE COURT: Yes, sir.

8 MR. MCDOW: Ladies and gentlemen of the jury, as I
9 was at home last night -- I'm a baseball fan. October
10 means the fall classic. And I was sitting back thinking
11 about my opening statement and making a few notes on what
12 the Yankees -- I'm not an Yankees fan and no, I don't think
13 it was an infield fly rule last week either -- but as I was
14 sitting there watching the Yankees, I started thinking
15 about Yogi Berra and the Yogisms and some of the statements
16 that he had made over the years, both while he was a player
17 and after he was a player. And this case is about déjà vu
18 all over again.

19 My name is Bill McDow. I introduced myself to you
20 earlier in the day. I work with Richardson Plowden law
21 firm here in Columbia. I do medical malpractice defense.
22 I have the honor and privilege of representing Dr. Jimmy
23 Williams. Dr. Williams is a gynecologist oncologist. He
24 works with South Carolina Oncology Associates and you can
25 tell by those two words, gynecology, made for women,

1 oncology being for cancer. So he is a women's cancer
2 doctor. He performs surgery. He treats women for various
3 types of cancer, ovarian cancer, cervical cancer, or pelvic
4 masses and in this case, complex surgery. It's what he
5 does. This is why Ms. Atkinson was referred to him back in
6 April of 2007.

7 Ms. Atkinson came to him as a result of a referral
8 from her doctors over in Hartsville, both a family
9 physician and a regular OB GYN over in Hartsville as well.
10 She was admitted to Carolina Pines Hospital over in
11 Hartsville in March of 2007. She presented to the
12 emergency room due to complaints of abdominal pain. They
13 did a CT scan over there. They did some other testing and
14 she had a mass in her pelvis. She had a mass on her
15 ovaries, both on the left and on the -- the other one being
16 on the right. The bigger one was on the right-hand side
17 and instead of that OB GYN taking care of Ms. Atkinson, she
18 decided that based on all the attendant circumstances,
19 Ms. Atkinson needed to be referred to a gynecology
20 oncologist, and that was Dr. Williams.

21 The mass was worrisome for cancer. That's what the
22 radiologist said on his radiology report. Yes, the CA-125,
23 which is a cancer blood test you may have heard of and --
24 it was read as normal, but that doesn't rule out the idea
25 that this could be ovarian cancer. This mass was 13

1 centimeters by 9 centimeters. It was big. So she was
2 referred over to Dr. Williams.

3 He saw her in his office on April 13th of 2007. He
4 examined her with a nurse present and was able to feel the
5 mass in her pelvis. The mass was pressing on her ureter on
6 the right side causing some hydronephrosis. She was in
7 considerable pain; and so it was decided at that time that
8 surgery needed to be performed to remove the mass.

9 Now, I'll tell you right now, did he discuss with
10 her the idea of following this mass with serial
11 ultrasounds? No, he did not. He did not do that because
12 the standard of care, which you have heard about, did not
13 require him to do that. This mass needed to come out, not
14 only due to the size, but also due to the other physical
15 findings and as a result of that particular office visit,
16 surgery was scheduled. Surgery was scheduled right here in
17 Richland County, Palmetto Health Richland. And that
18 surgery was scheduled for April 25th, 2007.

19 The material risk of that surgery was told to
20 Ms. Atkinson, and she agreed to the surgery, and Dr.
21 Williams proceeded on at that time. The name of that
22 surgery is called a by bilateral salpingo oophorectomy and
23 that is just the medical term for taking out your tubes and
24 ovaries. And again, it was that ovary on the right-hand
25 side where the mass was that was really -- was what was

1 causing her problems.

2 In that office visit, Dr. Williams was very aware
3 of the prior surgeries and when April 25, 2007 rolled
4 around, he scheduled her for surgery, brought her in, took
5 her into surgery. In the process of performing that
6 surgery, he encountered adhesions, not surprisingly. The
7 informed consent document that's in the medical records
8 shows that the surgery to be performed was bilateral
9 salpingo oophorectomy, BSO, and sometimes you'll see the
10 abbreviation, LOA, lysis of adhesions. So we knew kind of
11 what was going to go on at that time.

12 Now, luckily, to fast forward a little bit, the
13 mass did not turn out to be cancer. The pathology record
14 came back as negative. So that's a good thing. We took
15 care of that. As he was going in, he encountered these
16 adhesions. Now the question becomes, as has been framed to
17 you, why not go directly to the mass? Why would you free
18 up all of these adhesions? Well, you've got to be able to
19 see what you're doing in a surgery. You've got to be able
20 to see what you're doing in a surgery and being able to
21 identify where those landmarks are, those anatomical
22 landmarks in your abdomen.

23 And so her bowels were so adhesed that he started
24 to have to tease them out with a scissor and dissecting
25 those adhesions before he could get down to properly

1 identify where the tubes and ovaries were. And in order to
2 do that, he started where they call is Ligament of Treitz
3 that is an anatomical landmark in the upper abdomen. And
4 once you go there, you know where you are.

5 Now, you've been in the hospital before, you've had
6 somebody in the hospital before, you always get to ask this
7 embarrassing question, Are you passing flatus? Are you
8 passing gas? You know, is your plumbing working? How's it
9 going? Well, the reason is because, we know, when you
10 drink something, it goes down; it goes in your stomach, it
11 goes through the small bowel, works it's way around until
12 it attaches into the larger intestine kind of in the lower
13 right part where your appendix is located.

14 Then it comes up, what's called the ascending
15 colon, across, the transverse colon, down the descending
16 colon and then into your sigmoid colon there near the
17 bottom and finally comes out in the rectum. And that's why
18 you go in and have gastroenterologists do those procedures
19 to see whether or not you've got colonoscopies and polyp
20 and that sort of thing. So that's whether or not your
21 plumbing is working.

22 Well, he went in and he teased all these adhesions
23 out until finally he got down to the mass, properly
24 identified. Did not do more adhesions than was necessary
25 to identify the landmarks and get this mass out. That's

1 what he did. He had to do what he had to do to make sure
2 that he performed this surgery within the standards of
3 care.

4 Now, during the time of that surgery, the bowel was
5 so matted together and so adhered together that, that's
6 right, he took part of that diseased part of the bowel out.
7 He cut on one end, he cut on another, hooked it back up,
8 and that's called reanastomosis, and that part is hooked
9 together. And that's what he did.

10 Now, post-operatively, she goes to the floor and
11 we're watching her and Dr. Williams is there about every
12 day, if not every day. When he's not there, his partner,
13 Dr. Gary Smith is covering for him. And she progresses,
14 regresses, has some things occur, until finally on May
15 28th, 2007, she gets taken back in for a surgery again for
16 what's been diagnosed as a partial small bowel obstruction.
17 Some things are getting through. She's able to have bowel
18 movements, she's getting fed what they call a TPN at times.
19 There's been some times when we took her completely off of
20 anything by mouth because we didn't want anything to upset
21 the bowels as it was going through. So we did appropriate
22 compare during that time frame.

23 Now, when he went back in on May 28th, yes, there
24 were adhesions again. Yes, that was to be expected. This
25 was a complex surgery, this is what he does. As a result

1 of going back in the second time, he opens her up and he
2 again has to tease the bowel out and separate it and make
3 sure that it's okay. And in the course of doing that,
4 enterostomies are encountered. He didn't find open holes
5 when he went back in on May 28th. There was no stool
6 floating around in her belly. There was no barium,
7 peritonitis. He pulled up a piece of bowel that was stuck
8 to the back of the wall and there was a little bit of
9 barium where he pulled it out, a very small amount that was
10 clinically insignificant, not causing her any problems.
11 She wasn't septic, she wasn't on death's door and he
12 performed that surgery appropriately.

13 So we've got these kind of two bookend dates, April
14 25th, the first surgery; and May 28th for the second
15 surgery. So what happens in between there? What happens
16 in between that time, because that's kind of where we're
17 looking at the signs and symptoms and that's what we're
18 trying to figure out as to what her problem is. And
19 originally -- there are two things that could be the
20 problem. You have what is called a post-op ileus, a
21 post-op ileus; and what that means is when somebody goes in
22 and they manipulate your bowels, your bowels have this
23 reaction of shutting down because it doesn't like being
24 messed with basically. So you look for signs and symptoms
25 of a post-op ileus, which also, by the way, can be like

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1 **THE CLERK:** Please have a seat up here, sir. Speak
2 into that microphone; state your full name for the record
3 and please spell your last.

4 **THE WITNESS:** Robert W. Bailey, B-a-i-l-e-y.

5 **DIRECT EXAMINATION**

6 **BY MR. CORBIN:**

7 Q Welcome, Dr. Bailey.

8 A Thank you.

9 Q Where do you live, please?

10 A I live in Miami, Florida.

11 Q Can you give the jury a sketch of your educational
12 background, please.

13 A Sure. I grew up in Philadelphia and went to the
14 University of Pennsylvania for my undergraduate. I then
15 went to John Hopkins University School of Medicine in
16 Baltimore. After that I -- or during my residence, I
17 finished medical school and then did my residency at NYU
18 Medical Center in New York. I also went back to Hopkins
19 and did a two-year research fellowship at Johns Hopkins.
20 Went back to New York, finished my residency and then in
21 1988 I took a job as an assistant professor at the
22 University of Maryland. I also worked at shock trauma
23 there and then after that --

24 Q What is shock trauma, please?

25 A It's a -- it's one of the largest trauma centers in

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1 the United States.

2 Q What did you do for shock trauma at the University
3 of Maryland in Baltimore?

4 A You know, we'd be on call, we get called the knife
5 and gun club. We'd get a lot of shootings and stabbings
6 and a lot of major catastrophes dealing with major
7 abdominal injuries and liable for open surgeries and
8 certain procedures like that.

9 Q And Dr. Bailey --

10 A And then after that, I became chief of general
11 surgery at the Greater Baltimore Medical Center just north
12 of Baltimore and then in 1996 was offered a job as
13 Associate Professor up at the Medical College of
14 Pennsylvania in Philadelphia. And then '99 was offered a
15 position at the University of Miami to set up their
16 division of laparoscopic surgery.

17 Q Are you board certified in any particular medical
18 specialties?

19 A In general surgery.

20 Q Dr. Bailey, can you tell us in general what this
21 38 page document is?

22 A It's my curriculum vitae.

23 Q That curriculum vitae, that's a resume or --

24 A Yes, it is.

25 Q -- a listing of your accomplishments in your

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1 career?

2 A Correct.

3 MR. CORBIN: Your Honor, we would move to introduce
4 this as Exhibit No. 1, please.

5 THE COURT: Any objection?

6 MR. MCDOW: Seems cumulative to what he's already
7 testified too. I don't know that it needs to be --

8 THE COURT: All right. Just mark it for the time
9 being for identification and we'll deal with that later.

10 (WHEREUPON Plaintiff's Exhibit 1 was marked for
11 identification.)

12 THE COURT: You can use it for questioning, that's
13 certainly fine, but it's not into evidence. You want to
14 put a sticker on it?

15 MR. CORBIN: I can, yes, sir.

16 THE COURT: That's No. 1?

17 MR. CORBIN: Yes, sir.

18 BY MR. CORBIN:

19 Q Dr. Bailey, have we talked about all of your
20 accomplishments in this 38 page document so far?

21 A No, we have not.

22 Q Is this document accurate and correct?

23 A Yes, sir.

24 Q Tell the jury -- it looks like you have numerous
25 papers that you've prepared and had published. In general,

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1 tell the jury what the importance is of peer review,
2 medical journals, and how difficult it is to get something
3 published.

4 A Well, in the field of scientific medicine or
5 academic medicine, in the field of surgery, physicians do
6 research. It could be either research in the laboratory or
7 clinical research on patients, collecting data. And then
8 you submit that to what we call a peer review journal.
9 What that means is there's an editorial board, a group of
10 experts from around the world that take in the articles.
11 They review it and then they have to accept it before it's
12 published because they don't want just anyone being able to
13 publish anything; and they make sure that it's accurate and
14 that it fits with current medical literature and that it's
15 a valid paper that deserves to be published in the medical
16 literature.

17 Q Dr. Bailey, I notice you've written three books --

18 A Yes, sir.

19 Q -- on surgery. I notice you have written 28
20 chapters of other people's medical books --

21 A Yes, sir.

22 Q -- text books.

23 A Yes, sir.

24 Q In terms of the articles that you've done research
25 and had published, you've had numerous of those?

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1 A Yes, sir.

2 MR. CORBIN: Your Honor, we'd -- it's been marked
3 as 1.

4 THE COURT: Okay.

5 BY MR. CORBIN:

6 Q Tell the jury about your experience in adhesion
7 surgeries and small bowel obstructions and perforations and
8 the issues important in this particular case, please.

9 A Throughout my career, I've been in major academic
10 centers. They're all referral centers, working at Hopkins,
11 NYU, University of Maryland, we tend to get a lot of very,
12 very difficult cases transferred to us. These are cases
13 that either the surgeon in the community doesn't feel
14 comfortable handling or situations where there have been
15 really severe complications, patients end up getting
16 transferred. So part and parcel throughout my career has
17 been dealing with patients that are transferred having had
18 or having major abdominal complications such as adhesions
19 and post-operative bowel perforations and sepsis and
20 fistulas that develop, things of that nature.

21 Q Dr. Bailey, have you given lectures about surgery
22 all around the world?

23 A Yes, I have.

24 Q Have you taught medical students?

25 A Medical students, fellows, residents. I continue

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1 to teach all of those.

2 Q Have you treated patients with what is called
3 short bowel syndrome?

4 A Yes, I have. Typically patients with short bowel
5 syndrome, it's a very difficult course. There are some
6 centers like at University of Maryland we had one surgeon
7 that that's pretty much all she did was manage patients
8 with short bowel syndromes. So when I was at University of
9 Maryland for example, whereas I might have a patient that
10 is transferred in, I might be the surgeon on call that
11 night, I would manage them initially, but then down the
12 line, when they're ready to go in they would call in
13 additional help to manage it because they're very difficult
14 and complicated situations.

15 Q Dr. Bailey, would you tell the jury about any
16 significance of a patient suffering from short bowel
17 syndrome, what about twenty inches of short bowel left?

18 A Well, that's probably about the shortest length of
19 small bowel I've seen with someone that's still able to be
20 alive and have some what semblance of a life. Normally the
21 normal length of the small intestine is about 20 feet. You
22 make the diagnose of short bowel syndrome when you have
23 less than about six feet. So when you go down to 22 inches
24 or 20 inches, it's extremely, extremely short.

25 Q Do you know of any cure for Ms. Atkinson?

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1 A There's no real cure. There are some centers that
2 have tried intestinal transplantation, which is a very
3 risky procedure. It doesn't have the greatest success
4 rate. You're on lifelong steroids and then if it fails,
5 there's a high likelihood that you could die.

6 MR. CORBIN: Your Honor, at this time, we submit
7 Dr. Robert Bailey to the Court as an expert witness in the
8 field of surgery with a special Ms. On abdominal surgery
9 and the issues in this particular case.

10 THE COURT: All right. Any voir dire, Mr. McDow?

11 MR. MCDOW: No objection.

12 THE COURT: Okay. All right. Ladies and gentlemen
13 the witness is qualified as an expert in the field of
14 surgery and the specialty of abdominal surgery. I just
15 need your attention for just a moment.

16 Typically when someone testifies in a case we call
17 these folks lay witnesses, that person cannot give
18 conclusions -- or excuse me, give opinions. In other words
19 that person can say I saw this or I touched this from my
20 perspective. They can't give any opinion. For example a
21 witness to an automobile accident or a shooting, I saw this
22 and I saw that. There is an exception in our rules of
23 evidence for witnesses, who by education, training or
24 experience, are qualified as experts in certain arts,
25 sciences, or professions. Those witnesses can give

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1 opinions. That does not mean that you are bound by the
2 testimony of an expert witness just because it comes from
3 an expert.

4 In other words, you give the expert's testimony the
5 weight that you believe it deserves. I'll instruct you
6 more closely on that at the end of the case, but this
7 witness is qualified as an expert in the field of surgery
8 and the specialty of abdominal surgery.

9 All right. Mr. Corbin?

10 **MR. CORBIN:** Thank you, Judge.

11 **BY MR. CORBIN:**

12 **Q** Dr. Bailey, in this particular case involving Faye
13 Atkinson, have you reviewed sufficient medical records of
14 hers to come to conclusions as to whether or not Dr.
15 Williams met the standard of care or met the rules
16 applicable to this case?

17 **A** Yes, I have. There were numerous records and
18 x-rays.

19 **Q** With respect to the records that you reviewed, can
20 you tell the jury in general what types of records you
21 reviewed?

22 **A** Well, there were the medical records from the
23 initial surgery starting on April 25th through the surgery
24 by doctor -- the second surgery by Dr. Williams and then of
25 course the subsequent surgeries by Dr. Parker. And then I

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1 also looked at additional followup records, especially
2 those pertaining to her care and management of the short
3 bowel syndrome up until May of this year.

4 Q Dr. Bailey, do you feel comfortable telling the
5 jury at the appropriate time what Dr. Williams should have
6 done to properly treat his patient?

7 A Yes.

8 Q If you will, please, come down here.

9 MR. CORBIN: I would like to show the jury at this
10 time, Your Honor, and I've cleared this with defense
11 counsel, we have a program, Dr. Bailey --

12 MR. MCDOW: I wouldn't say prepared with me. It's
13 a still shot of them. I'm going to watch it as it goes
14 along.

15 MR. CORBIN: That would be fine.

16 THE COURT: Is it a just for recordkeeping
17 purposes, is this a DVD, a video tape or what is it.

18 MR. CORBIN: This is a -- iPad application. It's a
19 3-D model to show the jury what the inside of a normal
20 human being's body looks like, with reference especially to
21 the intestines and the ovaries and the locations of them.

22 THE COURT: All right.

23 MR. MCDOW: I'll watch it as we go.

24 THE COURT: All right. I can't see it, so somebody
25 let me know if there's an objection.

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1 And Mr. McDow, your client can look; and of course,
2 you can get to wherever you need to be, just as long as any
3 talking is between the two of you.

4 **MR. CORBIN:** Can everyone see? Do we need to turn
5 this or is this all right, sir?

6 (WHEREUPON there was no reaction from the jury.)

7 **BY MR. CORBIN:**

8 **Q** Dr. Bailey, would you step down?

9 (WHEREUPON the witness complied.)

10 **BY MR. CORBIN:**

11 **Q** In general -- and we'll get into specific parts in
12 a second -- but in general, can you tell the jury what this
13 3-D model actually depicts?

14 **A** Can I get you to enlarge it just a little bit?

15 (WHEREUPON the attorney complies.)

16 **THE WITNESS:** There you go.

17 **THE COURT:** And Dr. Bailey, if you would keep your
18 voice up for the court reporter's benefit, please.

19 **THE WITNESS:** Okay. I'll try.

20 It's an artists rendering just to state up front,
21 there's no -- you can have an artists rendering that
22 captures the basic anatomy, obviously, things look a little
23 bit different on the inside, but this -- these loops about
24 here represent the small intestine. That's the 20 feet
25 that we mentioned that's normally there. And it starts

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1 up -- this is the stomach up here and the stomach empties
2 and it's actually hidden behind the colon, but the upper
3 part of the small intestine is right here and it sort of
4 winds its way back and forth for that 20 feet until it gets
5 to the colon, the secum. This is where the appendix sits.
6 This is where the large intestine that you heard described
7 earlier starts with the ascending colon, transverse colon,
8 descending colon, and then down to the rectum where it's
9 passed through.

10 Q Dr. Bailey, if I may, please. Tell the jury what
11 are those body parts depicted there?

12 A This is the uterus, this is the right ovary of a
13 patient. The left ovary would be over in this area.
14 Typically during a normal situation when we open a patient
15 up, there will be several loops, two or three loops of this
16 portion of the small intestine that are draped down and
17 stuck to the uterus and the ovary. But this is where she
18 had her problem. That is where she had a mass in the ovary
19 that needed to be addressed. The goal of the surgery in
20 that situation is to free up two or three loops of bowel
21 that may be stuck down to the uterus and the ovary, lift
22 them up out of the way, do your surgery and be done with
23 it. There's absolutely no need to start way up here just
24 past the stomach and free up and take two-and-a-half hours
25 to free up every single loop of small bowel in the upper

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1 part of the abdomen.

2 Q Dr. Bailey, the ovaries are down here?

3 A Yes.

4 Q Okay. And can you explain to the jury -- you
5 heard stuff on opening statement that Dr. Williams needed
6 to gain access to the ovaries. Can you explain to the jury
7 why he would not need to come at the top of the small
8 intestines to gain access to the ovaries down there?

9 A I think I just did that maybe while you remember
10 addressing the graph there, but again, there's only several
11 loops of small bowel that lay down low in the pelvis. The
12 upper part of the small intestine up by the stomach and
13 two-thirds of the way down is nowhere near anatomically the
14 ovaries or the uterus. There's actually no reason to mess
15 around with the majority of the small bowel. Your goal is
16 to get to the ovary, take care of the mass and do what you
17 decide you need to do for it from the gynecological
18 standpoint and stop; especially in a patient that's had
19 previous surgery and you know there's going to be a lot of
20 scar tissue, there's going to be a lot of adhesions.

21 Q And Dr. Williams's perative record, his first
22 record, can you explain why he started way up here to
23 remove adhesions if he was going down to get access to the
24 ovaries?

25 A No, I don't have any reason why that would be.

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1 Especially the ligament Treitz, the ligament Treitz, you
2 can't really see it in this picture, but it's on the
3 posterior, the back part of the abdomen. It's at the root
4 of the mesentery. These bowels that you see here, some of
5 them may be stuck up to the previous incision towards the
6 front part of the abdomen, which was where the previous
7 surgery was, but the Ligament of Treitz is hidden. It's in
8 the right peritoneum, it's all the way towards the back of
9 the abdomen and it's hidden. It's hidden by the colon and
10 it's hidden by other obstructions, so it gets somewhat
11 difficult. There's absolutely no reason to be at the
12 Ligament of Treitz to try to free up enough adhesions near
13 the ovary to do the complete surgery.

14 Q But taking down these adhesions, that would get
15 rid of them, wouldn't it?

16 A Temporarily, but they reform and I think the
17 testimony that I've read from some of the other experts and
18 physicians in this case, even on the other side,
19 acknowledge that the adhesions reform, as they did from the
20 '95 surgery, and they did in this case. So there's no
21 benefit to a patient to lysis adhesions, especially if the
22 patient is having no problems with bowel obstruction before
23 the surgery, no complaints of nausea or vomiting or any
24 sign of any problem. There's no reason to then go through
25 this extensive, what we call lysis or freeing up adhesions.

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1 Q Dr. Bailey, could you please retake the witness
2 stand?

3 A (The witness complies.)

4 Q Dr. Bailey, based upon your review of the medical
5 records -- and if we could, please start with the first
6 operation that Dr. Williams decided to do -- do you have an
7 opinion -- and I'm going to ask you about your opinions.
8 Will you please base all your opinions that you give in
9 this case based upon a reasonable degree of medical
10 certainty for me. Will you do that?

11 A Yes, sir.

12 Q Tell this jury your opinion as to whether or not
13 Dr. Williams satisfied the standard of care involving the
14 first operation?

15 A Well, as we just discussed, with the first
16 operation, no, I believe that he did not; that doing this
17 extensive, complete lysis of adhesions in the beginning of
18 the small intestine up by the stomach, all the way down
19 until it reached the colon was not necessary in order to
20 complete the surgery.

21 Q The missing bowel --

22 A Yes, sir.

23 Q -- tell the jury your opinion, being a surgeon
24 working in shock trauma, removing -- resecting bowels and
25 that kind of issue -- tell the jury whether or not it's

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1 common place for a surgeon to lose feet of a patient's
2 bowel he took out?

3 A Absolutely not. I mean, it's hospital policy.
4 It's a strict hospital policy, I believe, I am sure almost
5 all states have regulations. You just can't discard human
6 body parts that are removed during surgery and then thrown
7 in the trash. That, I think, would violate many state
8 medical regulations.

9 Q The human body part had failed -- the abdomen or
10 the intestines that were cut out, would that be where the
11 perforations would be that Dr. Williams caused?

12 A Yes.

13 Q If that bowel that is missing would have been sent
14 to pathology, could they tell the jury how many holes were
15 in that piece that was cut out?

16 A Yes, they could tell you if it was one, if there
17 were multiple. They could also give you very, very
18 detailed description of the length, because we really don't
19 know how much bowel was removed; but by listening to the --
20 reading the deposition testimony, we understand was a
21 couple of feet, I believe, or something of that nature; and
22 it brings up one of many questions that I have with this
23 case because when I read the operative report of Dr.
24 Williams, it says there was one single hole that I had to
25 resect and remove and the hole was usually half an inch,

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1 maybe an inch at the most. So you're going to remove a few
2 inches of bowel. So why with one single hole would you end
3 up removing two feet of bowel.

4 Q During that first operation -- well, does a
5 surgeon have an obligation to notate somewhere in the world
6 how much of a body part he removed from a patient's body?

7 A Absolutely. Especially if it's going to be several
8 feet because we know that we're dealing with this issue of
9 short bowel syndrome and it's important to note the
10 location of the intestine because different parts of the
11 small intestines serve different functions as far as
12 absorption of vitamins and nutrients and electrolytes. The
13 terminal ileum, for example is very important with that and
14 you -- especially when you're removing parts of the ileum,
15 which is the last part of the small intestine, you want to
16 make sure you document the length of bowel that's being
17 removed; and as I said, the exact location.

18 Q Is it a deviation from the standard of care for
19 Dr. Williams not to indicate how much bowel he removed in
20 the first operative procedure?

21 A It is, in the fact that -- especially since the
22 specimen was lost and we can't document it; but yes,
23 removing, when removing -- as I said, if it's a small
24 sigmoidal resection and you say there's a single hole and I
25 remove just around this hole, you don't necessarily have to

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1 say it was exactly six inches or eight inches because we
2 all know as surgeons, it's a limited resection. But then
3 when you find out that several feet have been removed,
4 that's a very important thing for you to know.

5 Q Tell the jury whether or not there's any
6 importance in doing a surgery like Dr. Williams did to
7 preserve as much bowel as you possibly can.

8 A Always. I mean, you want to limit your resection
9 because if not, you end up in exactly the same situation
10 down the lines as we have in this case, where a patient
11 basically becomes what we call a gastrointestinal cripple,
12 that they have chronic, massive diarrhea; they struggle
13 with maintaining their weight and adequate nutrition
14 because they don't have sufficient length of intestine to
15 absorb all the nutrients that they need to survive.

16 Q Do you have an opinion based upon a reasonable
17 degree of medical certainty whether Faye is a
18 gastrointestinal cripple?

19 A The word -- cripple -- as I say, she -- we -- with
20 the short length that she has, she is in a very precarious
21 situation. I would say the majority of patients that I
22 have seen with such short length, have not survived, but
23 she, you know, she's able to sit here in the courtroom and
24 whatnot, but she's still having significant bouts of
25 diarrhea, I think 15, 20 times a day and is struggling with

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1 maintaining adequate weight and nutrition.

2 Q If the surgeon during the first surgery causes a
3 small hole, what is the appropriate way to fix it to
4 preserve the bowel?

5 A It depends on the size of the hole. Usually if
6 it's less than half the diameter of the bowel, you can try
7 to repair it with sutures, but if it's a large hole, you
8 just cut it out and hook the ends back together.

9 Q Did Dr. Williams decide to insert a drain during
10 that first surgical procedure?

11 A He actually put three drains in. There was one
12 that was left inside the abdominal cavity down into the
13 pelvic area and running along the bowel; and then there
14 were two drains left above the muscle layer of closure but
15 underneath the skin.

16 Q The pelvic region, and I think the records
17 describe it as a deep pelvic region --

18 A Right, that's where the tip of the drain was, but
19 that drain comes up in the lower part of the abdomen, so
20 it's traveling -- it's not just in the pelvis, it tracks
21 back up so it's running along the colon and the intestine
22 until it comes out through the muscle, through the skin on
23 the patient's side.

24 Q That particular deep pelvis drain, is that
25 something different than a subcutaneous skin wound or a

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1 drainage?

2 A Yes. Drains that are placed -- there were two
3 other drains that were placed above the closure of the
4 muscle there, but underneath the skin.

5 Q Dr. Bailey, could you tell the jury about any
6 significance in Faye's case about her wound drainage
7 between the first and second operations.

8 A There are two significant aspects of this. The
9 first is you always look at the color and the nature of the
10 drainage. Intestinal contents are green and brownish.
11 There is no reason -- there's no other source to have
12 green, brownish drainage coming from an abdominal drain
13 unless there is a leak from the intestines somewhere after
14 surgery. So on the second day after surgery, they saw a
15 green, brownish drainage coming from her drain. It was
16 coming out through the drain sight. That is what -- in
17 medical terms what we call pathognomonic. It means it
18 speaks for itself. It means that there's a leak in the
19 bowel somewhere and it needs to be investigated. There
20 were subsequent -- the second part is that for the next ten
21 days or so, there were large amounts of pus draining out
22 too.

23 Now, enterocutaneous fistulas, they start in the
24 intestine, that is they start at the site of the
25 perforation and then the material that's there, that's

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1 leaking out, slowly starts to wind it's way up through the
2 loops of the bowel, up through the muscle layer that's been
3 closed up through the skin through a very tiny track, like
4 a tiny little river tributary that's tracking up. Often by
5 the time it gets to the skin, you don't actually see the
6 intestinal contents and all that's left that comes out
7 looks like large amounts of pus; but a surgeon needs to be
8 aware and be alerted that that should be of major concern,
9 that he may be dealing with enterocutaneous fistula.

10 So the fact that it wasn't green and brown
11 throughout the entire time really is not what's important
12 here. The fact is it was at one point and there's no other
13 way for it to be anything else but a leak. It continued
14 and it needed to be investigated.

15 Q How did Dr. Williams on post-operative day two,
16 this is two days after this resection -- how did he
17 investigate, if at all, the significance of the green wound
18 drainage coming from the deep pelvis that speaks for
19 itself?

20 A No further -- I mean, no CAT scans were done. CAT
21 scans are very commonly done for all type -- you can't even
22 go to the emergency room these days with complaints of
23 belly pain without getting a CAT scan. We do it for
24 diagnosing appendicitis, any type of intestinal leakage,
25 anything at all. A CAT scan is pretty much a very common,

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1 routine test.

2 Q If Dr. Williams -- the second day after the first
3 surgery would have used the CAT scan to investigate the
4 green wound leakage, what do you think probably he would
5 have seen on the CAT scan?

6 A You would -- most likely you would have seen some
7 leakage. Basically if the patient had contrast to drink,
8 they then do the scan, typically an area where the
9 perforation is, you see a reaction, you see a collection of
10 fluid that's been leaking out. It's called an abscess and
11 you see this on the three-dimensional image that can be
12 missed quite easily on the two dimensional standard test.

13 Q Do you have an opinion if Dr. Williams would have
14 done a CAT scan and it would have shown him the
15 perforation, if it would have been drained appropriately,
16 what effect would that have on Faye's operative course
17 after it was drained?

18 A Well, if you can address the perforation early on
19 and fix it, then the problem goes away. It means typically
20 another surgery, but you close the hole in the bowel; you
21 may need to do another resection, but you're not left with
22 this ongoing chronic drainage and infection and then a
23 situation with where you're operating four weeks later,
24 which if we had to -- I don't think it should have been
25 done, but it would have avoided a great deal on her care.

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1 Q Dr. Bailey, the summary in Faye's hospital chart
2 is 2000 pages long. The summary involving the wound
3 drainage, I want to ask you a few questions about that.
4 The wound drainage during that 32, 33 day period, she had
5 28 days of wound drainage, 19 days of yellow or purulent
6 drainage. Is that medically significant?

7 A Yes, for the reasons we just went through.

8 Q What is purulent drainage and what does it show to
9 physicians?

10 A Well, it means that there's pus. As I said,
11 typically, these fistulas, these perforations, they often
12 can present with just pus draining out, but at the very
13 least, it means that there's a wound infection and the
14 standard treatment for a wound infection is to open up the
15 wound. Open up the skin, clean it out, pack it.
16 Typically, what happens, though, if you have a fistula,
17 once you open the skin and you get deeper inside, you start
18 to see obvious evidence of the bowel contents draining
19 there. So you also make the diagnosis. But to do nothing,
20 to not even open the wound, drain the wound is -- it
21 violates the standard of care.

22 Q Did you see reference of the medical records that
23 the nurses saw and reported in the records purulent
24 drainage?

25 A Multiple, yes.

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1 Q Any word from Dr. Williams that he had any
2 concerns or noted purulent drainage?

3 A I believe in his deposition he said that he never
4 noted any purulent drainage.

5 Q Did he believe the nurses?

6 MR. MCDOW: Objection.

7 THE COURT: Sustained.

8 BY MR. CORBIN:

9 Q On post-operative day two, the summary from the
10 medical records indicates -- this is April 22, the second
11 day after the surgery -- quote, At least three references,
12 wound drainage bag draining green; brown, foul smelling at
13 5 a.m. that morning. Any significance of foul smelling on
14 top of being green and brown and being collected in a
15 drainage bag?

16 A Just the obvious common sense. We all know what
17 stool smells like.

18 Q I'm not going to go through all these dates, but
19 there are 28 days. Another reference made first
20 post-operative day six, quote, At least two references of
21 wound drainage, three puncture wounds where drains were
22 removed; draining yellow drainage. Patient states drainage
23 is foul smelling. Continues to have yellow drainage. What
24 did Dr. Williams do with those warning signs?

25 A As far as I can tell nothing further was done.

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1 Q The very next day, May 2nd, post-operative day 7,
2 quote, Very large amounts of purulent drainage is coming
3 from the old jp site, drainage, purulent, large. Are those
4 warning signs to a surgeon?

5 A Yes, sir.

6 Q Did Dr. Williams do anything to change his course
7 of treatment given these references to having large amounts
8 of purulent drainage at this time?

9 A Not the test that I would expect a surgeon to do in
10 this situation. At one point, he did order this upper GI
11 study with barium, which I believe also wasn't appropriate,
12 but we'll talk about that in a minute. But no CAT scans
13 where you can actually go to the x-ray, put a catheter
14 through the drainage site, inject x-ray material, contrast
15 to the -- where the pus is coming out and see if it
16 connects with the intestine. So very quick easy to do.

17 Q The very next --

18 MR. MCDOW: Your Honor, I hate to interrupt, but
19 he's reading from a summary. Could I ask if he has an
20 extra copy for us, please.

21 MR. CORBIN: We've given them copies.

22 MR. MCDOW: I don't have it in that bound form that
23 you're looking at.

24 THE COURT: You got -- are they numbered? Page
25 numbers?

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1 **MR. CORBIN:** It's just -- it's the wound drainage
2 summary. We've given them to counsel and we've attached
3 the supporting documentation to it?

4 **THE COURT:** But are those pages numbered.

5 **MR. MCDOW:** No, sir, I don't have the supporting
6 documentation. He did give me these charts that he had
7 prepared, but I don't have the supporting document pages to
8 follow along. I didn't know if he had an extra copy for us
9 as opposed to us finding it ourself or not. That's all I
10 wanted.

11 **MR. CORBIN:** We do.

12 **THE COURT:** There you go.

13 **MR. CORBIN:** And Your Honor, the purpose of the
14 summary is not having to read all the supporting documents.
15 We can, but --

16 **THE COURT:** I understand.

17 **MR. CORBIN:** -- I was reading it off of the chart.

18 **THE COURT:** As long as he got a copy, which he's
19 got. That's fine.

20 **MR. CORBIN:** Yes, sir. Thank you.

21 **BY MR. CORBIN:**

22 **Q** So we have the next day --

23 **THE COURT:** What date, please?

24 **MR. CORBIN:** May 3, post-operative day 8, again.
25 there's a reference, purulent large, purulent moderate.

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1 The next day after that on the fourth, this is the fifth
2 day in a row, at least two references, draining yellow
3 slough, large purulent amount of drainage coming from the
4 left side puncture wounds. Five or six days in a row,
5 purulent drainage. What is the appropriate course to take
6 if a doctor believes what's in the nurses notes, purulent
7 drainage for five or six days in a row.

8 A It needs to be investigated. You have at the very
9 least an infection going on. You're draining pus. You
10 have an infection that needs to be -- if it's a wound
11 infection, you need to investigate that wound infection.
12 You need to open up the staples, the skin incision, you
13 need to open the skin. Obviously, we try to do this --
14 it's large -- in the operating room with anesthesia so the
15 patient is comfortable. Look at the wound, make sure that
16 the muscle layer is intact, take him to x-ray, check the
17 catheter to see where the pus the tracking from.

18 You do a CAT scan. So there's a number of things
19 that can be done, but my nature cursory of this case is
20 that not really none of these appropriate tests or steps
21 were taken.

22 Q Another summary indicates abdominal distension.

23 A Yes, sir.

24 Q In general, tell the jury what abdominal
25 distension is and does that have any significance in

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1 treating a patient like Faye.

2 A Distension is -- you know, the abdomen is swollen,
3 it's big, it's bloated. As a surgeon, we're concerned
4 about abdominal distension because it could mean anything
5 from what was referred to earlier as a mild postop ileus..
6 It is normal for a day or two for the intestine to go to
7 sleep after surgery, but, in -- we do major abdominal
8 surgery all the time. Patients usually stay in the
9 hospital three days, four days, five days. And then the
10 intestine wakes up and they get to go home. That's what is
11 normally expected to happen. When that doesn't happen,
12 that in and of itself is a huge warning sign or should be a
13 huge warning sign to a surgeon. Because you know that
14 something is going on that is causing this patient delayed
15 recovery and you need to investigate it further.

16 Q Thirty separate days out of thirty-two days of
17 abdominal distension, including twenty-seven consecutive
18 days of abdominal distension, can you think of any reason
19 why it would be appropriate not to follow up and check for
20 surgical complications.

21 A No, I can't. And also just realize that it's just
22 because maybe on one or two days it wasn't documented that
23 doesn't mean she didn't have it on those days. It's more
24 likely than not. She was persistently distended the entire
25 time and maybe not as just recorded by the nurses. The

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1 second thing is if you are dealing with persistent bowel
2 distension, persistent nausea, persistent vomiting,
3 sometimes large amounts, that standard of care requires
4 placement of a nasal gastric tube.

5 I mean we -- medical students learn this the first
6 day of their surgical. It's in every basic surgery
7 textbook. Anybody with -- even if your diagnosis is that
8 of a possible bowel obstruction, the patient needs a nasal
9 gastric tube. And to not put a nasal gastric tube in a
10 patient for thirty plus days with continued vomiting,
11 nausea, vomiting, and distension is really -- it's way out
12 of the norm.

13 Q Faye's complaints were full in the center of the
14 abdomen, abdominal pain, nausea, and vomiting. Would the
15 NG tube treat those particular conditions?

16 A It decompresses the abdomen. We know for example
17 when they finally put the nasal gastric tube in, she had
18 two liters of fluid in her stomach. So what it does, it
19 relieves the build up of fluid, helps to decompress it.
20 Typically when we have a patient that presents with a
21 partial small bowel obstruction from adhesion after
22 surgery, it resolved within a few days. Overwhelmingly the
23 majority of patients with a nasal gastric tube, we don't --
24 if they have an obstruction, you shouldn't be feeding them,
25 you should be giving them liquids because it's like a

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1 toilet that's backed up. You know it's backed up, you
2 don't just keep pouring water on top of the toilet, it's
3 going to overflow. You decompress it and you try to let
4 the tube decompress the intestine and treat the patient and
5 usually it resolves.

6 Q The nausea and vomiting, the records indicate that
7 Faye had 65 episodes on at least 25 separate days, despite
8 nausea medication every day. Do you have an opinion as to
9 whether it violates the standard of care for Dr. Williams
10 not to consider these red warning flags for perforation?

11 A Yes, sir. I mean, when you have a perforation,
12 obviously, that's one reason why you have this ongoing
13 infection, leakage of intestinal contents. The intestine
14 is going to shut down. It's not going to work. It's going
15 to present like this ileus or possibly look like a small
16 bowel obstruction. We know that it wasn't a complete
17 obstruction because when he gave the large barium it could
18 get through to the large intestine, so we know that the
19 small intestine was not completely blocked and there didn't
20 appear to be any high rate of obstruction.

21 Q Is there any significance in Faye's case -- and
22 I'll read you just a few references, May 12th, for example.
23 There was nausea and vomiting 5 times that day. This is
24 post-operative day 17. Vomiting 5 times in a day;
25 persistent nausea, large, thick, foul smelling, yellow and

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1 she was medicated with Zofran and phenergan. Now, what's
2 going on that particular day?

3 A Well, again, it just shows the continuation of the
4 same problem. What happens over several weeks though when
5 you're left with a situation where the intestine is not
6 functioning, you get the overgrowth of bacteria, like the
7 same bacteria you have in your large intestine, your colon.
8 It begins to smell like stool, it gets to look like stool
9 and the color and everything, but it's the same issue, it's
10 something that is not regular.

11 The patient should normally be expected to go home
12 after a few days; or else you give them a couple of extra
13 days. You put a nasal gastric tube down and you treat them
14 appropriately. You do some tests. You have to exclude and
15 rule out that you're not missing some major complication.
16 Our job is not to make assumptions, our job is to make sure
17 we're not missing something that is really going to be very
18 serious and life threatening to the patient.

19 Q Did Dr. Williams miss something in Faye's case
20 that was really serious and life threatening to her?

21 A Yes, perforation.

22 Q Was that a violation of the standard of care?

23 A Yes, sir.

24 Q The failure to timely diagnose the post-operative
25 complications, can you tell me how in the world can you

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1 prove, from the medical records that you do have and you
2 reviewed, that in fact Faye did have a perforation between
3 the first and second operations that Dr. Williams missed?

4 A There are two pieces, one we discussed, that is the
5 green, brownish drainage the second day after surgery.

6 There's no other way to get that green, brownish drainage.

7 Then at the second operation, they found barium --
8 this was a barium that she had drunk before in that upper
9 GI Study that you heard of. And the barium was outside of
10 the intestinal lumen, outside the intestine itself.

11 There's no way for that barium to get from inside the
12 intestine to the outside of the intestine unless there's a
13 perforation.

14 Q If a patient has --

15 A And I just mentioned on that, that before they
16 do -- before they did this upper GI Study, before they gave
17 her any barium, they always do what they called a scout
18 film. They take a plain picture of the abdomen. There was
19 no barium in it, okay. It's like buried somewhere, they
20 say well maybe the barium was from ten years ago or prior
21 surgery or some kind of problem. There was no barium.
22 Barium is -- it's a liquid form of heavy, dense metal.

23 It's why radiologists love it because it lights up
24 the intestine. You may see some in these pictures. It's
25 bright white. You can't miss it on an x-ray. So the

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1 barium wasn't there before and they found it outside the
2 bowel in the second surgery. There had to be a
3 perforation.

4 Q The scout that you were talking about, is that the
5 same thing as a KUB?

6 A Yes. KUB, plain abdominal x-ray, they're all the
7 same type of x-ray.

8 Q In Dr. Williams's second operative report, 33 days
9 after the first surgery, did you see any proof that in fact
10 he identified a barium leak at that point in time?

11 A Yes, he wrote it in his operative record.

12

13 **MR. CORBIN:** Can we go to that slide?

14 (WHEREUPON the attorneys were working with the slides.)

15 **THE COURT:** Mr. Corbin, is the question that the
16 defendant identified the barium leak or someone else --

17 **MR. CORBIN:** Yes, sir.

18 **BY MR. CORBIN:**

19 Q Did Dr. Williams identify a barium leak in the
20 second operative report?

21 A Yes, he did.

22 Q If you could come down here, please. This is Dr.
23 Williams's second operative report dated May 28th, 2007, 33
24 days after the first.

25 A Yes, sir.

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1 Q What, in general, are findings that a surgeon puts
2 in an operative report? What is the significance of
3 findings?

4 A The operative report has several -- the top you
5 list the procedure that was done. It lists the
6 pre-operative diagnosis, it lists the post-op diagnosis and
7 then a list of the different procedures, then a list of the
8 surgeons, the type of anesthesia. All of this is pretty
9 standard. Then, typically, you have a section where you
10 list the major findings from the operation. And then
11 following that, you go into a more detailed description,
12 anywhere from half a page to one, two or three pages of
13 more detail from the surgery.

14 But the findings here, massive inflammatory change
15 in the abdomen. I know you probably can't see this,
16 especially in the back. Pocket of -- dye along the
17 posterior peroneum and a pocket at the base of the
18 mesentery, not within the intestine. If it's within the
19 intestine, you're not going to actually see barium. You
20 may see it through the wall of the bowel, but you're not
21 going to see it in a patient's --

22 Q What is peritonitis?

23 A That's a generic term that we use for inflammation
24 of the peritoneum. Peritonitis -- when you hear the word
25 itis in medicine, it means inflammation of infection. So

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1 peritonitis is inflammation of the peritoneum which is the
2 lining of the abdominal cavity.

3 Q Dr. Bailey, in your opinion, with the
4 understanding of her course during those 32 days or so with
5 the perforation, can you tell the jury what the most likely
6 cause of the massive inflammatory change in her abdomen
7 was?

8 A Well, as we mentioned, when you're leaking -- you
9 know a leakage from the intestine, the intestinal contents
10 are very toxic. It has a digestive enzyme to it, it's
11 vile, pancreatic enzymes. These aren't meant to be outside
12 of the lumen, the intestine, so it causes a lot of
13 inflammation. The barium, unfortunately -- there are two
14 types of x-ray material we can use. One is called water
15 side, it's not permanent. If it leaks out, it goes away.
16 Your body absorbs it, which is why the standard of care --
17 we haven't gotten to this, so forgive me, but this is all
18 logical -- but when you suspect that there might be a leak
19 of some sort, or even if your dealing with a small bowel
20 obstruction, there might be a leak, you do -- you use water
21 soluble contrast first because if there is a leak and you
22 leak barium out, it gets stuck inside the abdominal cavity
23 and it's almost impossible to get rid of it because it's a
24 heavy metal, bacteria bind to it. You get concretions,
25 like little pieces concrete of this barium material and

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1 it's very difficult to remove and clear away an infection.

2 So the standard of care requires you to use the water
3 soluble contrast first. That's your first choice, not the
4 barium.

5 Q Did you --

6 A Unfortunately, the barium was used first here in
7 this case. And of course, it leaked and it was found out
8 and it stayed there in all of the subsequent films.

9 Q The -- can you look at this and tell how much --
10 or at least the general areas, where Dr. Williams removed
11 Faye's bowel? Approximately from the terminal jejunum,
12 removing most of the ileum. What is that?

13 A As I said, the small intestine has three portions.
14 The first portion is the duodenum, just past the stomach,
15 it's very short, maybe a foot. Then you have the jejunum,
16 which is probably another five or six feet. Then you have
17 the terminal ileum. This is where most of the small bowel
18 absorbs nutrients and vitamins and whatnot. And he
19 removed, as he said, pretty much most of a chunk of it -- a
20 large section of the remaining terminal ileum that she had.
21 In doing so, you're setting the patient up for a lot of
22 problems because where as you can get away with removing
23 large portions of the jejunum, when you remove large
24 portions of the ileum, you run into a lot of problems with
25 the short bowel syndrome.

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1 Q The ten centimeters of terminal ilium that --

2 A Four inches.

3 Q Four inches. Thank you, Doctor.

4 (WHEREUPON the witness returned to the stand.)

5 BY MR. CORBIN:

6 Q The next issue I want to ask you about is
7 something called tachycardia.

8 A Yes, sir.

9 Q Tell the jury what tachycardia is and whether or
10 not that's important in Faye's case?

11 A Tachycardia is the medical term for a fast heart
12 rate. We all know that a normal heart rate is usually 60,
13 70, 80 -- our pulse, our pulse rate that they measure every
14 time you go see the doctor. Ms. Atkinson's normal heart
15 rate before surgery, I believe was around 70. We expect
16 some slight tachycardia maybe the first 24 hours after
17 surgery, maybe 90 to 100, patient is uncomfortable, they
18 had a major surgery, it's a major stress to the system.
19 But when you get into a situation where your heart rate is
20 up to 110, 120. I think it was as high as 130 the first
21 few days after surgery and then it doesn't go away. And
22 it's unexplained, that's -- to me one of the most important
23 warnings that -- unexplained tachycardia in a post-op
24 patient that's persistent, that's a big red flag. It
25 needs -- you're missing something because the patient

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1 should not be having a heart rate that high for that long
2 without a good explanation.

3 Q Faye's records indicate she had tachycardia of
4 over 100 on 30 separate days during those 32 days. Did Dr.
5 Williams, in your opinion, do anything to investigate what
6 was causing the tachycardia or explain it in any way in the
7 records?

8 A No, sir. And a partial, you know, small bowel
9 obstruction should not be causing, you know, that
10 significant amount of tachycardia. And a partial small
11 bowel obstruction needs to be getting better after 48, 72
12 hours. If it's not getting better after 72 hours, then
13 again, you're missing something or you need -- it's a worse
14 obstruction than you think, but something is not right.

15 So when you -- you have to look at the whole
16 constellation of features. You know, you look at elevated
17 or persistent abdominal pain, persistent distension,
18 persistent nausea, persistent vomiting, pus draining from
19 the abdomen. I mean, you go through all of these and you
20 look at the big picture of the patient. You make an
21 assessment that, you know, something just isn't right here.

22 Q The --- was Ms. Atkinson on pain medications during
23 those 32 days?

24 A Yes, she was.

25 Q Are there references that she was still having

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1 grimacing or cramping pains?

2 A Yes, sir.

3 Q Is -- does that have anything to do with a red
4 flag that should have warned Dr. Williams perhaps to do a
5 CT scan?

6 A It's the same thing as before. These are all signs
7 that the patient is not recovering as they should
8 initially. You should not -- yes, we all need pain
9 medications after major abdominal surgery, but after a few
10 days, you should be weaning yourself off of the pain
11 medications and your pain should be going away. You know,
12 most of us, or some of us who have had surgery or broken
13 bones, the body heals itself over time and you get that --
14 if you're not, and it's going on for such a long period of
15 time, something's not right and you're missing something.

16 Q Did Ms. Atkinson receive medication for fever
17 during her hospitalization?

18 A She was getting pain medications orally, some of
19 them, which have Tylenol components. That will mask, help
20 keep down temperature, even though a temperature elevation
21 is a normal response to infection. Sometimes the infection
22 though is -- after a certain period of time, you see a
23 patient will have fevers for several days and if the
24 problem is not dealt with, the temperatures will start to
25 go away because the body starts to adapt. And that,

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1 combined with getting the Tylenol, getting the pain
2 medication, the narcotics, slow down intestinal function.

3 Q Based upon your review of the medical records, did
4 Dr. Williams even consider Faye had a post-operative
5 perforation leak?

6 A No, he did not, which is, I guess one of the other
7 major areas that had me scratching my head because he
8 acknowledges that there was a 30 to 50 percent chance that
9 she would have a post operative intestinal leak, but yet
10 throughout the post-op period, he never once considers it
11 in his differential diagnosis as a possibility, as a
12 possibility as a complication; nor did he do any of the
13 tests that would help to find out if there was a leak.

14 Q The radiology report, the KUB on May 12th that you
15 talked about --

16 A Yes, sir.

17 Q That's proof to you that it was a bowel leak. Did
18 Dr. Williams do anything to follow up with a more sensitive
19 test to rule out a bowel leak?

20 A No. There was a report that said they saw an area
21 of possible extravasations. The radiologists, sometimes
22 when they look at films, they can't say for sure, but when
23 you have a patient, now it's 12 days after surgery and you
24 have all these other findings that we have, and the
25 radiologist writes, possible externalization, which means

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1 leakage of the x-ray dye outside the intestine, you need to
2 investigate. That's a -- at that point, that's just one
3 more reason to investigate further to insure you haven't --
4 you're not missing an intestinal leakage.

5 Q Did Dr. Williams even get an adequate CBC's or
6 blood tests done?

7 A Well, there was the, you know, I think the
8 frequency and volume of -- routine blood work, the lack of
9 even sending a culture -- I mean there are certain bacteria
10 that we know are commonly found in the intestine. So if
11 you were to take a culture of this pus and if it were to
12 grow back, bacteria that -- we would say this is coming
13 from the bowel, that would be one more piece of evidence to
14 help confirm the diagnosis; and that culture was never
15 done. It's a little swab. Take it, send it to the lab and
16 you'll have your answer back in a day.

17 Q Did Faye have a fistula?

18 A Yes. I mean a fistula, a perforation that -- if
19 it's left untreated turns into a fistula because the
20 leaking contents find a way out to the skin at one point.
21 At that point it's termed a fistula.

22 Q Did Dr. Williams properly treat Faye's fistula?

23 A It gets -- you get to a complex area because as was
24 mentioned earlier, after any surgery, after about two
25 weeks, the adhesions, as they start to heal become very

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1 dense and it's like pouring glue inside the abdomen. So we
2 know that when you diagnose a fistula and you're out past
3 that 2 week period, especially when you're at 4 weeks, if
4 you try the reoperate, it's like trying to go in and
5 separate a bowl of spaghetti that may be left out overnight
6 without making any holes in the spaghetti. You don't want
7 to touch it, you don't want to go back inside that abdomen.
8 You want to get x-ray, get a CAT scan, see the areas where
9 the perforations are. The radiologist can put a drain in
10 there, but if you do operate, you do a limited operation.
11 You don't attempt to free up the bowel because you're going
12 to make multiple holes in it. That's happened here.

13 It drains into the area where the leakage is. You
14 keep the patient supported nutritionally, feed them
15 intravenously, NG tube, you let things settle down for 3 to
16 4 months. Let all this massive inflammation go away, all
17 the swelling, pretty much what happened, even when Dr.
18 Parker took over.

19 Q Did you see any evidence in the medical records
20 that Dr. Williams gave Faye the right to choose between
21 that second surgery you described as risky and dangerous or
22 avoid the surgery and wait? Any evidence that he gave her
23 that right?

24 A Well, there was no -- I mean a problem was he
25 didn't make that direct diagnosis, number one, but this --

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1 the aspect of not going in and doing this major surgery,
2 and removing this large portion of her intestine or the
3 complications from that, I don't believe were discussed.

4 Q Was there any reference -- well, who assisted Dr.
5 Williams with this second, more complex surgical procedure?
6 Was it a surgeon or somebody else?

7 A It was a surgical resident, a surgeon in training.

8 Q In your opinion does that violate the standard of
9 care?

10 A It depends on the situation and the surgeon. I
11 mean, if -- that's a tough question to answer. If you've
12 had a lot of problems -- I mean it's a common -- it's more
13 of a common sense argument than a firm violation. If you
14 had a situation where you had one bad operation, it's gone
15 bad and it's a month later and you really have -- you're
16 expecting to have a difficult time, you may want to seek a
17 surgeon that operates on these type of difficult abdomens
18 on a more regular basis, that is used to handling complex
19 abdominal fistulas and things like that.

20 Q Under the standard of care, what should Dr.
21 Williams have informed Faye about before doing the second
22 surgery with respect to complications?

23 A Well, with the timing of the surgery being about a
24 month and all of this purulent drainage, he should have
25 informed them that the risk of the surgery is just exactly

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1 what happened. Trying to get in there and free up the
2 bowel again doesn't serve any useful purpose and it will
3 only lead to making multiple holes in the bowel to the
4 point where you have no choice but to remove this whole
5 section of damaged bowel and leaving the patient with short
6 bowel syndrome.

7 Q Dr. Bailey, reviewing all of the medical records
8 and given your background and experience and teaching all
9 over the world, can you give this jury a summary as to your
10 opinion about the care Dr. Williams provided to the
11 Atkinson's.

12 A I think that from -- as we started with the first
13 surgery, a lot of decisions that were made in this case
14 were just wrong decisions. The decisions to do the
15 expensive lysis adhesions, the failure to follow up with
16 the appropriate diagnostic tests in the face of these
17 obvious signs and stomachs of intestinal leakage and then
18 doing the second surgery, which I believe by that point was
19 not the proper way to approach this fistula, contributed to
20 all of the problems that she's having now.

21 Q Do you have an opinion if Dr. Williams would have
22 appropriately treated Faye under the standard of care, for
23 all those reasons that post-op day two, the green and not
24 doing CT scans and these kind of things, if he would have
25 abided by the rules of the standard of care, do you have an

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1 opinion as to whether or not Faye most probably could have
2 avoided surgery's two through six?

3 A Yes, definitely.

4 Q What is that --

5 A Well, see, she would have needed one second surgery
6 to fix the -- that initial leak that was there early on --
7 at that point would have been the appropriate operation.

8 Q Dr. Bailey answer any questions Mr. McDow might
9 have for you, sir.

10 THE COURT: All right. Ladies and gentlemen,
11 you've been in here for about 2 hours and 15 minutes.
12 We're going to take a very brief recess and then Mr. McDow
13 will be cross-examining the witness. Again, this will be a
14 brief recess. Please do not discuss the case.

15 (WHEREUPON the jury left the courtroom at 4:33
16 p.m.)

17 THE COURT: All right. Doctor, you can step down,
18 but you may not discuss your testimony with anyone.

19 THE WITNESS: Yes, sir.

20 THE COURT: This will be very, very short.

21 MR. CORBIN: Just if I may one quick thing? Eve --
22 I believe we have an agreement getting in the medical
23 records, I would just like to mark the summaries that we
24 discussed with Dr. Bailey.

25 MR. MCDOW: I don't object to that. He's the one

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1 that made them. He's entitled to do that pursuant to the
2 rule and that was our agreement.

3 **MR. CORBIN:** Yes, sir.

4 **MR. MCDOW:** Provided they're sworn and medical
5 records are attached.

6 **MR. CORBIN:** Yes, sir.

7 **THE COURT:** All right. That's fine. We'll tell
8 the jury that he's the one that prepared those. No
9 problem.

10 (WHEREUPON exhibits were marked.)

11 (WHEREUPON a recess was observed.)

12 **THE COURT:** All right. Mr. Corbin, you ready?

13 **MR. CORBIN:** Yes, sir.

14 **THE COURT:** Mr. McDow.

15 **MR. MCDOW:** Ready to proceed.

16 **THE COURT:** All right. Dr. Bailey is out of the
17 courtroom right now?

18 **MR. CORBIN:** He may have stepped out to the
19 restroom, Your Honor.

20 **THE COURT:** Okay.

21 (WHEREUPON the doctor entered the courtroom.)

22 **THE COURT:** All right. Dr. Bailey, you can come on
23 back up to have a seat.

24 **THE WITNESS:** I apologize.

25 **THE COURT:** I just got in, don't worry about it.

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1 Okay. You are ready, Mr. McDow?

2 If the jury is ready, they may come on in. They
3 may not quite be ready.

4 **THE BAILIFF:** Yes, sir.

5 (WHEREUPON there was discussion off the record
6 about scheduling.)

7 **THE COURT:** All right. The CV will come in. No. 1
8 is in.

9 **THE COURT REPORTER:** Okay.

10 (Plaintiff's Exhibits 2 through 6 were stipulated
11 to and entered into the evidence.)

12 (WHEREUPON the jury entered the courtroom at 4:44
13 p.m.)

14 **THE BAILIFF:** Jury is all seated, Your Honor.

15 **THE COURT:** Thank you, sir.

16 All right. Mr. McDow.

17 **MR. MCDOW:** Thank you, Judge, may it please the
18 Court?

19 **THE COURT:** Yes, sir.

20 **CROSS-EXAMINATION**

21 BY MR. MCDOW:

22 Q Dr. Bailey, I'm Bill McDow. We met earlier this
23 summer when I took your deposition in this case. Do you
24 recall that?

25 A Yes, I do.

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1 Q I think we were by video conference at the time.

2 I was actually here in Columbia and you were down in Miami;

3 is that right?

4 A Yes.

5 Q And I believe that Mr. Corbin was actually down

6 there with you; is that correct?

7 A Yes, sir.

8 Q Okay. Doctor, I have some questions for you just

9 really out of your deposition. You would agree that there

10 are risks associated with complex abdominal surgery;

11 correct?

12 A Yes, sir.

13 Q And those complications include bowel obstruction,

14 bowel perforation, bowel leakage, and reoperation, correct?

15 A Yes, sir.

16 Q And then additional risks include anesthetic

17 complications, bleeding requiring transfusions, infections,

18 visceral injury to the bowel, bladder, ureter, other

19 organs, including major problems and death as well;

20 correct?

21 A Yes, those are all, you know, general problems that

22 may occur during any abdominal procedure.

23 Q Doctor, you are a social practitioner?

24 A Yes.

25 Q Okay. Do you practice law socially, by yourself

Robert W. Bailey - Cross-Examination by Mr. McDow

1 as well?

2 A No, I don't practice law. I went to law school,
3 but mostly for the education and for my wife's business at
4 the time. I don't practice law.

5 Q All right. Doctor, the records you reviewed in
6 this case were the ones from Palmetto Health Richland; is
7 that right?

8 A Yes.

9 Q Okay. And your -- in your deposition, you
10 testified, I think you had three volumes of records. Did
11 you have the complete chart or did you have a summaries as
12 prepared by Mr. Corbin?

13 A No, the complete record.

14 Q Okay. So you went through all of those records
15 back at the time?

16 A Yes, I did, sir.

17 Q All right, sir. When you reviewed those records,
18 you also read, I believe, the depositions of Dr. Williams
19 and the depositions of Mr. and Ms. Atkinson?

20 A Correct. Yes, and others since then.

21 Q You've read others since then?

22 A Yes.

23 Q What else have you read since then?

24 A I received depositions of Dr. Reynolds, your
25 expert, Dr. Irvin.

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1 Q All right. Did you ever read the deposition of
2 Dr. Parker?

3 A Yes.

4 Q You did? When were you presented with that?

5 A I believe the day I arrived over -- within the last
6 month.

7 Q Okay. You had not been presented with the
8 deposition of Dr. Parker at the time that you gave your
9 deposition back on June 25th, 2012, had you?

10 A No, I had not.

11 Q And he had been deposed before that. You
12 understand that, don't you?

13 A I don't recall the dates of those.

14 Q Okay. Did your opinions change in any way as a
15 result of your reading the deposition of Dr. Parker?

16 A No, sir.

17 Q Okay. You were not testifying that Dr. Williams
18 was not qualified to perform the first surgery, are you?

19 A No, I'm not.

20 Q And if I understand your testimony correctly, you
21 are giving the opinion that the appropriate informed
22 consent was not given for the first surgery; is that right?

23 A I think the discussions and based on my reading of
24 the depositions of the Atkinson's and whatnot that -- that
25 this extensive lysis adhesions, which I believe was not

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1 necessary, I don't believe was discussed and presented as
2 it's really -- it's not needed, it's not going to really
3 help her situation in any way in order to remove an ovarian
4 cyst deep down in the pelvis.

5 Q Did you ever review the office records from South
6 Carolina Oncology Associates?

7 A I can't remember if I did at this point.

8 Q Did you ever see the office note dictated by Dr.
9 Williams for the office visit of April 13th?

10 A I believe I did.

11 Q Where did you see that?

12 A I believe it was in some of the records that were
13 sent to me by Mr. Corbin's office.

14 Q Okay. And your problem with the informed consent
15 with the first surgery is based on the deposition of
16 Ms. Atkinson; is that correct?

17 A I believe I said the fact that that's part of the
18 basis of that, yes. That she was not informed. But it's
19 also related to the fact that it was an unnecessary portion
20 of the operation. I don't believe that was discussed with
21 her.

22 Q And that was based on the deposition of
23 Ms. Atkinson, correct?

24 A And Dr. Williams.

25 Q All right, sir. Well, you didn't say that about

Robert W. Bailey - Cross-Examination by Mr. McDow

1 Dr. Williams in your deposition when I deposed you, did
2 you?

3 A I don't know if you asked the question, I don't
4 remember.

5 Q Well, I'll be happy to show it to you if you'd
6 like me to.

7 Doctor, you've not given an opinion on the first
8 surgery being needed, are you?

9 A No, sir.

10 Q You're deferring to the gynecologist oncologist in
11 this respect?

12 A Right. I'm a general surgeon. I don't operate on
13 ovarian cysts. So I would defer to a gynecologist to make
14 a decision as to whether she actually ever needed the
15 surgery for this cyst to heal.

16 Q Okay. And if I understand your testimony, free up
17 the adhesions only as much as needed to properly expose the
18 pelvic mass; is that correct?

19 A Yes, sir.

20 Q And, of course, Doctor, as an expert witness, you
21 weren't there for this surgery, were you?

22 A No.

23 Q The only doctor in this case that was actually
24 present for the first and second surgeries and before that
25 surgery was Dr. Williams, correct?

Robert W. Bailey - Cross-Examination by Mr. McDow

- 1 A And his assistant.
- 2 Q And a resident that was there, correct?
- 3 A Yes.
- 4 Q Do you train residents as part of your program,
5 your job as well?
- 6 A Yes, I do.
- 7 Q So it's not uncommon to have a resident
8 participate in those surgeries is it?
- 9 A No.
- 10 Q Okay. Doctor, would you agree that you can't cut
11 in surgery what you can't see?
- 12 A You shouldn't cut --
- 13 Q You shouldn't cut?
- 14 A -- what you can't see.
- 15 Q You do some testimony, expert testimony for
16 laparoscopic cholecystectomy, taking a gallbladder out; is
17 that right?
- 18 A Yes.
- 19 Q And a lot of times that's one of the issues in a
20 gallbladder case is whether or not you could particularly
21 view the common bile duct and the cystic duct or however
22 that works; is that right?
- 23 A It's a little bit of a different issue. You're
24 talking about bile ducts that lead to the gallbladder that
25 are about 2 or 3 millimeters, less than a quarter of an

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1 inch in diameter. And yes, sir, in that situation if you
2 come across a bile duct that you don't know what it is, you
3 shouldn't cut it before you divide it, but that's really
4 not what we're talking about here.

5 Q Okay. But I say that for the premise of your
6 statement, I think I heard you correctly, correct me if I'm
7 wrong, that you shouldn't cut what you can't see in
8 surgery, correct?

9 A Yes.

10 Q Okay. Now, doctor, freeing up the Ligament of
11 Treitz, I think you said is in the high, upper part of the
12 abdomen; is that right?

13 A And towards the back, (indicating) yes.

14 Q And in your demonstration with the video there,
15 typically there are several loops of bowel that fall down
16 to or drape into the pelvis; is that right?

17 A Yes, sir.

18 Q And certainly some of those adhesions would have
19 to be lysis in order to expose the pelvic mass, correct?

20 A Yes, sir.

21 Q Okay. You would agree that based on
22 Ms. Atkinson's history, she was not a typical patient?

23 A I would not say that. She had one prior operation,
24 you know twelve years before. It's not uncommon for
25 patients to have prior abdominal surgery.

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1 Q Okay. Doctor, did you see -- ever see a
2 description of that particular procedure?

3 A I saw -- I don't believe I did.

4 Q Okay. You did not review Dr. Reynolds' records?

5 A I did review Dr. Reynolds' records.

6 Q You did review Dr. Reynolds' records?

7 A Yes.

8 Q Well, then you saw on page 843 of her records on
9 September 28th, 1995, that now approximately six weeks
10 status post two surgeries for bowel obstruction, secondary
11 to adhesions. Did you see that?

12 A I recall seeing that. I haven't reviewed it -- as
13 I -- you know, there are more than two thousand pages of
14 records and I was focused mostly on the current surgeries
15 that were performed in 2007.

16 Q And they repeated the blood work and I think they
17 started a B-12 injection, shot, at this time as well,
18 correct?

19 A Yes, sir.

20 Q Okay. Then on 11/27/95, in Dr. Reynolds' office
21 records -- Not Dr. Reynolds, but Dr. Bullard, he gave a
22 description of past medical history, small bowel
23 obstruction with ovarian cyst and re obstruction before she
24 could be discharged. She had a closed loop, small bowel
25 obstruction, and internal hernia with segmental small bowel

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1 infarction and multiple adhesions. General exploratory
2 lap -- lysis of adhesions, resection of segment of the
3 small bowel, and side to side small bowel reanastomosis.

4 Do you recall seeing that?

5 A Yes, sir.

6 Q All right. Doctor, is the running of the bowel or
7 a complete lysis, that might be indicated for a small bowel
8 obstruction, correct?

9 A For a small bowel obstruction, yes.

10 Q All right. Doctor, you looked at the placement of
11 the NG tube, correct?

12 A Yes, sir.

13 Q Did you see it there on April 28th, where Dr.
14 Smith offered to Ms. Atkinson an NG tube and she refused.

15 A Yes, I saw that. I think -- I've had patients
16 every day -- not every day, but every time a patient comes
17 to the emergency room with a bowel obstruction, they're
18 very resistant to put a tube down. No one wants to have
19 this tube down, but if they do refuse, I personally will go
20 down -- initially the resident may see them, I would go
21 down to the emergency room and have a very firm discussion
22 with the patient and explain the importance of the nasal
23 gastric tube and how it would help with the surgery and
24 relieve their obstruction.

25 Q All right. Doctor, you're not convinced that she

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1 had a small, partial bowel obstruction here, were you?

2 A No, I'm not.

3 Q Okay. And you didn't look at the records from the
4 standpoint to give a specific date as to when an NG tube
5 should have been placed, did you?

6 A I believe that you when you get a patient -- that
7 you're getting out to the 3 to 5 days and having persistent
8 nausea, vomiting, abdominal distension that -- and you're
9 making the diagnosis of a bowel obstruction, the standard
10 of care requires a nasal gastric tube. I can't say that
11 it's where -- it had to be on the third day or the fifth
12 day, but sometime in that time -- sometime during that time
13 period.

14 Q All right, Doctor. We know it wasn't a complete
15 obstruction because the barium contrast moved through the
16 colon, correct?

17 A Yes, sir.

18 Q Okay.

19 A And we also know that no obstruction was found at
20 the second surgery.

21 Q Yeah, there's no evidence of that in the pathology
22 report, correct?

23 A Correct.

24 Q There was no transition point, right?

25 A No obstruction transition point or otherwise.

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1 There was no sign of any obstruction in the second surgery.

2 Q But she had a partial small bowel obstruction due
3 to the matting at this time from the adhesions, do you
4 believe?

5 A I'm not sure she ever had a partial small bowel
6 obstruction. I believe that her intestines stopped
7 working. When the bowel stops functioning, stops
8 squeezing, it gets dilated. It can look like a partial
9 small bowel obstruction, but I don't believe she had a
10 partial small bowel obstruction.

11 Q Doctor, you mentioned in reviewing the records the
12 green, brown drainage. Do you recall what date and time
13 that came from?

14 A That was the second day after the surgery.

15 Q Which --

16 A It was in the morning.

17 Q In the morning. Do you have a copy of the summary
18 that Mr. Corbin has prepared?

19 A Not up here now.

20 Q You don't? I'm handing you what he gave to me and
21 ask if you will look through there and tell me if you see
22 the page that you're relying upon for that green, brown
23 drainage that you referenced.

24 A You mean in the medical records?

25 Q Yes, sir.

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- 1 A Okay. It will be in -- this says PHR 0370.
- 2 Q Okay. That's on --
- 3 A Bottom of the page.
- 4 Q That's right. We bait stamped the page numbers
- 5 down on the bottom of them. So you're on page 370? And
- 6 there's an entry by a nurse at 5 a -- well, for 5 a.m.
- 7 performed, entered at 5:26 a.m., correct?
- 8 A Yes, sir.
- 9 Q And it's that drainage there -- it says green,
- 10 brown, foul smelling; comment, leaking; patient prefers not
- 11 to have drainage bag changed at this time. Do you see
- 12 that?
- 13 A Yes, sir.
- 14 Q And that's what you're talking about as evidence
- 15 for you to indicate some type of small bowel leak at that
- 16 point; is that right?
- 17 A Yes, sir.
- 18 Q Okay. Doctor, I didn't ask you this at your
- 19 deposition and I'll take the chance of asking you now, what
- 20 if that's wrong?
- 21 A It's wrong?
- 22 Q Yeah.
- 23 A I don't know how -- why would it be wrong?
- 24 Q Well, what if it was? Would it change your
- 25 opinion in any way about what happened here?

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1 A No, because there are numerous other red flags that
2 occurred. There was still the pussy drainage that was
3 coming out and they said to -- the color itself, if it's
4 yellow, you can't say 100 percent that it's connected to
5 the bowel, but you have to have a high suspicion,
6 especially when you're doing a surgery where you
7 acknowledge that there's a 50 percent chance that you're
8 going to have a leak. But -- what I'm saying is that the
9 green and the brown is very determinative to indicate the
10 fact that there is a leakage in the intestine.

11 Q And we know which drain that's coming from?

12 A I don't believe it says which one. There were
13 multiple areas that were draining.

14 Q The records are somewhat confusing with the
15 description and location of the drains; do you agree with
16 that?

17 A I wouldn't say confusing. There were 3 previously
18 placed, small, little openings where the drains had been.
19 They took the drains out and they were leaking. Probably
20 the nurses, you know, they -- there are many reports
21 here -- they had to put a colostomy bag on these to help
22 collect the drainage it was so much, and was saturating the
23 dressing. So in this situation, especially if the drain
24 holes are close together, sometimes it's hard for the nurse
25 to know exactly where it's coming from -- you know, all the

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1 drainage.

2 Q Okay. Doctor, could you turn to page PHR 0534 in
3 your records up there?

4 A '05 -- do you know what section that is because
5 they're not in order.

6 Q Well, it's -- what Mr. Corbin has put together --

7 A I'm just saying --

8 Q I don't --

9 A The page numbers aren't -- it goes like 638, 370,
10 542 -- I was wondering if you could tell me, help me out.

11 Q Well it's the Systems Review Date for April 27th
12 at 7:52 a.m.

13 A And the page number again?

14 Q 534.

15 A So far I don't see it. You have a copy?

16 Q Yeah, I do. I'll show you what I've got. I'll
17 show you my copy. Right there.

18 MR. MCDOW: If I can approach the witness?

19 THE COURT: Yes, sir.

20 BY MR. MCDOW:

21 Q That describes the drains at that time too, does
22 it not?

23 A This is a systems review. Okay. And there's a
24 section there where they talk about the wound dressings.

25 Q Basically two-and-a-half hours after the previous

Robert W. Bailey - Cross-Examination by Mr. McDow

1 entry, correct?

2 A Yes.

3 Q And what does that entry say for the description
4 of the wounds?

5 A It has --

6 Q Perhaps --

7 A Wound number, says one, midline, and then it has
8 dressing -- the wound dressing, wound drainage, then you're
9 meaning the midline one then, not the jp site. Then it
10 says two left lower quadrant jp drains and one right lower
11 quadrant jp, all putting out serosanguinous.

12 Q What does that mane?

13 A It's a mixture of clear and bloody drainage.

14 Q Any significant to the fact that two-and-a-half
15 hours later it's not being described as serosanguinous?

16 A I don't know.

17 Q Doctor, the drainage amounts also taper off
18 throughout the stay; isn't that correct?

19 A Yes, sir.

20 Q And you would expect that, would you not?

21 A I wouldn't expect that purulent drainage to begin
22 with, so let alone the green, brown range. So it's hard to
23 say you expect something to stop that shouldn't be there to
24 begin with.

25 Q Doctor, you don't know the extent of the prior

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1 surgery or the prior adhesions and whatnot, correct?

2 A We know she had a close -- obstruction as mentioned
3 and she needed an intestinal resection. I don't know the
4 severity of the adhesions 12 years later until you open the
5 patient back up. We do know that for those 12 years, she
6 didn't have any further episodes of intestinal obstruction
7 or blockage.

8 Q And, Doctor, in the -- we talked about the
9 temperature as well. There were days that she did not have
10 a fever, correct?

11 A Yes, sir.

12 Q Doctor, the blood tests that were performed, the
13 white blood cell count was normal in between the first
14 surgery and the second surgery, correct?

15 A I believe some of them -- most of them were normal,
16 yes, sir.

17 Q And you would expect there to be a rise with the
18 white blood count if there was an infection, correct?

19 A Yes. Unless you're getting antibiotics; or as I
20 said, after a while your body will adapt to a lot of the
21 signs that you might see early on. They tend to be muted
22 so to speak.

23 Q You have no opinion as whether Ms. Atkinson should
24 have been taken back to surgery on May 21th of 2007 when
25 Dr. Parker examined her, correct?

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1 A As I said, once you get past the first two weeks
2 that reoperation on a bowel that's 3 weeks, 4 weeks after
3 surgery, it should -- it should be avoided at all costs, if
4 you can. Unless the patient is in septic shock and you
5 need to operate to save their lives.

6 Q And she wasn't in septic shock on May the 21st,
7 was she?

8 A No.

9 Q She wasn't in septic shock on May 28th, was she?

10 A That's correct. That's why she didn't need another
11 surgery.

12 Q The tachycardia that you described, again, there
13 were times it was below a hundred during that time frame as
14 well, was it not?

15 A Yes.

16 Q As a matter of fact, I believe she still had some
17 tachycardia after some of Dr. Parker's surgery; is that
18 correct?

19 A For a time.

20 Q And as I understand it, you believe at the very
21 latest she had a perforation as of May 2nd; is that right?

22 A I said post-operative day -- the 2nd, when she was
23 draining green brown.

24 Q Do you have a copy of your deposition with you?

25 A I don't.

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1 Q Let me hand you a copy of your deposition.

2 THE COURT: While he's getting that, ladies and
3 gentlemen, during the pretrial phase of the case, the
4 parties are entitled to engage in discovery. Those
5 discovery tools consist of questions that are exchanged
6 where one side must answer. Another discovery tool is a
7 deposition. That's where the witness is placed under oath.
8 A court reporter is present, the lawyers are present and
9 that's what Mr. McDow has referred to now.

10 You can hand him --

11 MR. MCDOW: May I open the original, Your Honor?

12 THE COURT: Yes, go ahead.

13 BY MR. MCDOW:

14 Q There you go, Doctor.

15 A Thank you.

16 Q Could you turn to page 48 of your deposition?

17 A Page 48?

18 Q Actually it will be -- yeah, page 48?

19 A Okay.

20 Q And in response to the question from the previous
21 page on line 4, your answer was, So we know at the very
22 least, she had a perforation as of May the 2nd, and the
23 most obvious source of that was an injury at the time of
24 the first surgery on April 25th. Did I read that correct?

25 A What page is the question on?

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1 Q On page 47.

2 A Which line?

3 Q Line 21.

4 A Twenty-one, it says, And what do you base that
5 opinion on, on my copy here.

6 Q That's right. What was your answer on page 47,
7 reading onto line 4 on page 48?

8 A The previous testimony is, Do you believe she had a
9 perforation at the end of this first surgery; and my answer
10 was, Yes.

11 Q Right. Okay. Well, all right. Let me read it to
12 you then, Doctor. Your answer was, From the first surgery,
13 yes. And then on line 17 on page 47, the question was,
14 Okay. Let me back up a little bit then. Do you believe
15 that she had a perforation at the end of Dr. Williams'
16 first surgery? What was your answer?

17 A Yes.

18 Q Okay. And the follow up question was, What do you
19 base that opinion on. And what was your answer?

20 A I said that she was persistently tachycardic after
21 the surgery. She had persistent nausea and vomiting, large
22 amounts of vomiting. She had persistent abdominal
23 distension, firm abdomen, tender, and that we know later on
24 that --

25 Q No, no, no, wait. On page 47, please. Continue

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1 your answer?

2 A That's all that's there on page 47.

3 Q I know. Turn to page 48.

4 A I did then it said the tachycardia. The fact that
5 we know she has extravasation of barium from the upper GI
6 that was done on May 2nd.

7 Q And then line 4 through 7, please.

8 A So we know at the very least she had a perforation
9 as of May 2nd, because I saw it on the barium study. But I
10 believe she had it right after the surgery, that's why she
11 has the green, brown drainage on the second day after
12 surgery. And that's why she had tachycardia immediately
13 after, and that's why her temperature was elevated. That's
14 why her abdomen was distended.

15 Your question was, I was just making a statement,
16 we know for sure that she has extravasation of barium. I
17 believe I saw it on the barium study on the second, but we
18 know that it was definitely there at the reoperation on the
19 28th.

20 Q Okay. Well, I --

21 A I'm confused.

22 Q I apologize, Doctor, I may have asked it in
23 artfully because I'm trying to get clarification in your
24 deposition because I wasn't sure whether it was based on
25 May 2nd, or whether it was based on May the 12th, and there

Robert W. Bailey - Cross-Examination by Mr. McDow

1 was a 12 that -- the 1 was left out of your deposition.

2 **MR. MCDOW:** Your Honor, may I approach the witness
3 again?

4 **THE COURT:** Yes, sir.

5 **BY MR MCDOW:**

6 Q I want to show you the radiology reports that I've
7 pulled out of the Palmetto Health records.

8 A Should I keep the deposition open?

9 Q Sure.

10 A Okay.

11 Q Okay. And the only thing I'm trying to get to,
12 Doctor, is, if you look at the last page --

13 A Of the x-ray report or the deposition?

14 Q In the x-ray reports?

15 A Okay.

16 **MR. CORBIN:** Which date, please.

17 **MR. MCDOW:** May 7th.

18 **THE WITNESS:** The last --

19 **BY MR. MCDOW:**

20 Q Well, the last two pages, pages 31 and 32 because
21 that's the K -- I mean that's the small bowel
22 follow-through on May the 2nd.

23 A Okay.

24 Q All right. And I'm trying to find out if it's May
25 the 2nd that you're telling me that you believe that there

Robert W. Bailey - Cross-Examination by Mr. McDow

1 was barium that had come out of the bowel as a result of
2 this report?

3 A On this report, no. I said when I looked at the
4 x-ray I was concerned that there might have been some
5 extravasation.

6 Q Okay. So when you looked at the x-ray?

7 A Yes.

8 Q When did you look at the x-ray?

9 A Excuse me?

10 Q When did you look at the x-ray?

11 A I was sent copies of the films.

12 Q Before your deposition?

13 A I believe so.

14 Q And you didn't mention that you reviewed your
15 x-rays at the time I discussed the record with you?

16 A I don't remember.

17 Q Okay. So in your reading of the May 2nd film, you
18 believe that there's barium showing on that particular
19 radiology film that's not mentioned by the radiologist?

20 A Well, I understand that correctly, but even on the
21 second record the radiologist wasn't sure. When I looked
22 at it, it seems to be that there's some extravasation of
23 barium.

24 Q That's why -- I want to make sure I understand
25 then. You're telling this jury that based on your

Robert W. Bailey - Cross-Examination by Mr. McDow

1 individual personal review of the small bowel
2 follow-through on May 2nd of 2007, you see an extravasation
3 of barium?

4 A I said I have a concern, a suspicion, okay?

5 Q All right. Well, I'll change the question a
6 little bit, Doctor. In the report of May the 2nd?

7 A It's not in the record.

8 Q Not in the report. Thank you. That's what I was
9 trying to introduce.

10 A Okay.

11 Q As a matter of fact, Doctor, the only suspicion is
12 that on the May 12th one; is that correct?

13 A Correct.

14 Q And even when it says suspicion on May 12th. It
15 only talks about the possibly that this is an extraluminal
16 focus, the contrast is not entirely excluded, but this is
17 felt less likely as this selection appears smaller than on
18 the previous film; correct?

19 A Yes, it says that.

20 Q And that's not even -- that's in the findings,
21 that's not even in the impression, is it?

22 A No, sir.

23 Q No, the impression was that there's evidence of
24 marked delay in GI transit as a large amount of contrast
25 remains in dilated portions of the small bowel as well as

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1 portions of non-dilated colon. A small collection of
2 contrast with somewhat angular margins in the left lower
3 quadrant appears less prominent than on previous exams.
4 Continued followup is suggested. Did you read that?

5 A Yes, especially the continued followup.

6 Q Okay. And the continued followup doesn't show
7 anything about there ever being any leaking of barium;
8 isn't that correct?

9 A What continued followup?

10 Q Well --

11 A The CAT scan or --

12 Q No, the multiple KUB, the multiple films that were
13 done.

14 A Okay.

15 Q That angular margin is not there, is it?

16 A It's not reported, no.

17 Q Doctor, the small bowel and the colon continued to
18 secrete liquids as a natural course -- you see bowel
19 movements, correct?

20 A I'm sorry?

21 Q The small bowel continues, even though if you have
22 a partial small bowel obstruction, it still produces
23 juices, does it not?

24 A Yes, it does.

25 Q And your stomach does as well?

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1 A Yes.

2 Q And I believe -- I think I read one of your old
3 depositions that it puts out about two liters a day?

4 A Up to -- between one and two liters.

5 Q Okay. And doctor, you're not criticizing Dr.
6 Williams for not having another surgeon at the second
7 surgery, are you?

8 A As I said, I think I tried to address this in my
9 deposition. Under normal circumstances, no, I wouldn't
10 have a criticism, but given what happened in some of the
11 errors that were made, she should have had assistance with
12 more experience.

13 Q Well, no, you said in your deposition that you
14 didn't question it because he says that he does that
15 surgery and you're not contesting his qualifications.

16 A He's saying if he's going to be judged as a
17 gynecologic surgeon on the same standard as a general
18 surgeon, that routinely works on the intestine, then I'm
19 not going to criticize him.

20 Q Doctor, you haven't reviewed the records to say
21 that Ms. Atkinson has short bowel syndrome, have you?

22 A I'm not going to dispute that. She definitely has
23 short bowel syndrome.

24 Q Well, you were asked about a gastrointestinal
25 catastrophe and I just wanted to make sure you're not

Robert W. Bailey - Cross-Examination by Mr. McDow

1 testifying to that?

2 A I don't understand your question, sir.

3 Q You're not prepared to testify how much of the
4 bowel remains, correct?

5 A I looked at the x-ray. I believe somewhere maybe 20
6 to 22 inches.

7 Q Well, you weren't prepared to testify to that back
8 in June when I took your deposition.

9 A I hadn't seen the followup records from the last
10 two years yet, at that point.

11 Q I thought you said you had the x-rays at this
12 time?

13 A I hadn't seen the followup records.

14 Q Doctor, you've reviewed 10 to 20 cases per year?

15 A Yes, sir.

16 Q You give three to five depositions per year?

17 A Yes, sir.

18 Q Ninety percent of those are for the plaintiff?

19 A Currently. It used to be the other way around.

20 Q And of course, you're out of your office today.

21 You need to be compensated \$550 an hour for review; is that
22 right?

23 A For time spent here. I don't charge that much for
24 the travel.

25 Q Seven, fifty for travel time?

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1 A Yes, sir.

2 Q Seven, fifty an hour. And you've testified in
3 Florida, Georgia, Virginia, Maryland, Pennsylvania, New
4 York, West Virginia, Colorado and Ohio, correct.

5 A Yes.

6 MR. MCDOW: Beg the Court's indulgence.

7 THE COURT: All right.

8 MR. MCDOW: Thank you, Doctor. I hope you make
9 your flight.

10 MR. CORBIN: No questions, Your Honor, may Dr.
11 Bailey leave to catch his airline flight?

12 THE COURT: Yes, sir, Doctor, you may be excused.
13 Thank you, sir.

14 MR. CORBIN: Thank you, Dr. Bailey.

15 THE COURT: All right. Gentleman --

16 MR. CORBIN: Thank you, sir.

17 THE COURT: Can we conclude today?

18 MR. CORBIN: Your Honor, may we approach?

19 (WHEREUPON, there was a bench conference out of the
20 hearing of the jury and the Court Reporter.)

21 THE COURT: All right. Ladies and gentlemen, we're
22 going to have one more witness testify. I'm told by the
23 attorneys he will be a short witness and I can tell you
24 this, we won't be here this late any other day unless it is
25 absolutely necessary. And I'm just trying to do the best I

Bright Williamson - Direct Examination by Mr. Corbin

1 can to accommodate as many people as I can at once.

2 So Mr. Corbin, you can call your next witness.

3 **MR. CORBIN:** Your Honor, at this time, we'd call
4 Dr. Bright Williamson to the witness stand, please.

5 **THE COURT:** Okay.

6 **THE COURT:** All right. State your name, please?

7 **THE WITNESS:** Bright Williamson.

8 **THE COURT:** All right.

9 **BRIGHT WILLIAMSON,**
10 having been duly sworn, testified as follows:

11 **THE COURT:** All right. Thank you, sir, you can
12 have a seat. Spell your first -- say your name and spell
13 your first name and I believe we can spell your last name.

14 **THE WITNESS:** All right. Bright Williamson.
15 B-r-i-g-h-t Williamson.

16 **THE COURT:** Okay.

17 **DIRECT EXAMINATION**

18 **BY MR. CORBIN:**

19 **Q** Dr. Williamson, I appreciate you waiting today to
20 testify. Can you tell the jury what your current
21 profession is, please?

22 **A** I'm a gastroenterologist.

23 **Q** In general what is a gastroenterologist?

24 **A** We deal with problems from the esophagus all the
25 way to the rectum and deal with livers and pancreatic

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1 disease.

2 Q Where is your office located, which town?

3 A It's in Camden.

4 Q And how long have you been a gastroenterologist?

5 A Since '75, thirty --

6 Q Thirty-seven years?

7 A -- seven years.

8 Q Are you Faye Atkinson's current treating
9 gastroenterologist?

10 A I am.

11 Q Dr. Williamson, will you put to rest right quick
12 the issue of whether or not Faye really does have short
13 bowel syndrome? Please tell the jury.

14 A She definitely has short bowel -- short gut
15 syndrome. She has about 20 inches based on the x-rays.

16 Q What are you primarily treating Faye for, please?

17 A I actually don't see her too much now, but every
18 six months, she has -- she has to get vitamins, minerals.
19 She has to take -- get medicines to slow her gout down. We
20 found she's helped to some degree with antibiotics from
21 time to time. Nothing really controls her voluminous
22 diarrhea very well.

23 Q When you say voluminous...

24 A Large volume of gas, lots of stools and lots of
25 water and liquid up to 20 times a day she says.

Bright Williamson - Direct Examination by Mr. Corbin

1 Q Yes, sir. And Dr. Williamson, we've all reviewed
2 your medical records and there are references that you have
3 actually had to treat her anus because of the chronic
4 diarrhea. What's going on there?

5 A She's had -- she has so much diarrhea that she, of
6 course, irritates her anal area just keeping clean and so
7 she's had to use various creams for that.

8 Q Doctor, Faye Atkinson, does she have any troubles
9 with kidney stones?

10 A Well, one of the complications with short bowel
11 syndrome is the development of kidney stones and she had
12 developed those about two years ago.

13 Q Do you have an opinion, Dr. Williamson, based upon
14 a reasonable degree of medical certainty, number one, does
15 Faye Atkinson have short bowel syndrome?

16 A She absolutely has it.

17 Q Are the kidney stones secondary to her short bowel
18 syndrome?

19 A Yes.

20 Q What proof do you have -- if somebody wants to see
21 proof, and there's been some question as to whether or not
22 Faye has short bowel syndrome. What proof do you have?

23 A I've got a copy of her x-rays from about six months
24 ago.

25 Q Could you please come down here, Doctor, and show

Bright Williamson - Direct Examination by Mr. Corbin

1 the x-rays to the jury?

2 A Sure.

3 (WHEREUPON the witness leaves the witness stand.)

4 THE COURT: Is that a marked exhibit?

5 MR. CORBIN: May we mark it up after he shows it?

6 THE COURT: I just didn't know if anything had been
7 premarked, so...

8 MR. CORBIN: No, sir.

9 THE COURT: All right.

10 BY MR. CORBIN:

11 Q Dr. Williamson, what are you showing to the jury
12 now, please?

13 A Right. This is a study where she was given barium
14 to drink. This is barium in the stomach and you can barely
15 outline a little bit of the small intestine down here and
16 then it immediately goes into the colon in something like
17 20 minutes. It's even in the colon before it's left the
18 stomach completely. So it -- from the small bowel it goes
19 up here and it's down here (indicating). And that's -- the
20 radiologist estimated it was about 20 minutes remaining.
21 All of this is large intestine, colon (indicating).

22 Q So the part of the intestines that are missing are
23 what sections, please?

24 A We can show that this is a normal x-ray and the
25 intestine should be throughout here. It should be 16 feet

Bright Williamson - Direct Examination by Mr. Corbin

1 of small intestine.

2 Q And it's missing?

3 A It's gone.

4 Q This -- the second x-ray that we would like to
5 show to the jury --

6 THE COURT: And stand off to the side, please,
7 Doctor, so the jury can see.

8 BY MR. CORBIN:

9 Q Is that significant proof to you, Dr. Williamson,
10 that, in fact, she does have short bowel syndrome?

11 A It is. That's -- and her course is indicative too.

12 Q Dr. Williamson, have you treated or seen patients
13 with a shorter small bowel than 18 to 20 inches like Faye?

14 A I've seen -- yeah, I've seen -- I've seen a couple
15 for a legal opinion of people that have had the entire
16 small bowel resected, or infarcted, and they usually don't
17 survive.

18 Q They die?

19 A They die. And then I've had a couple who have had
20 a small bag and lived on parenteral nutrition and all the
21 attended problems that go with that.

22 Q Do you have an opinion, based upon a reasonable
23 degree of medical certainty whether the short bowel
24 syndrome that Faye has has affected her life expectancy?

25 A I would -- I would think so.

Bright Williamson - Direct Examination by Mr. Corbin

1 Q About how many years, please?

2 A It's hard to say, but, she was set up for
3 complications. I'd say maybe it has shortened her life
4 about 10 years possibly.

5 Q When you say 10 years, is that based upon the
6 information that you have to a reasonable degree of medical
7 certainty, most probably her life expectancy has been
8 shortened about 10 years?

9 A No, that's not very scientific, but I just know
10 that she can not stand a complication and she's more apt to
11 get gallstones and going into the abdomen to take her
12 gallbladder out would be risky.

13 Q Yes, sir. And this second x-ray?

14 A This is just a normal, again --

15 MR. MCDOW: Your Honor --

16 THE WITNESS: -- barium in the /SHO*PL --

17 THE COURT: Hold on, wait just a minute.

18 MR. CORBIN: I hate to object at this point, I
19 don't think there's a proper foundation. They're talking
20 about a second x-ray. I don't know what it is, if they
21 would just do that, so...

22 THE COURT: I would like -- just for recordkeeping
23 purposes, if anything you show him would be marked for ID
24 and then we'll have a number on it.

25 MR. CORBIN: Yes, sir.

Bright Williamson - Direct Examination by Mr. Corbin

1 **THE COURT:** And then if you want to offer it, the
2 two lawyers can debate it at the appropriate time.

3 **MR. CORBIN:** We would move to introduce the actual
4 x-ray of Doris Atkinson's bowel.

5 **THE COURT:** Well, mark what you want in.

6 **MR. CORBIN:** Yes, sir.

7 **THE COURT:** And then you can show it to him and
8 refer to it by exhibit number -- how many of those are you
9 handing her?

10 **MR. CORBIN:** Two. Just one at this time, Your
11 Honor.

12 **THE COURT:** All right. Where's the other one.

13 **MR. CORBIN:** The other one is on the screen.

14 **THE COURT:** All right. You're going to refer to
15 that one next, right?

16 **MR. CORBIN:** Yes, sir.

17 **THE COURT:** Okay. Hand that one to her also and
18 that can be marked as an exhibit.

19 That will be No. 3?

20 **THE COURT REPORTER:** This is No. 7.

21 **THE COURT:** No. 7?

22 **MR. CORBIN:** The summaries were marked earlier.

23 (WHEREUPON Plaintiff's Exhibits No. 7 and 8 were
24 marked for ID.)

25 **THE COURT:** All right. And if you would, please

Bright Williamson - Direct Examination by Mr. Corbin

1 lay the foundation for 3, if you want to offer that. If
2 not, we can move on to the next one.

3 **MR. CORBIN:** Yes, sir. This would be Plaintiff's
4 Exhibit No. 7.

5 **THE COURT:** Seven, I'm sorry.

6 **MR. CORBIN:** Yes, sir.

7 **BY MR. CORBIN:**

8 Q Dr. Williamson, who's bowel is that?

9 A This is Ms. Atkinson's.

10 Q And do you know when that was actually taken, sir?

11 A I think that's -- this is in April -- yeah,
12 4/19/2012.

13 Q Is that a fair and impartial (verbatim)
14 representation of Ms. Atkinson's small bowel?

15 A I think so.

16 **MR. CORBIN:** Your Honor, we would move to introduce
17 that, Exhibit No. 7.

18 **THE COURT:** Any objection?

19 **MR. MCDOW:** No objection, Your Honor.

20 **THE COURT:** All right. Seven is in.

21 (WHEREUPON Plaintiff's Exhibit No. 7 was moved into
22 evidence.)

23 **BY MR. CORBIN:**

24 Q Dr. Williamson, you mentioned that you brought
25 another x-ray for illustration purposes. Is this Faye

Bright Williamson - Direct Examination by Mr. Corbin

1 Atkinson's bowel?

2 A No.

3 Q What is the purpose of showing the jury this
4 particular x-ray?

5 A I just thought the jury might like to see the
6 difference in what a normal amount of small bowel looked
7 like and what Ms. Atkinson has just for education.

8 MR. CORBIN: Your Honor, we'd move to introduce
9 Plaintiff's Exhibit No. 8.

10 THE COURT: All right. Any objection?

11 MR. MCDOW: No objection.

12 THE COURT: All right. Eight is in.

13 (WHEREUPON Plaintiff's Exhibit No. 8 was moved into
14 evidence.)

15 BY MR. CORBIN:

16 Q Dr. Williamson, please use the x-ray to describe
17 to the jury how a normal bowel would look?

18 A This, again is the stomach. This is the small
19 intestine that's starting here, and then it loops on
20 around, maybe a little bit in the colon here, but it comes
21 on down and finally enters the large intestine of the --
22 what we call the secum, where the appendix is down here in
23 this right side (indicating).

24 Q Dr. Williamson, I appreciate your time. Please
25 answer any questions Mr. McDow might have.

Bright Williamson - Cross-Examination by Mr. McDow

1 **THE COURT:** All right. Mr. McDow.

2 You can have a seat, Doctor.

3 (WHEREUPON the witness returned to the witness
4 stand.)

5 **CROSS-EXAMINATION**

6 **BY MR. MCDOW:**

7 Q Dr. Williamson, hey.

8 A Hey.

9 Q My name is Bill McDow. I work with Richardson
10 Plowden Law Firm here in Columbia. I represent Dr.
11 Williams in this case. We've never met before, have we?

12 A No.

13 Q I don't recall that. You were not deposed in the
14 case is that -- that's right. So this is the first
15 opportunity that I've had to ask you some questions.

16 The x-ray that you put up for April 19th, 2012, do
17 you have the radiology report for that?

18 A Yes, I think I do.

19 (WHEREUPON the witness was looking through his
20 notes.)

21 **THE WITNESS:** Right. Yeah.

22 **BY MR. MCDOW:**

23 Q And you had ordered that as a small bowel series
24 following ingestion of barium; is that correct?

25 A Uh-huh.

Bright Williamson - Cross-Examination by Mr. McDow

1 Q Okay. And it said impression, short bowel and
2 there's calcification to be seen in the right abdomen which
3 could be gallbladder or renal in origin. If further
4 evaluations clinically indicated, CT and/or gallbladder
5 ultrasound may be helpful, although right renal calculus
6 was demonstrated on the CT of August 7th, 2010; is that
7 right?

8 A That's right.

9 Q Okay. Is there any barium that's outside of her
10 colon on this film of April the 19th, 2012?

11 A No.

12 Q There's no --

13 A Not that I -- no, I don't think so.

14 Q Okay. There's no old barium that's still in from
15 whatever source from years ago or whatever in your opinion?

16 A No.

17 Q Did I understand you to say -- and I -- I want to
18 make sure I understand this. The 20 inches that you're
19 talking about, was that based on your reading or did the
20 radiologist tell you that?

21 A It's based on radiologist. The -- I sent a
22 question back for him to answer, how much small bowel was
23 left and he said over 18 inches.

24 Q Over 18?

25 A Over 18.

Bright Williamson - Cross-Examination by Mr. McDow

1 Q But less than 20 or whatever?

2 A Yeah, I think previous x-rays from Richland said
3 somewhere around 20 inches.

4 Q And the only reason I ask that is I think I saw
5 somewhere in your records where you used 30 centimeters; do
6 you recall that?

7 A Thirty centimeters would be about 20 some-odd
8 inches.

9 Q Is that right? Okay. All right. Very good.
10 Her last office visit with you was on May 21st,
11 2012; is that right?

12 A Yes.

13 Q Her pain scale was zero at this time?

14 A Right.

15 Q Her weight was 111 pounds; is that right?

16 A I think so.

17 Q Okay. And I think there were a couple of times
18 before then on November 21, 2011, the pain scale was zero.
19 May 23rd, 2011, she weighed 114 pounds. You just basically
20 follow her since she started coming to see you; is that
21 right?

22 A Right. She's primarily taken care of by her
23 internist there in Hartsville.

24 Q You mentioned the term parenteral nutrition. What
25 is that?

Bright Williamson - Redirect Examination by Mr. Corbin

1 A Parenteral.

2 Q Parenteral.

3 A It just means intravenous nutrition.

4 Q Does she get any of that at any time?

5 A Not since she's been under my care.

6 Q And the only -- if I understood what you said to
7 start with, she gets vitamins and minerals; is that right?

8 A She gets vitamins, right. She gets B-12. She gets
9 vitamin supplements.

10 Q And what is the B-12 for?

11 A She's -- I think she even started that way back
12 before she had the more recent operation, but I -- she
13 might have pernicious anemia if she -- might possibly have
14 enough resection back in '95 to -- but I sort of doubt it,
15 but any way, I don't know when the B-12 got started to tell
16 you the truth.

17 Q That's fine. I don't have any further questions.
18 You've been most helpful for us. Thank you.

19 A Okay.

20 THE COURT: Redirect?

21 MR. CORBIN: Judge, just one question.

22 **REDIRECT EXAMINATION**

23 **BY MR. CORBIN:**

24 Q Dr. Williamson, have you produced a copy of your
25 medical records for us in the past?

Bright Williamson - Redirect Examination by Mr. Corbin

1 A Yes.

2 Q Okay.

3 MR. CORBIN: Your Honor, he has brought the
4 original records and I think that Mr. McDow and I have an
5 agreement. He can keep the original records. We'll
6 substitute a complete copy that both defense and I have.

7 THE COURT: All right. Have they been marked yet?
8 You'll do that at some point?

9 MR. CORBIN: Yes, sir.

10 THE COURT: All right. Thank you.

11 MR. CORBIN: Thank you, Dr. Williamson.

12 THE COURT: Dr. Williamson, you can step down.
13 Can the witness be excused?

14 MR. CORBIN: Yes, sir.

15 MR. MCDOW: Yes, sir.

16 THE COURT: Any objection?

17 MR. MCDOW: That's fine, no objection. Thank you.

18 THE COURT: All right. Ladies and gentlemen, we
19 are going to stop for today. It's 5:30. I know it seems
20 like you put in a long day; that's because you have. We'll
21 begin tomorrow morning at 9:30. If you would, please, be
22 back in your jury room at or before that time so that we
23 can get started promptly. You may not discuss this case at
24 all. You know that I'm going to tell you that at every
25 break. Don't discuss it amongst yourselves. Don't do any

1 research on your own. I'm required to tell you by order of
2 the chief justice, basically that means anything under the
3 sun. You can't read anything about these issues, do any
4 type of research on your own whether it's computer based or
5 book based. You'll get everything you need right here in
6 this courtroom.

7 We'll see you tomorrow morning at 9:30. If there's
8 anyone who needs to -- well, it's not dark outside, is it?
9 I was going to -- if anybody needs help getting to their
10 automobile, just let the bailiff know. See you tomorrow
11 morning.

12 (WHEREUPON the jury left the courtroom at 5:33).

13 **THE COURT:** All right. Thank you. If you
14 gentlemen could be back no later than 9:15 and we'll go off
15 the record now.

16 (WHEREUPON court was in recess until the following
17 morning, October 9, 2012.)

18

19 * * * * * END OF VOLUME I * * * * *

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1 State of South Carolina)

In the Court
Of Common Pleas

2 County of Richland)

3 Docket No. 2010-CP-40-5705

4
5
6 Doris F. Atkinson and)
William E. Atkinson, Jr.,)
7 Plaintiffs,)

Transcript of
Record

8 vs.)

9 Volume II

10 James A. Williams, Jr., M.D. and)
South Carolina Oncology)
11 Associates,)
12 Defendant.)

13 October 8-12, 2012
14 Columbia, South Carolina

15 B E F O R E:

16 The Honorable George C. James, Jr., Judge and a jury.

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

18 Daryl J. Corbin, Esquire
19 Attorney for the Plaintiffs

20 William C. McDow, Esquire
21 Attorney for the Defendants

22
23
24 Brenda J. Sigwald, Circuit Court Reporter
For the Honorable R. Knox McMahon
25 P.O. Box 206, Jackson, South Carolina 29831

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TUESDAY, OCTOBER 12, 2012

1
2 **THE COURT:** Okay. Gentlemen, you ready to go over
3 the deposition with objections?

4 **MR. CORBIN:** Yes, sir.

5 **THE COURT:** All right. At some point, I guess, Mr.
6 McDow, inform me to make sure the record is clean, we'll
7 need to get a clean copy of the defendant's objections so
8 that they can be made a Court's exhibit.

9 **MR. MCDOW:** Okay.

10 **THE COURT:** With -- in other words, I've got notes
11 all over this one.

12 **MR. MCDOW:** Yes, sir.

13 **THE COURT:** With my rulings, I -- I don't want to
14 call out page numbers and line numbers. What I'm going to
15 do is I'm going to number these things. In other words,
16 your first objection block will be one -- in other words
17 one, two and three will be on the first page and four,
18 five, six, seven, on down the line. That way I won't have
19 to call out page 62, line so and so. But I'll clarify that
20 and I'll -- I'll complete the blank copy on my own so that
21 nobody will guess at what I'm saying.

22 But in any event, one thing I noticed is that a lot
23 of your objections, Mr. McDow, were based on -- were based
24 on the grounds that the question assumed the facts not in
25 evidence. Typically in a case at any given time,

1 especially in the preliminary, or the beginning of the
2 case, those facts aren't in. In other words, I assume that
3 some of the facts that you say are not in evidence, the
4 plaintiff is going to introduce something along those
5 lines. And typically that's cured, but there are probably
6 twenty or thirty objections where you say they assume facts
7 that are not in evidence. We could be here all day just on
8 this deposition to go over that. So I don't know how else
9 to handle it except to assume that Mr. Corbin is going to
10 at least try to introduce some evidence where you say right
11 now those facts aren't in evidence because he bases -- from
12 what I see, Dr. Smith's deposition, a lot of the battle was
13 over, well was it a perforation or obstruction. Well, he
14 says perforation, you say obstruction and he's saying as
15 soon as he has a patient like her who has the surgical
16 history she has who presents with a perforation, what do
17 you do. You assumed fact -- you object saying that those
18 facts aren't in evidence.

19 Are you going to have experts who say that?

20 **MR. CORBIN:** I'm sorry, Your Honor, what --

21 **THE COURT:** Are you going to have experts who say
22 that she has had a perforation.

23 **MR. CORBIN:** Absolutely, yes, sir.

24 **THE COURT:** And you disagree with that, Mr. McDow?

25 **MR. MCDOW:** Yeah, our position is that she did not.

1 **THE COURT:** So even though you might disagree with
2 it are those facts going to be in evidence.

3 **MR. CORBIN:** I think it will be. I think Dr.
4 Bailey testified to that yes, sir.

5 **MR. MCDOW:** Yes, sir.

6 **THE COURT:** I think he did and that's -- I'm a
7 layman up here and when I heard him say that it wasn't an
8 obstruction I was thinking, well, I thought that was what
9 the whole case was based upon. Then I realized, obviously,
10 there's a huge difference those two terms.

11 **MR. CORBIN:** Your Honor, if I may, the operative
12 reports of Dr. Williams talks about extravasation of
13 their -- and the experts say no, it gets out at the leak.

14 And Dr. Smith says that wasn't extravasation, it
15 was just -- it all washed through and --

16 **MR. CORBIN:** He says, if you don't believe the
17 operative report.

18 **THE COURT:** He agrees with a lot of your
19 conclusions, but he does not agree with the premise of your
20 question.

21 **MR. CORBIN:** Yes, sir.

22 **THE COURT:** And I think a lot of those objections
23 that you lodged object to the form, Dr. Smith, in his own
24 way basically told Mr. Corbin, well that's what you say,
25 yes, but that ain't what happened. So we've all been

1 through depositions where opposing counsel tries to paint a
2 picture and the witness, you hope, will be able to say,
3 your logic is false, but if that's what happened, then A,
4 B, and C are true and I agree with you. And that's just
5 why we have these.

6 All right. To get to the point, I'm going to
7 number one, two and three, Mr. -- and then four through
8 sixteen are your objections on page 2 and 17.

9 MR. MCDOW: I'm sorry, Judge, I'm not --

10 THE COURT: I know it's easy for me to say because
11 I'm up here reading my own notes. But let me -- if you
12 pull out your page one of objections.

13 MR. MCDOW: Yes, sir.

14 THE COURT: You see your plaintiff's designation
15 and those blocks that are there.

16 MR. MCDOW: That's correct.

17 THE COURT: Block -- the first block is No. 1.

18 MR. MCDOW: That's what I thought.

19 THE COURT: No. 2 and No. 3.

20 MR. MCDOW: Okay.

21 THE COURT: Then is next page, the first one will
22 be 4.

23 MR. MCDOW: Yes, sir.

24 THE COURT: Then you go 4 all the way down through
25 16. So if you number each one of those rectangles

1 successively, you have 4 through 16 on that page. Then on
2 the third page, 17 through 28. Then on the next page would
3 be 29 through 44. And the last page will be 45 through 54.
4 Of course, most of those have 2 or 3 or sometimes four sub
5 objections, but I'm treating these blocks as a whole.

6 MR. MCDOW: I understand.

7 THE COURT: All right. If you go to -- what I'm
8 going to sustain because I'm overruling most of your
9 objections. Block number 10 is on page 2 -- page 62, lines
10 15 through 17, that objection is sustained. On page 3,
11 block No. 19, that is sustained. I know you objected to
12 the form, which is technically not a trial objection, but
13 that is an argumentative question.

14 So, Mr. Corbin, are you taking notes? Because
15 you're going to have to --

16 MR. CORBIN: Yes, sir, I am.

17 THE COURT: -- know what these are.

18 MR. CORBIN: Yes, sir. 19 is out, yes, sir.

19 THE COURT: All right. And I'm going to come back
20 in a moment to 21 through 23 and show my ignorance, but I
21 will have to ask questions. Block 24, which is page 20 --
22 excuse me page 86, lines 20 through 24, that objection is
23 sustained. The question was not couched in terms -- I
24 think it was couched in terms based on a recollection
25 that -- which is better or what would you rather do.

1 That's -- the question is whether or not it comports with
2 the standard of care. So that page 86, lines 20 through 24
3 is sustained.

4 Block 28, the last entry or the last objection
5 block on that page is sustained. It's argumentative and
6 it's not only pitting one witnesses testimony against the
7 deponents, but two. I think you ask if he agreed with what
8 two other people said and that's not a proper question.

9 MR. CORBIN: Those are two other expert witnesses,
10 Your Honor.

11 THE COURT: I don't know if it was two other
12 experts. I think one of them might have been Dr. Williams.
13 I don't -- do you think you can ask a witness if he agrees
14 with an expert?

15 MR. CORBIN: I would think that you could, but I'm
16 not going to argue with that one, Your Honor, I agree.

17 THE COURT: All right. Page -- I just noted on the
18 very last page, No. 47, which is page 149, it's the only
19 entry on that page that has page 149, improper
20 characterization. I think most of the time you objected to
21 the form, Dr. Smith corrected Mr. Corbin, anyway. So those
22 are the objections that I'm going to sustain right now.

23 What I have a question about is if we go back to
24 page 3 of the objections, the blocks that are 21, 22, and
25 23, to talk about 64 episodes of nausea and vomiting on 23

1 days, you objected that that was assumed, facts not in
2 evidence and improper characterization of the testimony and
3 also this was confusing or misleading in part. I just
4 wrote in my notes, I don't know what you're talking about.
5 I -- evidently, Mr. Corbin contends there were 64 episodes
6 of nausea and vomiting and 23 days post-operatively -- I
7 don't have a clue. So your objection to that, Mr. McDow,
8 do you recall what that was based on?

9 MR. MCDOW: Let me see the objections.

10 THE COURT: Page -- it starts on page -- it's the
11 page 85 of the deposition.

12 MR. MCDOW: I think it was just 64 episodes and 23
13 separate days whether that was factually correct. I
14 didn't -- I mean I haven't counted those up and have those
15 numbers.

16 MR. CORBIN: Yes, but that's, in fact, why we did
17 the summaries on the Sea Pines case. The summaries, it's
18 my understanding, they're coming in without objections.
19 I've asked repeated questions of expert witness based upon
20 that summary in evidence.

21 THE COURT: Does an expert say that is the case?

22 MR. CORBIN: Yes, sir.

23 THE COURT: And does -- is the plaintiff -- is she
24 going to testify?

25 MR. CORBIN: Yes, sir.

1 **THE COURT:** Okay. I'm sure she didn't count,
2 but --

3 **MR. CORBIN:** Let me explain what we did, Your
4 Honor.

5 **THE COURT:** All right.

6 **MR. CORBIN:** And I've been around the block a few
7 times. What we did, we have 2000 pages of medical records.

8 **THE COURT:** Right.

9 **MR. CORBIN:** And we took the time and effort to go
10 through there and count every single one we could find. We
11 might not have enough, but we counted every single one we
12 could find. We did the summary pursuant to Sea Pines and
13 the rules of evidence. Not only did the summary -- we
14 attached to the summary every single evidence we could find
15 of that particular incident, nausea and vomiting or
16 distension. So when you look at the summary, all of the
17 supporting evidence is attached to it and is in evidence.
18 And so my position is if there's more than 63, you know,
19 we've got to supplement. That's why we did the summaries.

20 **THE COURT:** Well, I think the upshot of this, you
21 were talking about whether or not he had 64 episodes in 23
22 days, whether or not an NG tube was appropriate.

23 **MR. CORBIN:** Yes, sir.

24 **THE COURT:** And Doctor -- at the end, it was kind
25 of moot because Dr. Smith said, I don't know if it was 64

1 or 4, doesn't matter how many. If she had four episodes of
2 nausea and vomiting, he would use the NG tube.

3 MR. CORBIN: But it's still relevant to show --

4 THE COURT: I understand that, sir.

5 MR. CORBIN: His testimony, you know, it's
6 immaterial, well fine, well it's not on fire so it's not
7 relevant. I mean, that's the fact.

8 THE COURT: Okay.

9 MR. CORBIN: And the fact that the standard of
10 care -- you know, our experts say, you do it, so if he says
11 64 episodes, doesn't make any difference to him, you don't
12 need an NG tube, that's still relevant.

13 THE COURT: He didn't say that. He said four is
14 enough for him.

15 MR. CORBIN: Yes, sir.

16 THE COURT: So that's why I think the whole
17 objection might have been moot.

18 MR. CORBIN: I got you.

19 THE COURT: I don't think the case is going to rise
20 and fall with the jury on this deposition, but --

21 MR. CORBIN: No, sir.

22 THE COURT: -- we're in the position of making sure
23 the record is clear and the record is protected, but if
24 there's going to be evidence from somewhere that is -- that
25 says there's 64 episodes of nausea and vomiting in 23 days,

1 then I'm going to let this stay in and then you fellows can
2 debate it at the end.

3 MR. CORBIN: I think it's there and I think it's
4 No. 7 or 8 and it's in evidence already.

5 THE COURT: Okay. All right. That takes care of
6 those; and while the deposition is being read, I will take
7 somebody's clean copy of this and I'll make -- well, you
8 can probably get your office to e-mail me one.

9 MR. MCDOW: Yes, sir.

10 THE COURT: And I don't know how we print things up
11 here, but we can get it printed and I can make these notes
12 so the court reporter has a court's exhibit and everybody
13 knows what I did. Okay?

14 MR. MCDOW: Yes, sir.

15 THE COURT: And I'll note all of your objections
16 and if there's -- at some point Mr. McDow, you want some
17 time to put in any more expansive arguments on the record,
18 we'll have time to do that.

19 All right. Lastly --

20 MR. CORBIN: Your Honor, I don't mean to interrupt,
21 but for clarification, I wasn't sure, is 47 in? On the
22 last page.

23 THE COURT: Objection 47?

24 MR. CORBIN: Yeah, yes, sir.

25 THE COURT: Objection 47 is in. That was just kind

1 of an editorial comment I made.

2 MR. CORBIN: I got you.

3 THE COURT: Most of the time Dr. Smith, whose also
4 reading from his deposition, he's been around the block a
5 few times.

6 MR. CORBIN: Yes, sir.

7 THE COURT: He pretty much didn't agree with what
8 your premise was, but he said if it happened like you say,
9 Mr. Corbin, then I have to agree with you, but that's not
10 what happened.

11 MR. CORBIN: Yes, sir.

12 THE COURT: Okay.

13 MR. MCDOW: So 47 was not sustained?

14 THE COURT: The objection was overruled.

15 MR. MCDOW: Okay. I'm sorry. I put it down wrong
16 too.

17 THE COURT: All right. Now, as far as the
18 defendants -- do you have any objections to the defendant's
19 designations? Because I have some questions about at
20 least, from my standpoint, why he wants some of those in.

21 MR. CORBIN: Yes, sir.

22 THE COURT: Nothing substantive.

23 MR. CORBIN: Yes, sir.

24 THE COURT: But probably on 20 occasions. You want
25 to publish your objections.

1 **MR. CORBIN:** That's -- Your Honor, that's the
2 crux -- the only objection I had, and Bill and I talked
3 about it, I would like to add a few lines to his addendum,
4 which it's no problem. But the only objection I have in
5 the world is, I don't think that you can object to the form
6 of the question. You ask -- an attorney ask a question of
7 the witness, object, improper question; object to the form
8 of the question and then you wait. You wait to see what
9 the answer is and then you withdraw and publish that thing.

10 **THE COURT:** Well, Mr. McDow, what is it under the
11 rule, at least Rule 32, that allows an attorney's objection
12 to come in as evidence?

13 **MR. MCDOW:** Well, I think you have to rule on it at
14 this time. I guess in effect you have ruled on it.

15 **THE COURT:** Well --

16 **MR. MCDOW:** We're reserving all objections until --

17 **THE COURT:** Well, most of these are not ones that
18 you -- well I think all of them are ones that you did not
19 put in your objection memorandum. For example, if you look
20 at -- go to page 2, the third one down on page 44, lines 12
21 through 13, you did object to that one, but the words to
22 the jury, object to the form of the question, I've already
23 ruled on those.

24 **MR. MCDOW:** All right, sir.

25 **THE COURT:** So I don't see why those words need to

1 be spoken here in front of the jury. See what I'm saying?

2 MR. MCDOW: Well, I understand you've ruled on it
3 for us, but you haven't nicely ruled on it for the jury to
4 hear that.

5 THE COURT: Well, the jury shouldn't be concerned
6 with what my rulings are. The jury just considers
7 evidence. I've just never seen where an objection is read
8 into evidence for evidentiary purposes.

9 MR. CORBIN: And Your Honor, I concur. I think an
10 attorney's objection does not need to be published to the
11 jury, just the publication parts.

12 MR. MCDOW: Right. You've ruling on those.

13 THE COURT: Yeah.

14 MR. MCDOW: Now, I'm protected on the record, so
15 from that standpoint I would say I hear what you're saying
16 and I understand that.

17 THE COURT: All right. And I'll make that a part
18 of the record in a cleaner form at some point.

19 Now, Mr. Corbin, have y'all reached an agreement as
20 to what's going to be dovetailed into your publishing of
21 the deposition? Because I -- I have made notes on what I
22 think you should dovetail -- unless Mr. McDow, you want to
23 have the floor and read all of your responses? Some of
24 these logically would be included in his.

25 MR. MCDOW: Your Honor, I would like for it to be

1 -- I mean for purposes of flow, just, it all ought to be
2 read at one time. It shouldn't be play a brief part of
3 theirs and then I have to go back --

4 THE COURT: Some of them are many pages away from
5 what he read. So we'll get to that in a minute, but Mr.
6 Corbin, if you've got your copy there?

7 MR. CORBIN: I do.

8 THE COURT: On his first page, page 21, lines 6
9 through 10.

10 MR. CORBIN: Yes, sir.

11 THE COURT: You got that handy?

12 MR. CORBIN: I do.

13 THE COURT: Page 24, lines 11 through 13; page 24,
14 lines 16 through 20; page 25, line 24 through page 26, line
15 17, you're going to have to leave those into what you read.
16 They are either right before or right after something you
17 read.

18 MR. CORBIN: Yes, sir.

19 THE COURT: Okay. And I also made the notation
20 that -- if it makes any difference -- page 30, line 6
21 through page 31 line 20 through 21, when Mr. McDow, when
22 you read that, you probably ought to start off -- the
23 sentence in that, the word wouldn't -- but anyway I'll
24 leave that up to you.

25 All right. Going to the second page number 12 of

1 the defendant's counter designations. You with me Mr.
2 Corbin?

3 MR. CORBIN: I think so, yes, sir.

4 THE COURT: Page 43, line 19 through 24 will be --
5 you'll read that, because that's a continuation of an
6 answer or next logical question.

7 MR. CORBIN: I got you. So you're telling me which
8 ones I need to publish and then Bill's -- Mr. McDow is
9 going to come back and publish the other parts?

10 THE COURT: Except for the ones that just say
11 object the to the form of the question.

12 MR. CORBIN: Right, yes, sir. Okay.

13 THE COURT: And then you drop down -- there are
14 two -- page 86. You see those two entries on the same
15 page?

16 MR. CORBIN: Yes, sir.

17 THE COURT: Page 86, 13, 19 and page 86, 25. You
18 read those.

19 MR. CORBIN: Okay.

20 THE COURT: You also read the next one, page 87 and
21 then skip over the next one because that's an objection.
22 Then you're going to read page 95; and then page 99 his
23 designations for those two pages.

24 All right. About finished. On the third page, the
25 first six of those are not going to be read by anybody

1 because they're all objections. Page 145, lines 9 through
2 14. See that one?

3 MR. CORBIN: Yes, sir.

4 THE COURT: And the next two. You can circle those
5 to read well.

6 MR. CORBIN: So that was -- that was -- the only
7 objection I have to those is that's a question where he
8 objects to the question.

9 THE COURT: All right. Which one?

10 MR. CORBIN: The one, 145.

11 THE COURT: All right.

12 MR. CORBIN: Starting at line 9. I've got it
13 marked here.

14 THE COURT: All right. I may have missed that one
15 because my brain --

16 MR. CORBIN: That's where he objects to my question
17 and then after we have a chance to weigh the answer, then
18 he wants to publish it.

19 THE COURT: Well, he can to that. He can withdraw
20 any objection he wants.

21 MR. CORBIN: Okay. I got you.

22 THE COURT: Okay. All right. So we're at 145, 9
23 through 14; and the next two you will read along with
24 yours.

25 MR. CORBIN: Yes, sir.

1 **THE COURT:** And those are all the ones that I have
2 that would be included in your summary.

3 **MR. CORBIN:** Mr. -- Judge, if we could go to page
4 1. I was kind of brain dead when you started that one. I
5 want to make certain I've got it right. I'm supposed to
6 read, starting with page 21; is that --

7 **THE COURT:** Yes, sir.

8 **MR. CORBIN:** Yes, sir.

9 **THE COURT:** And the next one --

10 **MR. CORBIN:** I read this one --

11 **THE COURT:** That one and the next 3.

12 **MR. CORBIN:** Got you.

13 **THE COURT:** Probably from reading Dr. Smith's
14 deposition, I understand more about this case than anybody,
15 so Mr. McDow, you probably really don't have much of a
16 problem with anything he said. You don't like the
17 questions, but you don't mind the doctor's answers.

18 **MR. MCDOW:** Right.

19 **THE COURT:** So reading that, I must confess, it
20 wasn't a whole lot of fun, but it was very educational.

21 All right.

22 **MR. MCDOW:** It wasn't a whole lot of fun being
23 there either.

24 **THE COURT:** All right. Are we clear on that? And
25 after you finish yours, Mr. Corbin; we'll take a break, Mr.

1 McDow, and then you can kind of figure out exactly what
2 you've got and if you change any of your designations,
3 that's certainly up to you, but you said you had some that
4 you wanted to read because what he does now --

5 MR. CORBIN: I did and I don't think Mr. McDow
6 expressed no concern about me adding a few lines to what he
7 would like to have published and I will read that.

8 THE COURT: All right. Well, I will leave it up to
9 y'all to get this presented to the jury in the best way in
10 accordance with what I just said. I don't think anything
11 that I ruled on, what you have to read of his is --

12 MR. CORBIN: No, sir, it's not. And I just take --
13 we're reading a lot of his and I appreciate that.

14 THE COURT: All right.

15 MR. CORBIN: And Bill will follow along. If we
16 inadvertently miss something, we'll be glad to publish it.

17 THE COURT: Okay. And if -- I've got the original.
18 Who's going to read the responses.

19 MR. CORBIN: My paralegal will.

20 THE COURT: Okay. I'm -- this will be -- what
21 number of Court's Exhibits --

22 THE COURT REPORTER: One.

23 THE COURT: Okay.

24 MR. CORBIN: Your Honor, what I propose to do the
25 first thing this morning is I want to publish a certain

1 document out of the medical records.

2 THE COURT: All right. And then you're going to go
3 to this?

4 MR. CORBIN: Then I'm going to go to my expert
5 witness, Doctor Irvin, then --

6 THE COURT: We're not going to do this right off.

7 MR. CORBIN: Not first off.

8 THE COURT: All right.

9 MR. CORBIN: It will be in the first couple of
10 hours, though.

11 THE COURT: All right. Anything before -- yes,
12 sir?

13 MR. MCDOW: There is one thing I want to bring to
14 the Court's attention. I mentioned this to Mr. Corbin
15 yesterday because I forgot it when we were through. I
16 noticed when I was standing on the steps that there is a
17 juror, who I believe was taking notes yesterday. I don't
18 know that that concerns the Court or not.

19 THE COURT: Does either side object to that?

20 MR. MCDOW: I don't, but I wanted to bring it to
21 the Court's attention.

22 THE COURT: I appreciate that. I usually don't
23 bring that up, but I will bring it up and if you have
24 fourteen note pads and fourteen pens, you might as well get
25 those and stack them up here and I'll give them the typical

1 note-taking charge. And what I may do as part of that, I
2 had a juror ask me one time, well, we notice that you were
3 writing a lot of stuff down, so we thought you thought it
4 was important and I typically tell them, and I didn't this
5 time, that if they see me writing something down, I write
6 down times.

7 **MR. CORBIN:** Yes, sir.

8 **THE COURT:** You know, like when something -- an
9 exhibit was introduced or when certain things, a certain
10 topic started because if the jury ever wants to hear
11 testimony replayed, I'll at least know where I might go to
12 find it.

13 **MR. CORBIN:** Your Honor, one thing I have Your
14 Honor, it's not earth shattering, I'm just a little bit
15 concerned -- and Your Honor can fix this. If we say, Oh,
16 by the way, now you can start taking notes -- I don't want
17 to give the impression, you know, the stuff -- my
18 key-expert witness -- one of my key-expert witnesses was
19 yesterday and I don't want them to feel like -- now the
20 judge says we need to start taking notes.

21 **THE COURT:** No, I'm not going to say they need to.

22 **MR. CORBIN:** Could Your Honor say that, you know,
23 perhaps we should have mentioned yesterday that you do have
24 the right to take notes if you want to, take nothing from
25 the fact that we're all giving you the right to take notes

1 now that we didn't offer yesterday? Just words to that
2 effect.

3 THE COURT: I can cover that.

4 MR. CORBIN: Yes, sir.

5 MR. MCDOW: I just assumed he was making notes on
6 the trial. He may have been making his grocery list, I
7 don't know.

8 MR. CORBIN: Maybe what we need to do then is Your
9 Honor ask, has anybody taken notes in this case and if they
10 haven't, I would say not mention it.

11 THE COURT: Well, if he's taking notes about a
12 grocery list, you've got problems.

13 MR. CORBIN: Yes, I do.

14 THE COURT: Okay. Anything else?

15 MR. CORBIN: No. The thing we're going to
16 publish -- and this is in the records, it's his
17 psychological record, which is part of Dr. Williams'
18 records.

19 MR. MCDOW: Yes, we agreed on the disability of
20 medical records. So if he wants to publish that, that's
21 fine.

22 THE COURT: Okay. I will -- is everybody on the
23 jury here? I assume sir?

24 THE BAILIFF: Yes, sir.

25 MR. CORBIN: And to speed it up, Your Honor, I

1 would like to -- without objection go ahead and introduce
2 Dr. Allen's report which we're going to publish.

3 THE COURT: Okay.

4 THE COURT REPORTER: No. 9.

5 MR. CORBIN: It will be Exhibit No. 9.

6 THE COURT: All right. The bailiff is not in the
7 jury room talking to them -- talking to them about -- he
8 shouldn't be.

9 MR. CORBIN: Okay. And Your Honor, if we may take
10 five minutes, Bill and I -- Mr. McDow and I can create or
11 get these medical records in without objection.

12 THE COURT: Okay.

13 (WHEREUPON a recess was observed.)

14 THE COURT: All right. We're back on the record
15 and I believe, of course, all the jury is here and I'll
16 give them a brief charge on note taking and we'll go from
17 there.

18 Anything before we bring them in other than that,
19 Mr. Corbin?

20 MR. CORBIN: Nothing, Your Honor.

21 THE COURT: Mr. McDow?

22 MR. MCDOW: Nothing from the defense.

23 THE COURT: All right. You can bring in the jury.
24 There's one that I left out.

25 MR. CORBIN: Yes, sir.

1 **THE COURT:** Reading Mr. McDow's, recitation, page 2
2 of his counter designations.

3 **MR. CORBIN:** Yes, sir.

4 **THE COURT:** Page 102, line 19 through page 103,
5 line 1, should be read right before your designation number
6 44 because that's immediately prior to one and we'll
7 clarify that during the break if you have a question about
8 that.

9 **MR. CORBIN:** Yes, sir. And we agreed to add some
10 lines to accommodate that.

11 **THE COURT:** Okay.

12 (WHEREUPON the jury entered the courtroom at 10
13 o'clock a.m.)

14 **THE COURT:** All right. Thank you for your
15 patience, ladies and gentlemen -- oh, I'm sorry.

16 (WHEREUPON another juror entered the courtroom.)

17 **THE COURT:** I thought we had everybody. Thank you
18 for your patience, ladies and gentlemen, I get real
19 skittish when we don't start on time, and in this instance
20 we didn't start on time. It's not the attorney's fault,
21 it's just simply that typically in a trial where it may
22 last a few days, there are some issues that come up about
23 presentation of evidence; and to try to save time and make
24 things more time wise on the back end, sometimes I have to
25 spend to time on the front end and the lawyers were kind

1 enough and cooperative enough to go through some things
2 that we may be doing later this morning to make sure the
3 evidence is presented to you in a more orderly fashion. So
4 that's what we've been doing. We haven't been cooling our
5 heels and drinking coffee. We have been working in here
6 since about twenty after nine. So I do apologize for that.

7 Also, is there -- there may be some of you who
8 might want to take notes -- and I should have mentioned
9 this yesterday. You can take notes during the course of
10 this trial if you would like to. That is certainly fine.
11 You do not have to. For example, if I was on a jury, I
12 wouldn't take notes, because some people are better note
13 takers than others; and you know that if you went to any
14 type of school or you underwent any type of training,
15 sometimes you do better by listening or taking things in
16 without taking notes. If you do want to take notes down,
17 that's fine, but remember that, again, some people are
18 better note takers than others.

19 If you do take notes, your notes are not to be
20 considered as any stronger force in that jury room later on
21 than somebody's independent recollection. That's not the
22 way it would work. So the fact that you take notes doesn't
23 mean that what you wrote down is exactly what the evidence
24 was. Recollections of individual jurors are just as
25 valuable as the notes of the jury.

1 Also while you take notes, if you do take notes,
2 you may not notice the body language of the witness.
3 Because one of the things I told you, you might want to
4 take into account on credibility determinations is what was
5 that witnesses appearance. So when you're taking notes,
6 you might not notice that witness's body language and there
7 are certainly some other things about taking notes that may
8 cause you not to. If you're taking notes on something that
9 a witness is saying and while you're taking that note, you
10 might miss something that the witness is saying now because
11 you're so intent on writing down what you just heard. So
12 if you want to take notes, that's fine.

13 Having said that, there was a witness who testified
14 yesterday -- and I had not mentioned to you that you could
15 take notes -- that witness's testimony, as I mentioned to
16 you, is just as important as every other witness's
17 testimony in this trial, whether it's the first witness,
18 the middle witness or the last witness. And the fact that
19 I didn't tell you yesterday that you could take notes
20 doesn't mean that I'm giving his testimony any type of
21 short trip.

22 So having said all that, is there anyone who would
23 like to take notes? We do have some note pads and pens
24 available for you. Just raise your hands again.

25 **THE JUROR:** I've got one.

1 **THE COURT:** You've already got one. All right. We
2 have one other gentleman there. Of course, if you change
3 your mind and you want to stop, you can.

4 I will tell you this: You won't take your notes
5 home with you. Okay? At the end of the day, you leave
6 your notes here and we'll approach it in that fashion. At
7 the end of the case, the notes will be gathered up and
8 they'll be disposed of, so you don't need the worry about
9 people reading what you wrote. We're not going to do that.
10 Nobody will be permitted to read what you wrote.

11 All right. Anything further before we begin, Mr.
12 Corbin?

13 **MR. CORBIN:** Nothing from the plaintiffs.

14 **THE COURT:** Mr. McDow?

15 **MR. MCDOW:** No, sir.

16 **THE COURT:** All right. Okay. Mr. Corbin, you can
17 proceed.

18 **MR. CORBIN:** Yes, sir. Your Honor, at this time,
19 we would request permission to publish Exhibit --
20 Plaintiffs Exhibit No. 9, which is in evidence without
21 objection, please.

22 **THE COURT:** All right. Ladies and gentlemen, he'll
23 be publishing or reading to you an exhibit. That exhibit
24 will also be with you in the jury room since it is in
25 evidence.

1 It is Exhibit No. 9, and you have a copy Mr. McDow?

2 MR. MCDOW: Somewhere in my records, yes, sir.

3 THE COURT: All right. Go ahead, Mr. Corbin.

4 READING OF PSYCHOLOGICAL REPORT

5 MR. CORBIN: This is a psychological report taken
6 of Ms. Atkinson. The date is December 22, 2008, 18 months
7 after she got out of the hospital in Columbia. She's
8 applying for early social security disability. This
9 particular report states as follows: Dan H. Allen, PhD, a
10 psychologist from Florence. The claimant's name is Doris
11 F. Atkinson. The disability examiner is Patricia R. Meyer.
12 The date of examination was December 22, 2008. Adult
13 Mental Status Examination.

14 Identification: The claimant is a 61-year-old,
15 married woman brought to the evaluation by her husband.
16 She states that they live in the home which they are
17 purchasing. Referral source: The claimant was seen at the
18 request of the Disability Determination Service, Columbia
19 Regional Office, and seemed aware of the nature of the
20 examination.

21 She was given information regarding the limits of
22 confidentiality and rights to HIPAA regulations. Methods
23 of assessment: Structured clinical interview, psychosocial
24 history form; brief stomach checklist, mental status
25 checklist, and review of report of contact with the

1 claimant, dated November 4, 2008, supplied by disability
2 examiner.

3 Presenting complaints: Faye, she prefers to be
4 addressed by her middle name, states that she has been
5 diagnosed with super short bowel syndrome and she has
6 related this -- she immediately became quite upset. When
7 giving more details about her health situation. She stated
8 that she had had some six surgeries, the first in April of
9 2007. She notes that five surgeries occurred within a few
10 weeks of each other and there have been several
11 complications, including development of peritonitis. She
12 notes that she has very little of her large bowel remaining
13 and she has also developed two hernias, which she had been
14 told are inoperable. Also, she notes diagnosis of both
15 internal and external hemorrhoids. She has been told that
16 her electrolytes are out of balance and as a result she has
17 hypertension and, quote, I can't hold much food or liquid,
18 quote. She notes that she soils herself easily with no
19 warning. And this is very embarrassing to her.

20 She states that it has come to the point where she
21 is very fearful of being out in the public for more than
22 one or two hours at the time. Quote, I just didn't realize
23 how sick I was until I began having those surgeries. She
24 adds that sometimes she can soil herself up to four times a
25 day. Quote, sometimes I will have bad gas right before

1 this and other times there's no warning at all, end quote.
2 She states, quote, It can just happen at any time and I
3 guess you can understand why I would be afraid to get far
4 from the home, end quote. She is taking multiple
5 medications and states that these are of some help.

6 She states that she has had a hysterectomy sometime
7 in the 70's and in 1995, she had had some of her intestines
8 removed after having developed gain green. Quote, if the
9 pain hits, I hardly have time to even hang up the phone,
10 end quote. She recalled there had been several incidents
11 when, quote, the feces will be in my shoes even before I
12 know it, end quote.

13 Personal history, born in Darlington County, South
14 Carolina, she comes from a family of seven, but states,
15 quote, there are just three of us remaining, period quote.
16 Her father died in 1967 of a massive coronary and her
17 mother, now 89 is a double amputee as a result of diabetic
18 complications. She remembers that her father had owned a
19 used automobile lot. After his death, her mother began
20 working at the factory and then at a disabled center. She
21 describes her family as having been very close.

22 Educational history: She completed high school and
23 states she was a good student, quote, I remember I had
24 trouble only one time and that was for cutting class and
25 that was my first and only offense, end quote. She noted

1 that she had taken some courses related to special needs
2 children at a local community college.

3 After high school, she married and they have a
4 daughter and son. Her husband is employed as Sonoco, a
5 firm that manufactures paper packaging products. She
6 states she is hoping for an early retirement.

7 Employment history: Faye states that she last
8 worked on March 30, 2007, at which time she was doing
9 substitute teaching with special needs students at a high
10 school level and had done this off and on since 1979. Also
11 from the period of 1979 to 1985, she was a teaching
12 assistant.

13 Mental status examination: Appearance and
14 behavior: Faye is a slender woman of average height. She
15 is very neatly, almost meticulously dressed. She has a
16 soft spoken, very polite manner, about after the first ten
17 minutes --

18 (WHEREUPON there was a pause in the proceedings.)

19 MR. CORBIN: -- she found it difficult to compose
20 herself while talking about her health problems and it was
21 obvious that this was quite embarrassing to her when she
22 was sharing the frequent bouts of diarrhea. She states,
23 quote, I just feel like my life is out of control. At
24 several points throughout the interview, she found it
25 difficult to choke back her tears, saying, quote, I'm just

1 somebody who's a prisoner to her body, quote. Thought
2 content was linear with no indication of impairment in
3 reality testing or other perceptual disturbance. She
4 continued to appear quite sad, almost despairing when
5 describing her physical concerns.

6 Attention and concentration: Faye was able to
7 repeat five digits forward and only three backwards. She
8 apologized profusely for, quote, Not being able to do much
9 better, quote. With the visual memory task in which she
10 was presented a page of ten items to look at for ten
11 seconds, she could recall seven of those. She seems
12 encouraged by this. Quote, I guess I did a little better
13 at these things than when you called out to me those
14 numbers, end quote. With mental calculations her
15 performance was variable. Although she seemed to recognize
16 the steps needed to come up with the correct solution, she
17 was not able to follow through to completion for five out
18 of eight of these. She assured me that, quote, she had
19 never had any trouble with things like making change,
20 period, quote.

21 Orientation: She readily responded to inquiries
22 regarding month, year, day of week, current events and
23 could easily identify well-known historical political
24 figures and events.

25 Abstracting tasks: Again, Faye proved to be quite

1 articulate, readily giving proper responses to all five of
2 the proverbs and also good responses to the four visual
3 abstracting tasks. For example, as to the meaning of don't
4 count your chickens before they hatch, she replied, quote,
5 We don't expect anything until you have it at hand, quote.

6 As to quote, Don't judge a book by its cover,
7 quote, she responded, Well, you just shouldn't judge by the
8 outside. You need to get to know something or someone
9 better, quote.

10 Activities of daily life: Faye states that she is
11 to bed at different times between 9 and 12, quote and only
12 recently, I began sleeping through the night with the
13 medications, quote. She is typically up around 8 a.m.,
14 quote, it takes me about three hours to get really started
15 in the morning after taking my medications, quote. She
16 states she always takes a shower and, quote, I have to eat
17 a light breakfast for my medications, period, quote.

18 She can't to do the cooking and most of the house
19 chores, quote, But I sure can't lift anything and I can't
20 push a vacuum sweeper, quote.

21 Much of her day now is spent watching television.
22 She notes that she has to stop eating or drinking at least
23 two and a half hours before she leaves the house because of
24 diarrhea. With much sadness she related that she is no
25 longer involved in her church where she was a charter

1 member. Quote, It seems like my friends have really
2 drifted off now and this hurts.

3 She states that most of them have been there all
4 her life and quote, I guess when this kind of thing in my
5 body goes on and on, people just start wondering away. She
6 has got a contact through e-mail with a support group for
7 others who have severe intestinal problems. Otherwise,
8 quote, I read a lot but I'm just not able to focus well,
9 quote. At this point, she noted that she had increasing
10 difficulty with her right eye and that will -- she will
11 have this checked soon.

12 Near the end of the session, Faye was having much
13 more difficulty controlling her tears and again made
14 apologies for this. She shook her head slowly, saying,
15 quote, It is really hard to see how this can get better for
16 me since this is the kind of condition that I'll always
17 have. She felt that her life, quote, Has been completely
18 turned around, quote. She states that most of her
19 thoughts, quote, Are just centered around this problem and
20 trying to manage around it so that I'm not a nuisance to
21 myself or others, quote.

22 Summary: Cognitively I would conclude that this
23 claimant has the capacity well within the average range.
24 She is generally quite articulate with good abstracting
25 ability. She does seem to be making an almost valiant

1 effort, a valiant attempt to maintain some sense of dignity
2 in the face of her physical problems, which certainly
3 appears authentic and has been well documented. The
4 pressure which she describes seems almost totally related
5 to this condition and management. The complications from
6 these difficulties would be the primary and significant
7 hindrance to her employment. She would have to be able --
8 she would be able to handle her funds in her own best
9 interest.

10 Diagnosis: Depression related to general medical
11 condition. Three to four, moderate to severe. Limitation
12 of social life, mood disturbance and increased social
13 isolation.

14 Signed Dan H. Allen, PhD... quote, This is to
15 certify that the above has -- and this is a
16 transcriptionist's quote, This is to certify that the above
17 was transcribed from the recorded voice of Dan H. Allen,
18 PhD on December 23, 2008.

19 THE COURT: Yes, sir, Mr. Corbin?

20 MR. CORBIN: May I be seated, Your Honor?

21 THE COURT: Yes.

22 MR. CORBIN: With the next witness?

23 THE COURT: Yes, sir.

24 MR. CORBIN: Your Honor, at this time, we would
25 call Dr. William Irvin to the witness stand, please.

Dr. William Irvin - Direct Examination by Mr. Corbin

1 DR. WILLIAM IRVIN,

2 having been duly sworn; testified as follows:

3 THE CLERK: Have a seat in the witness box. State
4 your full name for the record, please.

5 THE WITNESS: My name is William Irvin, I-r-v-i-n.

6 **DIRECT EXAMINATION**

7 **BY MR. CORBIN:**

8 Q Good morning, Dr. Irvin.

9 A How are you.

10 Q I'm doing fine, thank you. Where do you currently
11 live?

12 A I live in Charlottesville, Virginia.

13 Q What is your profession, please?

14 A I'm a gynecologic oncologist.

15 Q Are you board certified in that particular medical
16 specialty?

17 A I am board certified in gynecologic oncology as
18 well as obstetric and gynecology.

19 Q Dr. Irvin, would you give the jury the benefit of
20 your educational background, please?

21 A I spent most of my time in Charlottesville,
22 Virginia getting my undergraduate training in
23 Charlottesville, Virginia. I went on to do my medical
24 school boards in Charlottesville, Virginia. I went on and
25 did my residency, a four-year residency in obstetrics and

Dr. William Irvin - Direct Examination by Mr. Corbin

1 gynecology in Charlottesville, Virginia. I then left
2 Charlottesville for a brief period of time and went to
3 Chicago and did a fellowship in gynecologic oncology. I
4 then returned back the Charlottesville and came back and
5 practiced at the University of Virginia for approximately
6 nine years in the department of obstetrics and gynecology,
7 specifically the division of gynecologic oncology.

8 And then in 2006, I became the director of
9 gynecologic oncology in minimally invasive surgery and a
10 residency training program in Newport News, Virginia,
11 called Riverside Regional Medical Center.

12 Q And tell me, Doctor, what is a resident and you
13 talked about training residents. Can you tell the ladies
14 and gentlemen what is resident is?

15 A A resident is an individual that has chosen a
16 certain medical field to try and become boarded in that
17 field and so there are different residencies. The specific
18 one at the hospital at the University of Virginia as well
19 as Riverside that I've been involved in has been in
20 residency training of educational gynecologists. That's a
21 four-year training program and residents will go to
22 facilities to learn their craft, if you will, so there are
23 certain specific training institutions where the residents
24 are taught and I've been involved in two of those.

25 Q And in fact, you've held assistant professorship

Dr. William Irvin - Direct Examination by Mr. Corbin

1 positions?

2 A I was actually an associate professor at the
3 University of Virginia and am currently an assistant
4 professor at the Eastern Virginia Medical School.

5 Q Doctor, I note that you've been named one of the
6 best doctors in America, in 2007, 2008. What, in fact, is
7 the designation that you received, selected by the
8 professional field that you're recognized as one of the
9 best doctor's in America 2007, 2008 data base?

10 A I just think it is a data base where your peer
11 physicians are polled and asked who they think are the
12 better people in their particular profession and if you are
13 named a certain number of times, I think you achieve that
14 designation as best doctor in whatever field you're in.

15 Q Okay. Your CV or resume indicates that you
16 received teaching awards, faculty excellence in teaching
17 awards in 2005, 2006, 2007, and 2008, 2009. What are you
18 teaching?

19 A Those are awards that are prescribed or awarded by
20 the residents themselves. There are a number of different
21 attending physicians that teach the residents as they're
22 going through their training program and then the residents
23 then select who they think have made the best effort or had
24 the biggest impact on their training and they then receive
25 awards for that recognition. Those are typically annual

Dr. William Irvin - Direct Examination by Mr. Corbin

1 awards. So my specific area of training for the residents
2 has been in surgical management and in gynecologic
3 oncology, both clinical management for the patient as well
4 as the surgical management, as well as to a lesser degree
5 general obstetrics and gynecology.

6 Q Would you consider receiving the faculty
7 excellence in teaching awards several years in a row to be
8 an indication of a pretty good teacher?

9 A I would presume.

10 Q Okay. What is the national faculty award for
11 excellence in resident teaching? You received that in
12 1998.

13 A That is an award that's put forth by a national
14 organization known as KREYAD (phonetic) and it is awarded
15 through KREYAD, again on the basis of input that is
16 received from the residents in a particular training
17 program. They're allowed to send in information to this
18 KREYAD national board and then on the basis of the input
19 they receive, they will select national teachers.

20 Q I see another award here faculty excellence and
21 teaching award at Loyola University Medical Center. What
22 is that, please?

23 A It's the exact same thing.

24 Q Where is Loyola university?

25 A Loyola is in Maywood, Illinois, just outside of

Dr. William Irvin - Direct Examination by Mr. Corbin

1 Chicago. That's where I did my fellowship for gynecologic
2 oncology.

3 Q Dr. Irvin, explain to the jury your experience in
4 doing abdominal surgeries, what the doctors call lysis
5 procedures and add adhesiolysis procedures relative to
6 Faye's particular case. What's your experience in that
7 particular field?

8 A Well, I think as gynecologic oncologists, we often
9 are required to operate on people that have had prior
10 surgical procedures and in that situation -- every time
11 somebody has a surgical procedure performed, more often
12 than not scar tissue forms inside the abdomen and pelvis as
13 a result of that surgical procedure. The more extensive
14 the surgical procedure, the more extensive the scar tissue
15 formation can be. And so each time you go back on that
16 particular patient to do the next surgery, you have to go
17 address the scar tissue that was formed from the prior
18 surgery, carry out this procedure and then more likely than
19 not, you will have even more scar tissue form after your
20 procedure.

21 That's just a natural part and parcel of opening
22 somebody, dissecting tissues, exposing -- it's just part of
23 any surgical procedure. So the more times a person's
24 operated on, the more adhesions you would expect to
25 encounter when you go in for the next surgery. And so at

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1 the time that you then go back into that next surgery, many
2 times you have to take a period of time to separate
3 everything that's stuck to everything else.

4 Now, a lot of people don't realize, inside of the
5 abdomen and pelvis, you've got roughly 30 feet of small
6 bowel and colon combined, so if you were to take it and
7 unravel it, and stretch it from one corner of the room to
8 the other, so roughly 21 feet of small bowel, which goes
9 from the stomach to the colon. It actually loops back and
10 forth, back and forth, back and forth through your abdomen
11 and then it empties into the colon and you have another 7
12 to 8 feet of colon and then that empties out in the anus.
13 So a lot of what's inside, a lot of what gets stuck
14 following prior surgery is a bowel. And so you will spend
15 sometimes minutes, sometimes hours dissecting the bowel
16 apart trying to get to what you're trying to do and do what
17 you're trying to do. That technique is called
18 adhesiolysis.

19 Q Dr. Irvin, do you recognize what this document
20 is -- and I apologize, I didn't count the pages. It looks
21 like 40 or 50 pages. What is that document?

22 A That's my curriculum vitae.

23 Q It's dated May 2009. As of that particular date,
24 was it accurate and correct?

25 A It was.

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1 Q Do you have additional awards and experiences
2 since 2009?

3 A I have some.

4 MR. CORBIN: Your Honor, we would move to introduce
5 this as Plaintiff's Exhibit No. 30.

6 THE COURT: Any objection?

7 MR. MCDOW: Without objection.

8 THE COURT: All right. Number 3? Is in.

9 MR. CORBIN: No. 30, Your Honor.

10 THE COURT: 30?

11 MR. CORBIN: Yes, sir.

12 THE COURT: Okay.

13 BY MR. CORBIN:

14 Q Do you belong to any professional societies?

15 A I do.

16 Q I know you're a member of the American obstetrics
17 and gynecology, you're a diplomate. What is a diplomate?

18 A An individual that becomes fully boarded in their
19 particular field is awarded the status of fellow or
20 diplomat.

21 Q Also the society of gynecologic oncologists? You
22 belong to that society?

23 A I do.

24 Q The gynecologic oncology group, that a society you
25 belong to?

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1 A I do.

2 Q Midwest Gynecologic Oncologists Society?

3 A I do.

4 Q MidAtlantic Gynecologic Oncology Society?

5 A I do.

6 Q The Society of Laparoscopic Surgeons?

7 A I do.

8 Q The South Atlantic Society of Obstetricians and
9 Gynecologists?

10 A I do.

11 Q Can you tell the jury in general what your
12 clinical responsibilities are in terms of teaching and
13 whatever you do in your practice. What are your clinical
14 responsibilities and in general what do you do?

15 A So my clinical responsibilities are -- basically
16 involve trying to care for patients first and foremost that
17 have gynecologic oncologic conditions or are being referred
18 for an evaluation of possible oncology issues. For
19 example, pelvic masses that might be ovarian cancer;
20 uterine leak, which might be uterine cancer, ultimately
21 found not to be but they're often referred to rule that
22 out. I also do some complicated benign gynecologic
23 surgery.

24 So the week, Monday is operative all day long from
25 7:30 in the morning until about 6:30 in the evening.

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1 Tuesday is clinic in the morning where I will see patients
2 in the office, either post-op or followups or new patients
3 or patients that I'm following that have been diagnosed
4 with cancer and we're just making sure the cancer isn't
5 coming back. Tuesday afternoon, I'll operate from noon
6 until about five. Wednesday is clinic all day from 8
7 o'clock in the morning until about 6 o'clock in the
8 evening. Thursday morning is clinic from 8 in the morning
9 until 12:30 and then surgery in the afternoon. And Friday
10 it can be a mishmash of both of those.

11 Now, during my week, I typically have two residents
12 that are assigned to me, generally a junior resident and a
13 very early, incoming interning -- intern is what we call
14 the first-year residents. So we'll have a third-year
15 resident and an intern and they are with me in the clinic
16 seeing patients. I try to instruct them as I go in to see
17 patients, why I'm doing what I'm doing, what we're looking
18 for, what's important in this situation, what you should be
19 cognizant of, what is the condition. We'll do that as
20 they're in the clinic. In the operating room, I try to
21 explain to them why we do -- what we do in terms of what
22 incision we choose, what technique we employ, when we
23 should use a laparoscopic approach versus open approach,
24 what the benefits of one to the other; so just trying to
25 teach them what they need to know since they're doing four

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1 years of having been with us they can then go out and be
2 safe and practicing obstetricians and gynecologists in the
3 community.

4 Q You teach your residents and medical students the
5 standards of care?

6 A We do.

7 Q I note here that you've been teaching medical
8 students, residents, since about 1997?

9 A That's correct.

10 Q Last 15 or 16 years?

11 A Correct.

12 Q Do you provide lectures to physicians and
13 residents, medical students, or anybody else that would
14 like to go to these lectures about surgical matters?

15 A I do.

16 Q What is a didactic lecturer?

17 A Didactic as opposed to socratic -- didactic is more
18 interaction, so they'll get a lecture and the residents
19 will interact during that lecture asking questions, posing
20 their own particular queries, that would be considered a
21 didactic lecture.

22 Q It indicates here that you've given didactic
23 lectures many places, including for the Regional CNE
24 Presentations, educational seminars, the National
25 Post-Graduate-Education invited lectures and the National

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1 Presentation of Scientific Clinical Research.

2 In general, what do you say -- what are the subject
3 matters that you cover when you speak at these regional and
4 national lectures?

5 A They really are very varied. It depends on what
6 we're -- what I was asked to speak on. The topics run the
7 gambit, but generally, they have something to do with
8 either gynecologic oncology or gynecologic surgery with
9 avoiding post-op complications, typically.

10 Q I note here on this CV you must have -- I don't
11 know 30 references to being the principal investigator or
12 co-investigator involving certain clinical trials. In
13 general, what are you doing there with these clinical
14 trials?

15 A We're typically trying to find new and better ways
16 to treat various forms of gynecologic cancers, be it new
17 drugs that have been developed, so we're looking at them in
18 clinical trials to see if they're beneficial. That's
19 typically -- most of the clinical trials involve trying to
20 find new and better ways to treat random gynecologic
21 cancers.

22 Q I misspoke, Doctor, you probably have 50 -- maybe
23 40 or 50 references to you being the principal investigator
24 or co-principal investigator for these clinical trials.

25 Do you serve -- tell me what the position is --

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1 well let's talk a little bit about publications. What is
2 the significance or importance of physicians in your
3 position publishing what is commonly called peer-review
4 medical articles? What is that?

5 A So a peer-reviewed article is an article that you
6 would produce, that you would author and then rather than
7 just having it published without anybody looking at it --
8 it could be a horrible article, it could have a conclusion
9 that's not made from any sound science. We have developed
10 what are called peer-review systems where people that are
11 in your similar field will review your article, multiple
12 people often, and see if it had validity, that it has
13 worth, that it makes sense and then if it passes that
14 criteria -- and each journal that you would submit an
15 article to, to be published has a peer-review panel
16 typically if it's a peer-review journal. And if they think
17 the article has validity and worth and is well done and
18 well put together and the conclusions make sense; then they
19 will sometimes make suggestions about how to modify it
20 slightly for their journal then they will publish that
21 article.

22 That is a peer-review journal. And generally --
23 generally articles that are published in peer-review
24 journals have more merit or worth and their conclusions are
25 sounder than articles that are published just in any

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1 journal that doesn't have a review board that evaluates
2 them.

3 Q Do doctors in general consider it an honor to have
4 their research published after being reviewed by peers?

5 A It's better than having it rejected. (Laughter).

6 Q I note that you have numerous peer-review
7 publications; is that correct?

8 A I do.

9 Q Book chapters, I note that you have some book
10 chapters that you've written; is that correct?

11 A Yes, sir.

12 Q You provide web teaching services as well?

13 A Yes, sir.

14 Q You sit on editorial boards. A journal editorial
15 board member -- for example the clinics of North America
16 for the 2004 to present, 7 or 8 years, you've sat on that
17 particular editorial board. What is that in general?

18 A It's a book called the OBG Clinics of North America
19 and it's published 4 times a year and it is a journal that
20 picks a specific topic quarterly; and we'll 6, 7, 8, or 10
21 different articles relative to that particular topic that
22 were prepared by various authors and we'll put those top
23 picks together.

24 Let's say for example one quarter we report on
25 ovarian cancer. There would be 10 or 11 sections in

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1 this -- it's a hard-bound book actually that comes out
2 quarterly that are relative to that specific topic. And my
3 role is to help -- to review all of the particular articles
4 that go in each quarterly book and I develop what's called
5 a CME post-review test that the individuals throughout the
6 country can read that journal and would then take this test
7 and they have to make a certain score on this test -- which
8 tests their retention or their understanding of the
9 material in the book basically; and if they make a certain
10 score on that CME test, they get a certain number of
11 continuing medical education credits.

12 Q So you actually prepare the test that physicians
13 take to get credit for additional education?

14 A Correct.

15 Q I note here that you're a reviewer for several
16 medical journals, including for example, you mentioned --
17 for example the American Journal of Obstetrics and
18 Gynecology; another one Obstetrics and Gynecology; another
19 one Gynecologic Oncology; in general, what is a reviewer?

20 A So again the peer-review concept requires peers to
21 do the review. So many times a journal will select people
22 in a particular specialty and say would you be willing to
23 review articles that are submitted to your journal for
24 consideration for publication and give us your opinion of
25 that article and why you think it's good or bad.

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1 So then you as a peer reviewer for a journal will
2 be given articles that are submitted to that journal. I
3 will give my opinion about an article and send it back in
4 and they will typically have several individual reviewers
5 on a specific article; and then on the basis of all the
6 different opinions that come in about that article from the
7 various peers will make a decision as to whether or not
8 it's worthwhile to be published or not.

9 Q In your CV, Doctor, you note several references,
10 but -- in 2006, for example, you participated in a 54th
11 Annual Meeting of the American College of Obstetrics --
12 obstetricians and gynecologists post-graduate course. And
13 the name of that course that you taught was avoiding
14 complications in association with complex gynecological
15 surgical procedures, quote. Did, in fact, you give that
16 lecture?

17 A That was the actual theme of the entire
18 post-graduate course and I and 3 other gynecologic
19 oncologists provided that course twice each year for
20 approximately 5 years to members of the American College of
21 Obstetricians and Gynecologists. So the -- all of the
22 various lectures that were given during the course of that
23 3-day-course address the general topic of aborting or
24 managing gynecologic complications from gynecological
25 surgical procedures.

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1 So I think there were a total of probably 16
2 lectures that were given, all focused on that specific area
3 of education.

4 Q One particular topic is, quote, the surgical
5 management of adnexal mass, quote. That's what Faye had,
6 isn't it?

7 A She did.

8 Q You taught that course in Washington D. C.?

9 A I did.

10 Q And Kingston, Jamaica?

11 A I did.

12 Q Dana Point, California?

13 A Yes.

14 Q San Francisco, California?

15 A Yes.

16 Q In fact, there was a meeting in South Carolina in
17 2004 -- the 19th Annual Meeting of the MidAtlantic
18 Gynecologic Oncology Society, held in Charleston, South
19 Carolina. You were the scientific program director,
20 weren't you?

21 A I was.

22 Q Dr. Irvin, do you feel comfortable, based upon
23 your education, training, and experience, in providing
24 information to this jury of what Dr. Williams was required
25 to do under the standard of care?

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1 A I do.

2 Q Are you familiar with that?

3 A Yes.

4 Q You feel comfortable?

5 A I can.

6 **MR. CORBIN:** Your Honor, at this time, we'd submit
7 Dr. William Irvin to the Court to be accepted as an expert
8 in the field of gynecologic oncology, with a special
9 reference to the issues in this case involving the surgical
10 treatment of Ms. Atkinson.

11 **THE COURT:** Mr. McDow, any questions or objections?

12 **MR. MCDOW:** No questions or objections.

13 **THE COURT:** All right. Ladies and gentlemen, as I
14 mentioned to you yesterday, if someone is qualified as an
15 expert in a particular art, science, or profession, that
16 does not mean that you have to accept the expert's
17 testimony. You weigh it as you would the testimony of any
18 other witness.

19 This witness is qualified as an expert in the field
20 of gynecologic oncology and also in the field of -- I guess
21 it would be Mr. Corbin, surgical intervention in that area?

22 **MR. CORBIN:** Yes, sir.

23 **THE COURT:** All right.

24 **MR. CORBIN:** Thank you, Judge.

25 **THE COURT:** Okay. You can continue.

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1 **MR. CORBIN:** Thank you.

2 **BY MR. CORBIN:**

3 **Q** Dr. Irvin, have you had an opportunity to review
4 Faye Atkinson's hospital records when she was under Dr.
5 Williams' care starting in April 2007 until she was
6 discharged sometime in July of 2007?

7 **A** I have.

8 **Q** Have you, in addition, reviewed other medical
9 records involving Ms. Atkinson, involving her subsequent
10 treatment and have you reviewed lots of records involving
11 Ms. Atkinson?

12 **A** Yes, I have.

13 **Q** Dr. Irvin, please tell us, in your opinion, based
14 upon a reasonable degree of medical certainty whether Dr.
15 Williams properly managed Faye Atkinson when she was in the
16 hospital?

17 **A** I do not believe he did, no.

18 **Q** When I ask for your opinions any time during this
19 examination or even on cross-examination, would you base
20 your opinions upon a reasonable degree of medical
21 certainty? Will you do that, please?

22 **A** Yes.

23 **Q** Doctor, tell the jury what your opinions are
24 involving Dr. Williams' care?

25 **A** It can be a relative lengthy diatribe, but I can

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1 begin. You want me to just kind of go -- or is there a
2 specific question you would like for me to answer?

3 Q Yes, sir, if we may, if we could start with --
4 well, the first surgery.

5 A So I think Ms. Atkinson came to see Dr. Williams, I
6 think on referral from her primary care physician, Dr.
7 Reynolds, ultimately for evaluation of an enlarged and
8 suspicious right adnexal mass. When you say adnexal, it
9 typically refers to the ovarian area in the pelvis, the
10 ovaries, fallopian tube, the adnexal. So she had, roughly
11 a 13 centimeter mass in the right side of the pelvis that
12 was suspicious for being a neo plasma. Dr. Williams
13 explained to Ms. Atkinson that he thought it was important
14 to go in and surgically take that out.

15 Now, Ms. Atkinson had a relatively complicated
16 surgical issues. She had surgeries in the 1990's. She had
17 bowel resections performed; and as we discussed, whenever
18 you have surgical procedures performed, you develop
19 adhesions. So subsequent surgeries can be more difficult
20 to close those adhesions. And so there was a very high
21 likelihood that Dr. Williams would encounter a significant
22 amount of adhesions when he went in to operate on
23 Ms. Atkinson to remove this mass.

24 Now, I had suggested the possibility upon my review
25 that I didn't see anywhere that Dr. Williams discussed with

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1 Ms. Atkinson the possibility of not resecting the mass.
2 One in ten women in their lifetime, one in ten, 10 percent
3 will develop benign tumors of the ovary. They are not
4 cancerous, they will not become cancerous. Once they begin
5 as benign, they remain benign. So one in ten women, it's
6 relatively common, actually. Only roughly 1.4 or 1.5 of
7 100 women will develop cancer of the ovary in their
8 lifetime. So it's much less likely that a mass in the
9 ovary will be malignant than benign.

10 We have an ability through radiographic studies,
11 through ultrasounds, that help us to look at the adnexal
12 mass and describe the adnexal mass to see if it had
13 characteristics that are a look and see. We have other
14 studies known as flow studies, doppler flow studies that we
15 can do at the time of the ultrasound. We can draw up blood
16 work to see if ovarian cancer tumor markers were elevated.
17 There are many things that we can do to evaluate a mass
18 before we go in and surgically take it out, in order to see
19 if you think this is going to be a malignant or a benign
20 mass.

21 None of those were done with Ms. Atkinson and I
22 think we could assume more likely than not that they may
23 have suggested this to be a benign process because it
24 ultimately was a benign process. There was a benign serous
25 adenoma, which is the most common benign gynecologic tumor

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1 in post menopausal women. So it would have been nice if we
2 could at least at that point for her to have the option to
3 say, Huh, it looks kind of benign, you think it may not be
4 malignant -- you've had a lot of prior surgery, let's
5 follow this.

6 I have many, many people in my practice that I
7 follow ovarian cysts or ovarian masses. Once we see that
8 they're benign, we repeat the ultrasound 3 months later and
9 then 6 months, 6 months and 6 months. So for 2 years we
10 look at this mass and if it doesn't change in any
11 significant way, we don't operate on it. We just follow
12 them. Once a year we'll get a repeat ultrasound. And so
13 many women that either medically infirm, that are not good
14 surgical candidates or don't want to have surgery done,
15 don't have to do that. And so that would have been, I
16 think, an option to at least pursued at that point, which I
17 don't think was offered to Ms. Atkinson.

18 Q Dr. Irvin, if I may, please. Assume that -- not
19 Dr. Williams but McClain, the local gynecologist had done
20 what is called a CA-125 study and it came back at a four.
21 Assume further that, not Dr. Williams, but the local doctor
22 in Hartsville had done an ultrasound and it came back
23 probably not cancerous, do you think Dr. Williams had an
24 obligation under the standard of care to tell Ms. Atkinson
25 the CA-125 indicates it's probably not cancer, the

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1 ultrasound indicates probably not cancer? Should she have
2 known that?

3 A If she was not aware of that and Dr. Williams was
4 aware of that, I think that as part of an informed consent,
5 you explain to people your best knowledge of the situation
6 at that moment in time to allow them to make an educated
7 decision about what they want to do. And in Dr. Williams
8 defense, CA-125 will not be elevated in 50 percent of --
9 one-half of women have stage 1 ovarian cancer, so it
10 doesn't completely rule it out, but at the same time, the
11 ultrasound information is much more telling in terms of
12 trying to determine on the basis of the known morphologic:
13 How thick are the walls of the mass? What's inside of the
14 mass? How big is the mass? Does it have flow going
15 through it versus not having flow? So there are many
16 things we look at that helps get a really good
17 impression -- actually we can use morphologic index scoring
18 system that give us a number, actual number, an objective
19 number to know whether it's benign or malignant.

20 Now, the CA-125 didn't completely rule it out, but
21 I think she had the right to know all of the information
22 that Dr. Williams knew so that she could make an educated
23 choice at the time that she was considering going to the
24 operating room.

25 Q And, in fact, when Dr. Williams removed the

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1 masses, were they cancerous?

2 A They were benign.

3 Q Not cancer?

4 A Not cancer. They were common benign ovarian
5 masses.

6 Q Dr. Irvin, do you believe that Dr. Williams needed
7 to do what the medical records indicated as a complete
8 lysis of adhesions on top and the bottom to gain access to
9 her ovaries?

10 A So the question being kind of -- Dr. Williams did a
11 very long period of lysis adhesions, several hours in her
12 initial surgical procedure to resect her ovaries.

13 Now, having not been there, I can't comment on
14 exactly where the adhesions were or weren't, but there's
15 always the option if it is possible, to leave the adhesions
16 present that are there because Ms. Atkinson was not
17 complaining of obstructive stomach. She wasn't having
18 nausea or vomiting. She wasn't complaining of a symptom
19 that would suggest that her adhesions were causing problems
20 in her bowel. So there's always the option, if possible to
21 leave the adhesions there that were there. We don't need
22 the separate all the bowels one from another and get all 21
23 feet unadhesed, but rather just take down the portion
24 that's needed to expose the ovary and the pelvis and remove
25 that ovary and find that it's malignant or benign. So I

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1 don't really know what Dr. Williams found. Only he would
2 know what they looked like. But that would have been an
3 option if all of the adhesions had not been focalized into
4 the pelvis. They were never ever -- I would have just gone
5 into the pelvis and did what you had to do and gotten out
6 of there.

7 Q If we could talk about the actual first operation.
8 Describe to the jury your opinions as to whether or not Dr.
9 Williams met the standard of care during the first
10 operative procedure.

11 A I think doctor -- again, not having been in the
12 surgery, I can't comment if all of the adhesions had been
13 localized in the upper abdomen, there were not significant
14 amount in the pelvis or the left-upper abdomen leave it
15 alone. It sounds like he spent a long amount of time
16 taking those adhesions apart. But I think his management
17 was not to be surprised from the standpoint when he first
18 made the abdominal incision, he made an enterotomy. An
19 enterotomy is making a whole in the bowel, not meaning to.

20 Well, she had a lot of adhesions from her prior
21 surgery. One of those adhesions caused the bowel to stick
22 to the anterior abdominal wall. So the first thing you
23 find out when you go in, boom you've got a piece of bowel
24 that's now stuck to the abdominal wall. It shouldn't be
25 stuck there, normally, with normal patients. After

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1 surgical procedures, you do develop those kinds of
2 adhesions. So immediately he had an issue of trying to get
3 into the abdominal pelvis. He was able to ultimately get
4 in. He spent a very long period of time, several hours,
5 separating bowel from bowel. Sometimes that can be done
6 gently with your hands, sometimes it requires scissors to
7 separate the bowel, sometimes it require what we call bogie
8 carving (phonetic), an electrical unit to separate the
9 bowel.

10 He spent a very long period of time separating all
11 these adhesions and then ultimately went into the pelvis
12 and took both ovaries, the right and the left, and both
13 ended up having benign tumors in them. The right roughly
14 13 centimeters, the left roughly 6 centimeters. The area
15 of bowel that had been injured when he went in, he resected
16 that piece of bowel, which means if you've got 21 feet of
17 bowel and you've got a hole in part of it, you cut just
18 above the hole and just below the hole, take out whatever
19 portion of bowel is required, and then remove that.

20 Now, in the initial surgery, I think Dr. Williams
21 had such a difficult time getting all these adhesions taken
22 down and there are so many potential areas of injury to the
23 bowel in doing that -- again you're taking scissors to cut
24 the bowel apart, you're doing -- you can injure the bowel
25 actually trying to separate it. Sometimes it's difficult

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1 to avoid that. He ended up taking out a large portion of
2 the bowels, he described as feet of bowels. We don't know
3 exactly how many feet it was because that segment one
4 percent bowel -- we don't know how much was taken out. But
5 by his definition, it was so difficult getting to where he
6 wanted to be, he ended up injuring enough bowel, he had to
7 take out several feet of injured bowel and then what was
8 left behind, sew the two ends back together and restore her
9 continuity.

10 Q Is it a big deal that a patient has feet of bowel
11 removed and it never gets to pathology?

12 A Typically, when you remove something from a
13 patient, you will send that to a pathologist to have that
14 specimen evaluated, find out what it is or what's unique
15 about it, what's injured and what's damaged about it. When
16 you remove a large portion of bowel, it would have been
17 nice to have a pathologist say, Yes, there were multiple
18 holes in this bowel or it was ischemic or something about
19 it that required it to be removed. So it is typical that
20 you will send specimens that you remove to a pathologist.

21 Q Did you see any evidence at all in the medical
22 records of Dr. Williams sending feet of bowel after that
23 first surgical procedure to pathology?

24 A No.

25 Q Did you see anything at all in the medical

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1 records -- if Dr. Williams did send feet of bowel to
2 pathology and somehow it was missing, did you see anything
3 in the medical records at all about Dr. Williams perhaps
4 complaining or asking pathology what happened to my
5 patient's bowel?

6 A No.

7 Q No concern?

8 A I saw no record of that.

9 Q Dr. Williams (sic), did you review his sworn
10 deposition testimony?

11 A I did.

12 Q After doing this extensive lysis procedure, can
13 you describe to the jury what running the bowel -- he
14 indicates that he removed adhesions running the bowel from
15 the Ligament of Treitz all the way down to the terminal
16 ileum. The -- where is the Ligament of Treitz?

17 A So when you -- when you eat food, it goes from your
18 mouth to the esophagus into the stomach. Then empties from
19 the stomach into the small bowel and there are 3 components
20 of small bowel. The first of all is the duodenum, it's
21 about 3 to four feet long and it's hidden behind a sheet of
22 peritoneum. Then the duodenum exits behind -- in your
23 posterior abdominal wall, that then exits into the
24 abdominal cavity, roughly just below the stomach, comes out
25 into the abdominal cavity at the now jejunum, what we've

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1 come to know as the jejunum. And it's attached at that
2 point to the posterior abdominal wall by a ligament called
3 the ligament of the duodenum or the Ligament of Treitz is
4 what it's called.

5 And then the duodenum will run for several feet and
6 then will come to the ilium. The ilium is the third part
7 of the small bowel. So collectively, the duodenum, the
8 jejunum and the ilium make up roughly 21 feet of small
9 bowel and each has a different function. Most of your
10 nutrients are absorbed through the jejunum. The ilium
11 absorbs, vitamin K. And other substances and then
12 ultimately whatever gets to the end of the ilium is stuff
13 the body can't use and it then goes into the colon. Most
14 of it's liquid at that point. The purpose of the colon is
15 to absorb the fluid from that liquid and make it into
16 something solid. So the small bowel runs from the Ligament
17 of Treitz all the way down to what's called the ileo seal
18 bowel. It's where the ilium empties into the colon, the
19 part known as the secum.

20 So at the end of a surgical procedure that's been
21 very difficult and you're concerned that there may be some
22 injuries to the small bowel that you may not have
23 recognized when you were doing the surgery, you would, at
24 the end of the surgery, run that ligament or run that
25 section of bowel from the very beginning, the Ligament of

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1 Treitz, just below the stomach to the very end where it
2 empties into the secum. That's called running the bowel.
3 And if you find an injury that you hadn't noted that you
4 had done, you can fix it at that time.

5 Q The ways that you can repair -- if you put a hole
6 in the patient's small bowel, what are the ways to repair
7 it? We've been told about sewing or actually cutting out.
8 Explain the difference between those two techniques,
9 please.

10 A If the incision -- if the hole in the small bowel
11 is small but it was made by scissors or a knife and not by
12 cauterization, you didn't burn the hole -- if it's a small
13 hole and you can close it easy without narrowing the lumen
14 of the small bowel, without making it so narrow the stuff
15 won't come through, then you would use sutures and you
16 would sew that hole together. There's a specific technique
17 of how to do it, but you can just sew it back together.

18 Now, if you had injured that small bowel using a
19 boli coli and burned a portion of the bowel, you really
20 can't tell looking at it at that moment how bad that injury
21 is going to be two or three to four to five days later
22 because that burn injury spreads. So the setting of a burn
23 injury or if that hole is so big you can't close it without
24 really compromising that segment of bowel, you would cut
25 the whole piece of bowel out. You would take out a piece

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1 of that garden hose and then you would sew the two ends
2 back together.

3 Q Dr. Irvin, in Faye's case, the missing bowel, when
4 Dr. Williams takes out feet of bowel, if the hole was too
5 large that it required him to take out feet of bowel, could
6 pathology tell us that if they got it?

7 A They could.

8 Q If Dr. Williams, during this surgical procedure
9 where the bowel is missing, if he caused numerous holes in
10 the bowel and had to resect feet of bowel, if that bowel
11 would have ended up in pathology, if somebody had made
12 certain it got there, could they tell us how many holes he
13 put in that feet of bowel?

14 MR. MCDOW: We would object, Your Honor, that calls
15 for speculation at this point and lack of foundation.

16 THE COURT: All right. Overruled.

17 BY MR. CORBIN:

18 Q Dr. Irvin, after the first surgery, do you recall
19 reading anything about Dr. Williams' calculation since he
20 was in her abdomen -- what her risk was of having a bowel
21 leak after the first surgery?

22 A I think in his deposition, he had felt that the
23 risk of her having a possible bowel leak was in the range
24 of 30 to 50 percent.

25 Q Coin flip? 50 percent?

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1 A (Witness nodded head.)

2 Q How does that affect at all the management of Faye
3 if the doctor has removed a large portion of bowel and he
4 knows this patient could have as much as a coin flip risk
5 of a leak, how does that affect his post operative
6 management under the standard of care?

7 A You would have a very high level of suspicion for a
8 patient that presented in any fashion post operatively that
9 might suggest that she had a bowel leak. In a case in
10 which you think the risk of leak is low and you would
11 think, well -- because there are often other things to
12 explain why a person may present in a certain way post
13 operatively, why they may have fever, why might they have
14 abdominal pain, why they might have abdominal distension.
15 I mean, there are things -- many different things,
16 differentials for that. But if you know how hard that
17 surgery was that you just did, if you know how much bowel
18 you took out, if you knew all the lysis that you did, the
19 potential that there may be a hole in the bowel left behind
20 that you didn't recognize -- that was just such a difficult
21 dissection, then your level of suspicion is going to be
22 much higher if someone has any of those things: Abdominal
23 distension, nausea, vomiting, fever, pain. All of those
24 could be symptoms of bowel leakage.

25 Q Doctor --

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1 A So you're just more vigilant of that as a
2 possibility post operatively.

3 Q How dangerous is a bowel leak?

4 A So the bowel contains contents that are meant to
5 stay in the bowel. The farther you get through the small
6 bowel and the closer you get into the colon, the more the
7 bacterial content in that liquid increases.

8 Now, if that material leaks into the abdomen or the
9 pelvis, that bacteria can cause an infection, abscess. The
10 patient can get very ill and if left untreated, the
11 bacteria and the infection that results from the spilling
12 of this material, really is stool that is picking -- that
13 bacteria can get into the bloodstream, the patient then
14 becomes septic and if they become septic then sometimes the
15 major organs will eventually start to shut down and they
16 will die. So that can be a very serious issue.

17 Q In your view of Dr. Williams' medical records, do
18 you see any evidence at all, him knowing 50 percent chance
19 of a bowel leak that could be deadly, that his -- that he
20 had any high intention of suspicion to rule it out?

21 A I think that there were several points in the very
22 early post operative course where Ms. Atkinson was
23 presenting in a way that would have me very concerned about
24 the possibility of a bowel perforation and I didn't see
25 what we consider to be the appropriate test ordered to rule

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1 that out. Because had that been done, had she had a bowel
2 perforation, it could have been detected relatively early
3 had those tests been ordered.

4 Q Did you see any proof that he had any suspicion,
5 not a high index of suspicion like you say he should have
6 had under the standard of care, but any suspicion of a
7 perforation that he acted upon?

8 A I mean, I can't know what was in his mind, but I
9 can only say that on how she was presenting on the first
10 seven to ten days post operatively, very concerning in my
11 mind for a bowel perforation. I didn't see any of the
12 appropriate gold-standard tests ordered to see if that, in
13 fact, was going on. So I didn't see that he did anything
14 to try and see if that was the case. I mean, abdominal
15 films were obtained and they suggested that she might have
16 a bowel obstruction. We can't really diagnose that
17 definitively on just an x-ray of the abdomen. A CAT scan
18 where you inject dye go through the vein and you swallow
19 dye, I then look on a picture and see where all that dye
20 goes and if you're worried about a -- if you're worried
21 about a perforation, that dye leaks out of the bowel, so
22 you'll get a picture on the CAT scan of dye going through
23 the bowel and boom, right here there's dye extravasating
24 out of the bowel and the pelvis and confirm that they have
25 a bowel perforation. And also, I mean, an abdominal film

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1 won't clearly tell you that they have an obstruction. It
2 may suggest that the bowel is obstructed. That means
3 something mechanically has kinked off, but a post
4 operative, sleepy bowel called an ileus will look similar
5 to that on an x-ray. A CAT scan would actually show you
6 that there is a place where the dye won't go through that
7 bowel where it's actually mechanically obstructed or if the
8 dye goes through but really slow, suggests the sleepy
9 bowel. So a CAT scan would have been an important test to
10 order, to have ruled out either of those issues.

11 Q If a doctor in Dr. Williams' position with a
12 patient like Faye has a suspicion there's a bowel leak,
13 what is the appropriate standard test to rule out a bowel
14 leak?

15 A A CAT scan for the very reason we just talked
16 about. There's really no other test that will clearly tell
17 you if she has a bowel perforation or not.

18 Q If someone were to say that doctors who are
19 gynecological oncologists do CT scans by the wheelbarrow
20 full, would you agree to protect their patients?

21 A We order them frequently, yes.

22 Q Tell the jury how many CT scans Dr. Williams
23 ordered of Faye between the first and second surgeries,
24 which was about 33 days. How many CT scans did he order?

25 A None.

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1 Q Dr. Irvin, if Dr. Williams would have had that
2 index of suspicion about a bowel perforation and would have
3 done what you say under the standard of care was required,
4 do a CT scan, do you have an opinion based upon a
5 reasonable degree of medical certainty, with that CT scan,
6 we probably would have seen the perforation?

7 A It's my opinion that he would have, yes.

8 Q You mentioned that you had concerns about Dr.
9 Williams' post surgical treatment of Ms. Atkinson right
10 after the first surgery all the way up to 33 days when he
11 did the second surgery. Tell the jury what Dr. Williams,
12 under the standard of care, was required to do during those
13 33 days and he failed to do.

14 A Well, I'll begin by saying, when somebody has a
15 surgical procedure done, over the course of a week or so
16 after that procedure they should gradually get better. In
17 the first 24 to 48 hours, they could have problems with
18 ileus and that sleepy bowel. You could have a low grade
19 fever from a condition called add atelectasis. You could
20 have pain of the abdominal wall, depending on how big the
21 incision is. So all of those are normal things for people
22 to complain of in the first one to two days after a
23 surgical procedure. But how you know that someone is
24 healing appropriately is they should get gradually better
25 over the next five to seven days, to the extent that they

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1 typically go home after five to seven days from a major
2 surgical procedure.

3 Now, Ms. Atkinson was not getting better. She was
4 complaining of nausea, vomiting. She was complaining on
5 persistent abdominal pain, despite having narcotics that
6 she was getting on a regular basis. She had abdominal
7 distension; she had abdominal films that were obtained on
8 post-operative day No. 7 that suggested ileus versus
9 obstruction. Post-operative day No. 8, they actually did
10 suggest obstruction. She was having foul-smelling drainage
11 from her wound, which is markedly abnormal. Post-operative
12 day No. 2, she had green, brown, foul-smelling drainage
13 coming from her wound. That's not normal. She continued
14 to have drainage on post-operative day six, seven, eight
15 and nine. So we're now in the second week after her
16 surgery. What would cause that kind of drainage? One
17 thing that has to be in the back of your mind, she could
18 have a hole in her bowel and if she does have a hole, then
19 this kind of greenish, brownish liquid, which is what small
20 bowel contents look like is draining out of that hole into
21 the abdomen. It can work its way up to the abdominal wall
22 where you had made that incision and be leaking out and
23 could be leaking out of that incision. Sometimes the bowel
24 will actually stick to the abdominal wall where you sewed
25 it shut and will leak directly into an incision hole called

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1 a fistula.

2 So you don't really know what's going on, but in
3 somebody you know you've got a 30 to 50 percent suspicion
4 that they're going to develop a leak post operatively, that
5 is developing this four-smelling drainage and discharge for
6 several days then that's bound to suggest obstruction that
7 has pain, that it's distension -- all of these things would
8 have me extremely worried. She's not going in the right
9 direction. And you've got to figure out, okay, what's
10 going on. What's on your differential diagnosis? Well,
11 she could have a bowel obstruction. That's what the KUB,
12 the x-ray suggests. It can't definitively tell you that, a
13 CT could tell you that. She could have a bowel
14 perforation, I'm worried about that because that's a -- a
15 very difficult surgical procedure, and I've got a one in
16 two chance in my mind that may develop a leak somewhere
17 after that, 50 percent chance.

18 So she had a perforation. How do you determine
19 that? You get a CAT scan. You just order a CAT scan.
20 It's not a hard thing to do. And that CAT scan early on
21 could have helped give him the answer of what she had, was
22 she leaking or was she dying. Did she have an obstruction?
23 It would have given information you needed to then direct
24 the rest of her post operative care.

25 Now, without that CAT scan, you're just shooting in

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1 the dark. You're hoping she doesn't have a perforation.
2 You're hoping she doesn't have an obstruction. You just
3 don't know. So I think that should have been ordered very
4 early in the course of her post-operative management to try
5 to -- to sort out that in his mind, why isn't she getting
6 any better. Clearly something's wrong. Folks get better,
7 you should get better. She's not getting better. In fact,
8 she's stayed worse for a month. So something was going on
9 and short of just getting an abdominal x-ray, I didn't see
10 any other intervention at all. I mean the material that
11 was leaking from the wound, it would have been very easy to
12 collect a little bit of that and just have a lab look at it
13 and see what's in it.

14 Q Did he do that during those 32 or 33 days -- well
15 we're going to go over the numbers of yellow, thick, brown,
16 foul-smelling, purulent wound drainage. Tell this jury how
17 many times he took a little swab of that and sent it to the
18 laboratory to have a culture to tell him what's going on
19 with this wound?

20 A He didn't do it at all.

21 Q Not a single?

22 A So that laboratory evaluation, which is a very
23 benign convention, is to collect a little bit of the fluid,
24 send it to the lab. They can tell you if there is bacteria
25 in that and there's a specific bacteria that is unique to

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1 the bowel, e coli among others. So it can kind of tell you
2 that she may have had according organisms that you
3 typically find inside is lumina bowel in this liquid. So
4 that's going to make it kind of suspicious that something
5 is leaking out -- so that there are a variety of different
6 things that could have been done, some very simple, some a
7 little bit more involved, CAT scan, but not horribly
8 involved to figure out what was going on and none of that
9 was done. The only thing that was done was just repeated
10 x-rays.

11 Q How simple is it -- talk about simple things. You
12 talked about a culture, number one. You talked about the
13 CT scan, number one. How simple is an NG tube
14 decompression procedure? How simple is that.

15 A It's very -- it's minimally uncomfortable for the
16 patient to put it in, but once it's in, they typically say
17 they feel much better because all of that liquid and all of
18 that gas that your swallowing that can't get past the
19 obstruction or the ileus, whatever you have, causes you to
20 get distended, causes pain, causes nausea, and you're
21 vomiting it up. When you put that tube in and up suck all
22 that stuff out and they go, God, I feel so much better.
23 With all that liquid that their vomiting it up, you're now
24 sucking it up, so they don't have to throw it up anymore.
25 So typically they report being much more comfortable once

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1 the tube is placed.

2 Q The NG tube in Faye Atkinson's particular
3 situation, the 32 or 33 days between surgeries, Doctor, do
4 you have an opinion based upon a reasonable degree of
5 medical certainty, if Dr. Williams would have inserted this
6 simple NG tube, would it have provided her with relief from
7 distension, the swollen belly?

8 A It would have.

9 Q Would it have provided Faye with relief from
10 persistent nausea and vomiting?

11 A And the reason for that is, again, as we mentioned,
12 if you have an obstruction or if the bowel is not moving
13 things through, everything you're swallowing, all the air
14 you're swallowing, all that's going through to a certain
15 but like a clogged drain. It can't get past that point so
16 the bowel starts to fill up. It fills up and it starts to
17 back up toward your stomach.

18 So that's what you get the abdominal distension
19 from. And then there's a trigger in your brain that sends
20 a signal through the vagus nerve to the stomach that says,
21 vomit this stuff out because that's the only way I can get
22 it out of the body.

23 All right. So then you vomit and you throw all
24 that stuff up and then you feel good for a period of time
25 until all of that fluid collects again and then you throw

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1 it up again. So the repetitive vomiting is suggestive of a
2 bowel obstruction or ileus. So typically if you think
3 somebody has a bowel obstruction, the general management of
4 that is, don't give anymore food. Why be putting fuel on
5 the fire? Don't give them any food. Oftentimes we will
6 give them some liquid nutrition to try and support their
7 body because they're not really taking in nutrients because
8 you're not allowing them to eat. And you put that NG tube
9 in. The NG tube is put in at the bedside. It's a little
10 pliable, soft plastic tube you push through the nose. It
11 goes down into the stomach and it's hooked up to a suction
12 pump on the wall and that suction pump sucks all that fluid
13 out of the stomach so it doesn't get distended and they
14 throw up. Another advantage of the NG tube to some degree,
15 if you can prevent all that fluid from distending the
16 bowel, particularly if you have an area of anastomosis,
17 where you've sewn two pieces of bowel together, you prevent
18 putting tension on that anastomosis from this fluid
19 dilating and potentially disrupting that anastomosis.

20 So in this setting, I think the NG tube could have
21 A, made her feel much better acutely; and B, potentially
22 could have protected that anastomosis that Dr. Williams did
23 when he took all that bowel and sewed the two ends back
24 together.

25 Q Dr. Irvin, you told the jury that Dr. Williams

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1 knew that Faye had as much as a 50 percent chance of a
2 bowel leak. How does that plug in that -- given that fact
3 that he knew that, that then he allowed 30 separate days,
4 27 consecutive days in a row of abdominal distension. Does
5 that comport with the standard of care?

6 A No.

7 Q If I have -- well, let's talk about Faye. Faye,
8 assume that she was complaining, you're not a medical
9 doctor. She was asking for help. I'm asking for help, my
10 belly is feeling full. I've got the horrible nausea and
11 vomiting, sometimes it's the most foul smelling, worst in
12 the world, what is the simple way to treat about what she's
13 complaining?

14 MR. MCDOW: Your Honor, I'm going to object to the
15 testifying nature of the question.

16 THE COURT: You can rephrase the question.
17 Objection is sustained.

18 BY MR. CORBIN:

19 Q If a patient -- if Faye was complaining about
20 belly being full, nausea and vomiting, what's the
21 appropriate medical treatment for those conditions?

22 MR. MCDOW: Same objection.

23 THE COURT: That's overruled.

24 MR. MCDOW: Okay.

25 ///

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1 BY MR. CORBIN:

2 Q What's the appropriate treatment for those
3 conditions, please?

4 A Put an NG tube in place and suck all that material
5 out. That will make her abdominal distension get better.
6 That will make her nausea get better. That will make her
7 more comfortable from the standpoint of the distension. To
8 stop her from eating and drinking, so nothing by mouth; and
9 provide some form of nutrition for her during the period of
10 time that you're waiting for whatever this issue is to
11 either get better on it's on or if not, then to go
12 surgically correct it.

13 Typically, if you think somebody has a bowel
14 obstruction, it's NPO, give nothing by mouth; NG tube for
15 patient's comfort and to prevent distension of the bowel;
16 and the nutrition, those are kind of the triad for the
17 management of suspected bowel obstruction.

18 Q Exhibit No. 5, which is the summary of the abdomen
19 distension for Faye, I just want to read you one reference.

20 THE COURT: Is that in?

21 MR. CORBIN: Yes, sir, it's in without objection.

22 THE COURT: No. 5 is in?

23 MR. CORBIN: Yes, sir.

24 BY MR. CORBIN:

25 Q One reference on post-operative day 9, May 4th,

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1 the reference in the medical records is that Faye had
2 abdominal -- abdomen distended and firm. Then she had to
3 be diapered for diarrhea. Is that some kind of warning
4 flag or red flag involving her care?

5 A I think that the red flag to me, the initial 10
6 post-operative days were persistent abdominal distension,
7 persistent pain despite any use of narcotics. Fever,
8 tachycardia, nausea, vomiting, they were all red flags
9 because they persisted. If they were part of normal post
10 operative recovery, they should have either not been there
11 or should have resolved within 48 to 72 hours. They all
12 persisted. And in fact, may have gotten slightly worse
13 from the standpoint of her nausea and vomiting. So they
14 would all be red flags because they all could be suggestive
15 of a bowel perforation. And that's high in my mind
16 according to Dr. Williams of something that could occur
17 post operatively.

18 And that is a condition that if not recognized and
19 not treated, can ultimately result in a patient's death and
20 has resulted in a patient's death. So that would be
21 something you would have to really be thinking to yourself,
22 I'm worried about this possibility. This is worsening,
23 this doesn't make sense. I don't quite know what's going
24 on. I need to figure this out better. And a CAT scan
25 would have been something that would have allowed him to

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1 figure that out.

2 Q Did you see any proof in the medical records of
3 Dr. Williams that he considered the 27 days of distension
4 to be any kind of red flag warning to him?

5 A No, I did not.

6 Q What is feculent vomiting?

7 A Feculent vomiting is vomiting that smells like
8 feces, smell like stool. And generally that can occur if
9 you have an obstruction for whatever reason, the liquid
10 that's being obstructed, bacterial, the bacteria in that
11 liquid can start to grow and proliferate. As that bacteria
12 grows and proliferates, it can give foul smells to that
13 vomit and so feculent vomiting is vomit that smells exactly
14 like stool. And it is almost invariably consistent with a
15 bowel obstruction.

16 Q Did she have feculent vomiting?

17 A She did.

18 Q The nurses reference it, didn't they?

19 A They did.

20 Q Did the feculent vomiting, based on your review of
21 Dr. Williams' records change his course of treatment in any
22 way with respect to Faye?

23 A Not that I saw.

24 Q The nausea and vomiting, Plaintiff's Exhibit 4,
25 which is a summary of 2000 records, it states at least --

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1 Faye had at least 65 episodes on at least 25 separate days,
2 despite nausea medication every day. Do you see any
3 evidence at all that Dr. Williams considered these 65
4 episodes of nausea and vomiting, sometimes feculent, as
5 maybe some kind of warning sign to him, perhaps I need to
6 do a CT scan?

-3 7 A He never ordered a CT scan.

8 Q Did you see any evidence of Dr. Williams, the 65
9 episodes of vomit, sometimes feculent, that prompted him to
10 change his course of treatment and perhaps give her an NG
11 tube to relieve her symptoms?

12 A She did not receive an NG tube until, I believe,
13 the day prior to her second surgical procedure, which would
14 be post-operative day No. 32.

15 Q Thirty-two days. And thirty-two days into the
16 nausea and vomiting, she did get an NG tube. Was it
17 effective?

18 A Yes. She was greatly relieved of her distension
19 and her nausea, as they're designed to do.

20 Q Do you have an opinion based on a reasonable
21 degree of medical certainty, if Dr. Williams had not have
22 waited 32 days to treat the nausea and vomiting, would her
23 symptoms have been relieved lots earlier?

24 A I think her symptoms would have been improved from
25 the standpoint of the obstructive process from the minute

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1 she had the NG tube put in.

2 Q Did you see any evidence in the medical records
3 involving Dr. Williams when he did insert the NG tube
4 post-operative day 32, the day before the second surgery,
5 that when all this green and brown stuff came out of her
6 abdomen provided her with relief, did it change his course
7 of conduct or treatment of her in any way?

8 A I got the impression he had planned to take her to
9 the operating room the next day and that was still his
10 plan. He did not change that plan on the basis of her
11 relief from the placing of the NG tube.

12 Q He carried out his plan to do surgery the next
13 day, didn't he?

14 A Yes.

15 Q Wound drainage, under the standard of care, do you
16 have an opinion as to whether or not Dr. Williams should
17 have considered wound drainage as a red flag in treating
18 Faye Atkinson?

19 A I think he definitely should have. In this
20 particular instance, definitely.

21 Q Do you see any evidence in the records that
22 despite the twenty-eight days of yellow or purulent
23 drainage coming from her wounds, it changed his course of
24 /TREPLT of her in any way?

25 A I didn't. And the point I think to make is it's

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1 just not normal to have that type of drainage post
2 operatively. Occasionally maybe in the morbid obese
3 patients, you can get serous drainage in the lymphatic
4 channel if you cut through that big, thick, abdominal wall,
5 it will drain into the wound and you get clear, yellow
6 liquid that can sometimes drain out. Ms. Atkinson was not
7 a morbidly obese patient and you're worried that she's
8 going to have a bowel leak post operatively from all that
9 resection you just did. It's really high in your mind, she
10 may develop a leak either from where I sewed her back
11 together or I may have made a hole somewhere else with all
12 that resection that I didn't recognize and she could leak
13 from that. What would the leak look like? It's going to
14 be green and brown. It's going to be foul smelling. So
15 post-op day No. 2, she has green, brown, four-smelling
16 drainage from her wound. I would be really worried. I
17 mean that 's not normal. She shouldn't be doing that. So
18 he could have cultured that at that point to see what's in
19 that liquid. Could have considered potentially at a later
20 point, maybe opening just the top of the wound and see if
21 this is coming from the incision, is this bowel content
22 that we call succus. Then on post-operative day 6, 7, 8
23 and 9, she also continued to have kind of a purulent
24 four-smelling drainage from the wound.

25 So again, all of those are not normal. So you have

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- 1 to in your mind come up with an idea, what is going on.
2 What's my differential here? Why is she having this? And
3 you've got to kind of check them off. If they're all
4 incidental to the -- it doesn't matter what kind of order
5 you go through, but if one of them is that she's got a hole
6 in her bowel and I'm thinking that it's a possibility she's
7 got a hole in her bowel, I need to know that because she
8 can get deathly ill and die if this isn't diagnosed because
9 if she really does have a hole, I've got to go fix it.
10 I've got to go fix it before she gets sick. So I would
11 have been -- that was a significant red flag to me that she
12 had something bad going on inside that wasn't evaluated
13 with a CAT scan and that would have been what you would
14 have ordered. You would have ordered a CAT scan.
- 15 Q What does it mean to -- do you abide by surgical
16 standards of care in your profession?
- 17 A We all do, yes, sir.
- 18 Q What does it mean to a surgeon or to somebody like
19 Dr. Williams, rule out the worst first?
- 20 A Again, you get a differential diagnosis. What
21 could this be? Well, it could be serous drainage from the
22 wound, unlikely, but it could be. She could have maybe an
23 infection in the abdominal wall, it's a possibility. Again
24 unlikely with a thin patient more so with thick patients,
25 but she could have had an infection in the abdominal wall.

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1 She could have a leak from the bowel, so she could have a
2 fistula where this stuff is coming out through the
3 incision. All of those are possibilities. The serous
4 drainage, it's not going to do anything but stop on it's
5 own. Wound infection, start her on an antibiotic, culture
6 it, start an antibiotic. Fistula, hole in the bowel, she
7 can die from that.

8 So that's the first thing that you want to check
9 out. It's the first thing you've got to rule out because
10 it's the most significant and so you would get a CAT scan
11 to see, does it show that dye that she swallowed, does it
12 go down into her bowel and then at a certain point spill
13 out of that bowel, either into the wound or somewhere else
14 in the abdomen. You go, she's got a bowel perforation,
15 I've got to go fix that.

16 Q Dr. Irvin, you mentioned on post-operative day 2,
17 this is two days after the first complex difficult surgery
18 Dr. Williams had, two days later, April 27th, the summary,
19 Plaintiff's Exhibit No. 6, indicates there are at least
20 three references that day to the wound, drainage bag,
21 draining green, brown, foul smell at 5 a.m. in the morning.
22 Isn't that a red flag?

23 A Yes.

24 Q Did Dr. Williams act upon that red flag?

25 A No.

Dr. William Irvin - Direct Examination by Mr. Corbin

1 Q You mentioned post operative days 6, 7, 8 and 9
2 and if I may just read the references on those days,
3 initial comments?

4 THE COURT: The exhibit, please?

5 MR. CORBIN: Exhibit No. 6 still, Your Honor.

6 THE COURT: All right.

7 BY MR. CORBIN:

8 Q May 1st, six days after the surgery, at least two
9 references, three puncture wounds where drains were
10 removed, red and yellow drainage. Drainage foul smelling;
11 continues with yellow drainage. Is that a red flag?

12 A Yes.

13 Q The very next day, May 2, quote, Very large amount
14 of purulent drainage is coming from the old jp site,
15 draining, purulent, large. Red flag?

16 A It is because Dr. Williams had placed three drains.
17 He put two of them in the wound to try and reduce the risk
18 for developing wound infection and he had put one deep in
19 the pelvis. But the nurses in their notes, evidently the
20 drains weren't labeled, so it's hard to know what drainage
21 was coming from what location. So he has to assume that
22 the foul smelling, purulent drainage is coming from the
23 pelvis because that's the drain you can't overlook. If
24 it's coming from the abdominal wound, well, okay. That's
25 okay, we can fix that with antibiotics, open the wound up,

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1 you know, get wound management to take care of it. But if
2 it's coming from the pelvis, then you've got something bad
3 going on inside that can kill her. So he has to assume the
4 worst in that scenario and nothing was done to evaluate
5 that.

6 Q Did, in fact, Dr. Williams assume the worst?

7 A No.

8 Q Did, in fact, he assume anything?

9 A Nothing was done.

10 Q The next reference, May 3, about the wound
11 drainage. The drainage was purulent, large, purulent,
12 moderate, red flag?

13 A Yes. Purulent means infectious. Purulent means
14 pus.

15 Q Did you see any with references in Faye's hospital
16 chart by the nurses documenting purulent drainage?

17 A Yes.

18 Q Did you see any references in the medical records
19 of Dr. Williams, like the nurses, documented purulent
20 drainage?

21 A I did not.

22 Q The next reference is May 4th, or nine days after
23 the operation. At least two references of the wounds
24 draining yellow slough, large amount -- large purulent
25 amount of drainage coming from the left side puncture

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1 wounds. Red flag?

2 A Yes.

3 Q Change Dr. Williams' course of treatment?

4 A No.

5 Q You mentioned a while ago about tachycardia being
6 another warning sign. What is the significance of
7 tachycardia in a patient like Ms. Atkinson coming off of a
8 very difficult surgery involving a resection? What is
9 important about the tachycardia?

10 A So tachycardia means the heart's beating faster
11 than it should normally beat. There's a normal range that
12 your heart beats and it's beating too fast, we call that
13 tachycardia or too slow, we call it bradycardia. So her
14 heart was beating too fast, breaking 100 beats per minute
15 and most normal people have heart rates of 60 to 70, 70 to
16 75 is a regular resting heart rate. So she has a very
17 rapid heart rate. Why? Pain can cause that. Pain can
18 make your heart rate go up through catecholamines release
19 of your adrenal gland, just kind of -- you're keyed up and
20 your heart rate goes up because you're in a lot of
21 discomfort. So pain, fever can make the heart rate go up.
22 Shortness of breath can make the heart rate -- there are a
23 number of different things that can make the heart rate go
24 up.

25 Now, we will often see tachycardia in the first day

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1 or two after a surgical procedure. Again, the patient is
2 in pain from the wound and they're going -- but that should
3 go away. That should get better. As the pain from the
4 wound improves and they're getting better and better and
5 better, their tachycardia should resolve. She remained
6 tachycardic through virtually the whole month.

7 Q And in fact, Dr. Irvin, Plaintiff's Exhibit No. 3,
8 which again is a summary of the medical records, it
9 indicates that Doris Faye Atkinson had tachycardia where
10 her heart rate was above 100 for 30 separate days. Thirty
11 red flags?

12 A Yes.

13 Q Assume that Faye's heart rate before she saw Dr.
14 Williams was in the 60's or low 70's. Tell the jury what
15 the significance is of her having thirty separate days
16 after this major surgery of a heart rate of more than 100.

17 A So that's the body's response to something going on
18 inside. That 's the response of either ongoing pain or
19 that's the response to fever. There's something called --
20 sometimes elevated heart rate can be because the heart has
21 an abnormal rhythm, atrial fibrillation or atrial flutter.
22 It's where the electrical system is not controlling the
23 rhythm, it's a strange rhythm.

24 Sometimes we can have an elevated rhythm of a sinus
25 tachycardia. It's a normal physiologic response, that

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1 elevated heart, there's something going on inside the body.
2 Faye had sinus tachycardia. She had an elevated heart rate
3 which is normal physiologic response to something going on
4 inside her and so the most likely issue would have been
5 either pain or infection in that setting, that lasted for a
6 month.

7 Q Dr. Irvin, according to the summary, it was not
8 only 37 days of a heart rate of at least 100, I think we
9 have about 100 entries of tachycardia. A hundred red
10 flags?

11 A I'd be worried.

12 Q Did you see any evidence at all that Dr. Williams
13 was worried at all about maybe 100 references of
14 tachycardia?

15 MR. MCDOW: Objection, Your Honor, calls for
16 speculation.

17 THE COURT: Sustained. You can rephrase it.
18 Worried is not --

19 MR. CORBIN: Yes, sir.

20 THE COURT: -- within his.

21 MR. CORBIN: Yes, sir.

22 THE COURT: -- knowledge.

23 BY MR. CORBIN:

24 Q Did you see any evidence in reviewing the medical
25 records of Dr. Williams where 30 separate days of

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1 tachycardia and perhaps 100 individual reports of
2 tachycardia, did it change his course of treatment one iota
3 with respect to Faye?

4 A Not that I saw.

5 Q Did he ever even in the records reference anything
6 that -- about tachycardia, any concerns about tachycardia?

7 A Not that I saw.

8 Q The perforation, and you talked about
9 post-operative day 2, green, brown, foul-smelling stuff
10 coming out of the wound, evidence of perforation. Any
11 other evidence -- if somebody were to say to you, Dr.
12 Irvin, you're the one that's wrong, Dr. Williams is right,
13 there's no evidence of a perforation, what are you talking
14 about. What would you say?

15 MR. MCDOW: Object to the form of the question,
16 it's improper.

17 THE COURT: Sustained.

18 BY MR. CORBIN:

19 Q If somebody were to refute the evidence of a -- if
20 somebody were to say there's no evidence in these charts
21 involving perforation, what would you say?

22 MR. MCDOW: Same objection.

23 THE COURT: Sustained.

24 BY MR. CORBIN:

25 Q Did you -- tell this jury all the evidence that

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1 you saw of a perforation in Faye's chart.

2 A Again, the only way you can know for a fact that
3 somebody has a hole in the bowel is to open them up and
4 look at it and see the hole in the bowel. There are some
5 studies that we can get preoperatively before actually
6 going to that extent that can give a high suspicion that
7 there may be a hole in the bowel. Probably the best test
8 and the one that was never ordered was the CAT scan, but we
9 have a lot of clinical findings in the early post operative
10 course of this foul smelling, purulent drainage from the
11 wound that is suspicious for a bowel perforation. We have
12 this heightened clinical suspicion from what he just did,
13 the surgical procedure was so hard, even in his own mind,
14 there's a chance there could be an enterotomy that he
15 missed or this bowel anastomosis may leak, so he's worried
16 about that. She has abdominal pain that persists, which is
17 abnormal. She has fever, which persists that is abnormal.
18 She has abdominal films that were actually obtained on
19 post-operative day 17.

20 That's the only one that really kind of clearly
21 raised the specter of perforation and there was a
22 suggestion on that abdominal x-ray that there was
23 extravasation dye from the small bowel into an air outside
24 of the small bowel. Didn't clearly say she had a bowel
25 perforation, but again that's very hard to say on abdominal

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1 films, very hard. A CT is what you would order to make
2 that diagnosis. But it suggested it. So here we are
3 post-op day 17, we've had this very rocky, stormy, initial
4 post-operative course for 2 and a half weeks and we have a
5 patient that should have been better by post-operative day
6 5 to 7 and has continued to have problems with pain,
7 distension, nausea, vomiting, fever, et cetera. We have
8 films that suggests earlier post-op day 7 and 8 that she
9 had an obstruction. We now have a film post-op day 17 that
10 suggests a possibility, raising the possibility of a bowel
11 perforation. I am worried. I mean that lady, in my mind
12 is going back to -- you have to do something to address
13 this in some way. But again, the only way you can know for
14 a fact she has a bowel perforation is to open her up and
15 see it. And when Dr. Williams took her back for surgery on
16 post-operative day 33, he had a very difficult surgery as
17 you could fully anticipate he would have had then.

18 Q Dr. Irvin, if I may, please, could you please come
19 down here and show the jury part of the medical records
20 which is the second operative report, Plaintiff's Exhibit
21 No. 25.

22 A Now --

23 Q Hang on a second. The date of the operation is
24 May 28, 2007, 33 days after the first one, correct?

25 A Correct.

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1 Q And Dr. Williams decides -- what is his diagnosis
2 of the problem after thirty-two or thirty-three days?

3 A Bowel obstruction, small bowel obstruction.

4 Q And he indicates during this particular
5 procedure -- did he say anything about adhesiolysis?

6 A A very long period of time, four hours, so roughly,
7 80 percent of the entire surgical procedure time was spent
8 lysing adhesions.

9 Q Okay. Take that down, please. And tell me the
10 significance -- now, this is the second operation and your
11 position is perforation between the first and second. What
12 is the significance of surgical findings that a doctor puts
13 in his records about findings? What does that mean?

14 A I often think that the findings section is more
15 important in terms of dictating the operative report than
16 the actual description of what you did because this is so
17 important, at least in what I do or in any other person
18 that's going to go in after this to see what did he find?
19 What exactly was the finding. And the finding in this
20 particular situation were massive inflammatory change in
21 the abdomen. Inflammation means there has been infection.

22 There was something going on that's irritated the
23 peritoneum lining causing it to be inflamed. So massive
24 inflammatory change, not a little bit but massive. You
25 typically wouldn't see massive inflammatory change with

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1 just a bowel obstruction alone. Typically you would not.
2 Typically there would have to be some infection process
3 ongoing that makes this inflammatory change and so -- such
4 a profuse inflammatory change.

5 Q In fact, he says inflammatory change in most of
6 the abdomen?

7 A Right.

8 Q -- right?

9 A Yeah. So again his description of pocket of
10 probable extravasated dye along the posterior peritoneum
11 and a pocket at the base of the mesentery and what that
12 means is that the extravasated dye was -- that shouldn't --
13 the dye should stay within the small bowel. You shouldn't
14 have dye that is outside of the small bowel. That dye
15 should go through the small bowel and out through the
16 rectum. If there's a hole in the small bowel then some of
17 that dye can spill out and pool at the base of the
18 mesentery and that pooling of the dye suggests that she had
19 a perforation. That dye shouldn't be outside of the small
20 bowel.

21 Q Do you know of any other way in Faye's particular
22 case how barium dye could get outside of her small bowel
23 and extravasate outside of the -- except for a leak?

24 A No.

25 Q Do you know of any better proof than Dr. Williams'

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1 own findings in the second surgery, probably -- pocket of
2 possible extravasated -- and that means leak?

3 A Yes.

4 Q Pocket of probable leak dye along the posterior
5 peritoneum and a pocket at the base of the mesentery, any
6 better proof that Dr. Williams, in fact, found a
7 perforation?

8 A I mean you can only go by what he found and
9 described what he thought was dye outside of the bowel.
10 The only way dye can get outside of the bowel is for there
11 to be a hole in the bowel wall that lets it leak out.

12 Q Let's take that down, please. During -- the other
13 information that you had mentioned was the KUB, I think you
14 said May 12th?

15 A That's post-op day 17 and it suggested the
16 perforation.

17 Q Plaintiff's Exhibit No. 22. The radiology report
18 states, taken on May 12th, post-operative day 17, states,
19 quote, there was a selection of contrast in the lower left
20 quadrant which has somewhat anular margins. The
21 possibility is that this is an extraluminal focus of
22 contrast. It is not entirely excluded, but this is felt
23 less likely that this collection appears smaller than the
24 previous film.

25 What is going on here with the possibility -- when

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1 a doctor is given information from a radiologist that
2 there's a possibility of an extraluminal focus of contrast,
3 what does that mean?

4 A Again, radiologists can't tell for 100 percent with
5 just an x-ray, which is a picture that you come to the
6 table, lie down or sit down, depends on which shot you
7 need. They can't really tell from that x-ray if there's a
8 perforation or not. They can suggest it as a possibility,
9 but they won't say -- because it's not the right test to
10 determine if it's a bowel perforation. But they suggest
11 the possibility of a bowel perforation and then the
12 clinician, Dr. Williams, takes that information, with his
13 other pieces of information, his concern about her prior
14 surgery -- his 30 to 50 percent concern about the
15 possibility of a bowel leak post operatively, her
16 presentations for the last 17 days of continued abdominal
17 distension, bloating, nausea, vomiting, pain, fever; and
18 you put all that together, then you kind of think (makes
19 sound).

20 So this film doesn't clearly tell me she has a
21 perforation. I'm kind of worried about it. She looks
22 really worrisome. She's got this foul-smelling, purulent,
23 green-brown drainage that I can't explain. She's not
24 getting better, something is going on. Then I think the
25 clinician would take that one piece of information with all

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1 the other pieces he has available to him to come up with a
2 plan to address this.

3 Q Do you have an opinion based upon a reasonable
4 degree of medical certainty Dr. Williams, post-operative
5 day 2, brown, green, foul-smelling stuff coming from the
6 wound and just add one more piece, that KUB on
7 post-operative day 17 where the radiologist indicates she
8 possibly could be having a bowel leak. Under the standard
9 of care, what was Dr. Williams required to do to rule it
10 out?

11 A I would have ordered a CAT scan immediately.

12 Q Is that the standard of care?

13 A Yes.

14 Q And again, in fact, he did not do that, correct?

15 A No.

16 Q If we could get into the second operation.
17 Thirty-three days after the first.

18 THE COURT: Mr. Corbin, could you come up -- and
19 Mr. McDow, just one moment.

20 (WHEREUPON, there was a bench conference out of the
21 hearing of the jury and the Court Reporter.)

22 THE COURT: All right. Ladies and gentlemen, what
23 we're going to do at this point is we're going to take a
24 recess. You've been in the courtroom for about an hour and
25 a half and other folks have been in here a good bit longer

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1 MR. MCDOW: Yes, Your Honor.

2 THE COURT: Okay. You can bring them in.

3 And I'll tell the jury that one of their number, if
4 they didn't realize is it ill, so I released her from any
5 further service.

6 MR. CORBIN: I don't mind you saying abdominal
7 troubles.

8 THE COURT: No, sir.

9 MR. CORBIN: Okay.

10 (WHEREUPON the jury entered the courtroom at 12:13
11 p.m.)

12 THE BAILIFF: Jurors are seated, Your Honor.

13 THE COURT: All right. Ladies and gentlemen, as
14 you know more than likely, one of your numbers has fallen
15 ill so I've released her from any further service in this
16 case. So we're going to go ahead and continue. Obviously,
17 you're not to let the fact that one juror has been released
18 enter into your decisions at all in this case. It's just
19 how it goes sometimes.

20 All right. Mr. Corbin, you can continue
21 questioning the witness.

22 DIRECT EXAMINATION CONTINUED

23 BY MR. CORBIN:

24 Q Dr. Irvin, could you describe to the jury issues
25 about timing of the surgery between the first difficult

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1 surgery Ms. Atkinson had with the resection and the second
2 surgical procedure 33 days later. Is the timing
3 significant from a medical standpoint?
4 A So the timing is significant when you -- as we
5 discussed early on, when you have a surgical procedure and
6 you go inside and you perform what you are to do and you
7 close that patient up, adhesions start to form. They start
8 to form in the first twenty-four to thirty-six hours and
9 then those adhesions will continue to kind of develop over
10 a period of time. And then this first two weeks after the
11 initial surgical procedure, those adhesions are ultimately
12 filmy, generally. So if there were a need to go back in
13 and operate on somebody for whatever reason, that's the
14 ideal time to do it, the first two weeks after the initial
15 surgical procedure. Because the adhesions haven't changed
16 in a way that it makes it too horribly difficult to take
17 those adhesions down and to do whatever you need to do.
18 After that two-week period of time, after day 14, 16 or so,
19 the adhesions change from the perspective that they tend to
20 get more rock hard. They then become more vascular, and so
21 what initially could have been something that could have
22 been easily separated by taking the two pieces of bowel for
23 example and gently separating them to lysis that adhesion
24 will -- will now use scissors, maybe a scalpel to get the
25 rock-hard adhesions apart, to separate whatever is stuck

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1 together.

2 So there is a period of time, generally
3 post-operative day 14 to 16 to about roughly post-op day
4 16, so about 2 weeks to 2 months that it is incredibly
5 difficult to go back in and operate on somebody because
6 those adhesions are just ridiculously difficult to
7 separate. And almost certainly will be associated with
8 injury to the structure you're trying to separate and the
9 potential need to repair whatever you injure in trying to
10 do what you're there to do. So the ideal time if you're
11 going to reoperate on somebody after an initial surgical
12 procedure is by -- typically within the first 2 weeks.
13 Once you get much further beyond 2 weeks, if it's 14, if
14 it's 16, then you get into a really hostile window where
15 it's going to be very difficult to do what you're trying to
16 do without injuring things in the process. So timing is
17 important when you decide to reoperate on a patient.

18 Q Dr. Irvin, did you see indications that Dr.
19 Williams should have performed surgery under the standard
20 of care before that critical period of 14 to 16 days where
21 the adhesions become rock hard and dangerous?

22 A Well, Dr. Williams, I'm sure has done a good amount
23 of complicated surgery in his lifetime being a gynecologic
24 oncologist, so he's aware, as most are, that that hostile
25 window, you want to stay out of. So on post-operative day

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1 number 2 when you're starting to get this kind of green and
2 brown four-smelling drainage, the drainage continues on
3 post-operative day 6, 7, 8, 9, we've got abdominal films on
4 post-op day 7 that suggest obstruction. You have an
5 abdominal film on day 8 that most certainly say an
6 obstruction, not just an ileus. You've got a patient
7 that's getting worse, not better. So all of those things
8 would have probably precipitated ordering a CAT scan at
9 that point to see what's going on. That wasn't done and
10 Dr. Williams is aware, as any gynecologic oncologist would
11 be that you want to stay out of that hostile window post-op
12 day 14 or after. So I would think he would have said,
13 well, something is not right. I'm worried about a possible
14 bowel perforation. I mean I know he didn't want to go back
15 in on her because that first surgery was incredibly hard
16 and he has no reason to believe that this is going to be
17 any easier. This will be just as difficult and I know that
18 his thought was I just don't want to reoperate on this lady
19 if I don't have to, but you don't want it to drift into
20 that window of time, post-op day 14 on to like 2 months out
21 and go in that way because it's going to be so difficult to
22 reoperate on here. And it was. It was incredibly
23 difficult.

24 So I would think that he would be considering she's
25 got things going on. Something bad is going on. I don't

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1 quite know what it is. I'm worried about a perforation.
2 I'm going to do this sooner rather than later. At least go
3 in and see what's going on and see if I can fix it in the
4 simplest way that I can.

5 Q Tell the jury what it means to a gynecological
6 oncologist or a surgeon, the term informed consent
7 involving doing a complicated dangerous surgery like the
8 second one. What is informed consent?

9 A So if we want to operate on somebody, we have to
10 get their permission. We're not allowed to take them to an
11 operating room to do a surgery without them signing a form
12 that's going to give us permission to do so. Now, it is
13 appropriate if you're going to take someone to the
14 operating room that you explain to them what you want to do
15 and why. You explain the risks of what you want to do and
16 why. And you explain the alternatives to what you want to
17 do and why. And so if a patient then is given that
18 information and she or he elects to go to the operating
19 room, at least she's been fully counselled of what her
20 risks are; she's aware of the risks. She signed a form
21 saying she knows the risks. She's aware of alternatives,
22 particularly nonsurgical alternatives. So an informed
23 consent means the patient is informed about risks and
24 benefits and alternatives to the proposed surgical
25 procedure.

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1 Q Did Faye have a right to know? Did she have a
2 right to know before that second surgery all those dangers
3 that you talked about, the risks she faced going into that
4 second surgery?

5 A I think she did and more importantly, I think she
6 has the right to know that there was an alternative to
7 that. That there was some other option rather than going
8 back and doing that again.

9 Q Assume that Dr. Williams testifies that the second
10 surgical procedure he performed on Faye, at least in his
11 mind, was quote, elective, quote. What does elective mean?

12 A Elective refers to the fact there's nothing pushing
13 from a medical standpoint to do this surgery. When
14 somebody comes into the operating room -- or let's say
15 somebody comes into the emergency room with acute
16 appendicitis, they need to have an appendix taken out.
17 That's not an elective procedure. They will get worse and
18 they could potentially die if that's not addressed.
19 Someone comes in with a brain tumor and they have
20 visually -- they need to have that fixed. These are not
21 elective procedures.

22 An elective procedure is a procedure that you could
23 say -- let's say you come in with gallstones, that
24 asymptomatic. You've got gallstones. You could say, well,
25 this may cause you some problems in the future. You can

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1 either take them out now to try to avoid that or we can
2 wait and see how you do. To take that gallbladder out in a
3 patient that's asymptomatic or a patient that doesn't have
4 a pressing need to have it taken out at that moment in
5 time, it's an elective procedure.

6 Q Under the standard of care from all -- what you
7 know about Faye's condition, did she have a right to know
8 before the second surgery that Dr. Williams believed that
9 it was elective?

10 A Yes.

11 Q Who makes that election whether or not to have a
12 dangerous surgery?

13 A Excuse me?

14 Q Who makes the decision whether or not to have a
15 dangerous elective surgery?

16 A Well the surgeon would present it to the patient,
17 but the patient ultimately has to be the one to decide that
18 she wants to have that done or not.

19 Q Did you see any proof at all in the medical
20 records that Dr. Williams even presented a nonsurgical
21 option to Faye involving that second surgery?

22 A No.

23 Q Did you see any proof at all in the medical
24 records that Dr. Williams told Faye this second surgery is
25 going to be dangerous, but it is elective, if you want to

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1 have it?

2 A No.

3 Q Did you see evidence at all that Dr. Williams
4 honored her rights as a patient to reject the second
5 surgery?

6 A No.

7 Q The record is not filled with references that
8 see's been fully informed about the nonsurgical options?
9 There's no reference to it?

10 MR. MCDOW: Object to leading.

11 MR. CORBIN: I'll withdraw it.

12 THE COURT: All right.

13 BY MR. CORBIN:

14 Q Did Faye have an option under the standard of care
15 in her condition to avoid that second dangerous surgery
16 that Dr. Williams performed? Was there an option?

17 A Yes.

18 Q What option was Faye not told?

19 A The other option would have been, knowing that this
20 is going to be an extremely difficult surgical procedure,
21 knowing that the original surgery 33 days earlier was an
22 extremely difficult surgical procedure that resulted in the
23 resection of potentially several feet of bowel, depending
24 upon the impression that Dr. Williams conveyed; but a large
25 portion of bowel was taken out in her initial surgery.

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1 That was a hard surgery. This surgery is going to be
2 harder. We know it's going to be harder.

3 There's a significant risk of then having
4 significant injury to the bowel or other structures with
5 this surgery. So an alternative to consider would have
6 been to not do the surgery, to have continued her on liquid
7 nutrition so she's being maintained so she doesn't become
8 malnourished and that's given through an IV. To have
9 placed an NG tube, which actually was put in on post-op day
10 32, for that to be -- it's uncomfortable going through your
11 nose. An alternative would be putting in what we call a
12 peg tube, an easy procedure that's done in the GI lab where
13 the tube comes out through the stomach, which you're trying
14 to evacuate the stomach. It goes through the nose because
15 it's just a route to get to the stomach, but you can
16 actually go through the abdominal wall, directly into the
17 stomach so you don't have the discomfort of the nasal tube.
18 So she could have had a peg tube placed to decompress her
19 obstruction; she could have had liquid nutrition given to
20 maintain her nutritional status; and she could have been
21 maintained by not eating or drinking at all because she's
22 getting her liquid nutrition that suits all her nutritional
23 needs. And that would have allowed you to get her through
24 this very hostile window when you knew the surgery was
25 going to be difficult. Get out of that window, see if she

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1 doesn't spontaneously improve on her own. She may
2 potentially over that period of time.

3 If once you've made it through that period of time
4 she hasn't gotten better, there's still evidence that she
5 has some degree of obstruction, then you can operate on her
6 at that point in time when the abdomen will be much more
7 friendly to exploration than it would be in that two week
8 to two month window.

9 Q Was Dr. Williams' second operation in your opinion
10 a success?

11 A I think he did what he had to do at that surgery,
12 which as predicted, was extremely difficult. Four hours of
13 adhesiolysis as opposed to two hours with his initial
14 surgical procedure. The resection of 48 centimeters of
15 additional small bowel, multiple enterotomies or hole in
16 the bowel were created as he was trying to take all these
17 adhesions apart, these rock-hard adhesions. He identified,
18 I think what likely was the cause of her problems during
19 her initial post-operative course after surgery number one
20 on April 25th and that was that there was likely a bowel
21 perforation. He identified a pocket of extravasated dye
22 outside of the bowel. So it's likely he did identify the
23 source of the problem.

24 He resected the source of that problem along with
25 additional parts of the bowel and then reanastomosis. So

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1 from the standpoint of, did he accomplish what he had
2 wanted to accomplish, yes. Was there a price to pay? Was
3 it a morbid surgical procedure? Yes. Would you have
4 anticipated that? Yes.

5 Q Was that surgical procedure necessary?

6 A It was an alternative.

7 Q If a surgeon decides, I'm going to take on this
8 hostile abdomen and he opens up the belly and low and
9 behold he starts causing holes, multiple holes, so many he
10 didn't even count, under the standard of care, what is that
11 surgeon required to do facing causing multiple
12 enterotomies?

13 MR. MCDOW: Object again to testifying and the
14 hypothetical nature of the question.

15 THE COURT: All right. You can rephrase it without
16 making your own comment about any evidence.

17 BY MR. CORBIN:

18 Q Under the operative report is there references
19 during the second surgical procedure about how many holes
20 Dr. Williams put in Faye's bowel?

21 A Multiple.

22 Q Multiple. Do you have an opinion based upon a
23 reasonable degree of medical certainty that Dr. Williams
24 opening up Faye, starting to cause multiple enterotomies,
25 what was he required to do?

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1 A Again there were several points I think that Dr.
2 Williams came to forks in the road in Ms. Atkinson's care.
3 Several points beginning on post-op day 1 after her initial
4 surgery, where I think he could have chosen one road rather
5 than the other and each time it seems to me he chose the
6 wrong road.

7 Initially he was kind of ignoring the
8 post-operative finding that suggests perforation. He might
9 have ordered a CAT scan. Once he diagnosed what he thought
10 was the problem, a bowel obstruction, he never placed an NG
11 tube. He could have done that. When we get to this point
12 where we have this surgical procedure, he really could have
13 considered an alternative, a nonsurgical alternative to try
14 and get her through this kind of very difficult surgical
15 window. So at each point, we have forks in the road where
16 I think the wrong fork was taken.

17 Now, this is another example that once he gets into
18 her and realizes, this is just a mess. This is exactly
19 what I thought it was going to be, this is a mess. As you
20 start to try and dissect these incredibly difficult
21 adhesions -- I mean you can't really appreciate it when you
22 do it, but it's like somebody takes glue and just throws it
23 into the abdomen and all the loops of bowel just freeze
24 together, just glue together. They do not separate. You
25 have to take scissors and cut them apart and it's almost

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1 impossible to avoid injuring the bowel when you do that.

2 So as he started this process, started to make an
3 injury, he said -- he could have done two things that what
4 I would have probably thought was prudent, this is not the
5 time we're going to get into all sorts of trouble. And
6 what you would do is a very unwarranted procedure and you
7 go very high up to the top of the small bowel right where
8 it enters the abdomen called the jejunum, the very proximal
9 jejunum and you would just pull a loop of that up to the an
10 tier anterior abdominal wall and you'd make an opening in
11 that, called a jejunostomy and then you would close the
12 abdominal wall and you're done. You're assuming somethings
13 going on in there downstream, but now is not the time to
14 fix. So this jejunostomy lets the stool coming out of the
15 stomach from the anterior contents from whatever you're
16 eating that leave the stomach and come out through the
17 jejunum and empty itself so it doesn't keep going down to
18 the obstruction, making her throw up and to the leak that's
19 going into her pelvis.

20 So you divert that stream of food stuff to relief
21 the obstruction and to permit worsening of this
22 perforation, this leakage from the perforation, the
23 inflammation that that leakage is causing, continue her on
24 a liquid nutrition and get out of this window. Get out of
25 this horrible window, come back two months later, see how

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1 she's doing, take this route. It could be a much easier
2 surgical procedure. That would have been one option.

3 If for whatever reason he just felt that I just
4 have got to move ahead, I would have considered getting
5 some assistance. You know, I'll tell you it's a hard
6 surgery. It would be nice to have two minds that have both
7 done this before rather than just one just to help. And so
8 I would have called in a general surgeon, someone that had
9 done this frequently to get assistance in trying to carry
10 out the surgical procedure.

11 So I thought that those were the two options that
12 he had available to him and he elected to use neither of
13 them.

14 Q The assistance that Dr. Williams chose to help him
15 with this second hard surgery was the resident?

16 A Correct.

17 Q If you could come down here, Doctor, we have on
18 the screen, which is a 3-D model of the abdomen, and
19 according to the operative report, Plaintiff's Exhibit No.
20 25, Dr. Williams, quote, performed a, quote, small bowel
21 resection from approximately the terminal jejunum, removing
22 most of the ileum, but he did salvage approximately ten
23 centimeters of terminal ileum. Where is the jejunum that
24 he removed?

25 A So this picture, stomach, the polaris or the end of

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1 the stomach empties into the duodenum, which is kind of
2 hidden behind this loop of bowel there (indicating). This
3 duodenum comes around, that's the retroperitoneum and then
4 it comes out into this. This is the jejunum. So there's
5 21 feet from this point to here. All of this is 21 feet of
6 small bowel.

7 Now, the first half or so, the first 60 percent is
8 known as the jejunum. The second half is this kind of
9 arbitrary transition point where if something happens, it
10 starts a change in it, is known as the ileum. And the
11 ileum runs down and empties into this, which is the cecum.
12 So if you can imagine, normally if you open somebody, you
13 could just lift these loops up and separate them one from
14 another. It's like a hose, a garden hose laying on top
15 there. It's easy to kind of lift these and pull them
16 around and see what's going on underneath them. But once
17 you start to get these horrible adhesions, these things
18 freeze in that position. You cannot separate them, you
19 have to cut them apart. And you can see how many things
20 you have to cut apart to ultimately be able to run the
21 bowel from this end to this end and know that you've run
22 the entire length of the bowel and looked at it from one
23 end to the other.

24 Lots of adhesiolysis would occur. So he ended up
25 taking the proximal jejunum left behind, took out a portion

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1 of the ilium, but left about 10 centimeters of the ilium,
2 about 10 centimeters. From this point, 10 centimeters this
3 way, which was roughly about 4 inches or so of the ilium
4 was left behind. But the majority of the rest of the ilium
5 was taken out and he anastomosed the jejunum with this
6 terminal piece of ilium.

7 Q So he talks about at least he could salvage about
8 10 centimeters of the terminal ilium? That's about 4
9 inches?

10 A 2.5 centimeters is an inch. So 10 centimeters is
11 roughly 4 inches.

12 Q The operative report talks about massive
13 inflammatory change, inflammatory change in most of the
14 abdomen. Would leaking barium enter her system and cause
15 massive inflammatory changes?

16 A Yes.

17 Q Please take the witness stand.

18 (WHEREUPON the witness returned to the stand.)

19 BY MR. CORBIN:

20 Q What was Dr. Williams actually treating as his
21 diagnosis for Ms. Atkinson? What was his conclusion that
22 she was suffering from?

23 A His impression and he dictated in his second
24 surgery was that he thought she had a bowel obstruction, a
25 small bowel obstruction. The small bowel being the

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1 jejunum, ilium, large bowel being what it empties into, the
2 ascending colon, transverse colon, descending colon,
3 sigmoid and rectum, the big part outside of that small
4 bowel.

5 Q Dr. Irvin, I want you to assume that in fact Faye
6 Atkinson had a small bowel obstruction. Forget all the
7 stuff about perforation all those other conditions. Dr.
8 Williams diagnosed her as having a small bowel obstruction.
9 In you're opinion, based upon a reasonable degree of
10 medical certainty, did he meet the standard of care for
11 treating her for a small bowel obstruction?

12 A No.

13 Q Please explain.

14 A So when you diagnose a small bowel obstruction, the
15 general recommendation for that small bowel obstruction is
16 as we mentioned earlier, don't let them eat so you prevent
17 oral intake. You replace the nutrition that they're losing
18 in some fashion, typically through liquid nutrition given
19 through a vein and that's run throughout the course of the
20 day or 12 hours in the course of a day. And you put in an
21 NG tube. The NG tube is going to be there for a long
22 period of time is converted to this gastrotomy tube or peg
23 tube. And so those three things are the three components
24 that you would use to manage a small bowel obstruction.

25 Now, Dr. Williams did institute two of those on

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1 post-operative day 11. He made her NPO and on
2 post-operative day number 12, he began liquid nutrition but
3 never put in the NG tube. And in this situation I think it
4 caused her to have unrelenting nausea and vomiting for 33
5 days that could have been treated. As soon as she had the
6 tube put in on post-operative day 32, she felt immediately
7 better. She had 700 cc's of nasty material that came out
8 of her stomach which was making her feel bad.

9 So I think he could have made her symptomatically
10 much better and more importantly if you do have an
11 obstruction, he has just taken out a big chunk of her bowel
12 and sewn the two ends back together. You want that to heal
13 well. If that doesn't heal, that can leak and if that
14 leaks then you have bowel leakage into the abdominal
15 cavity, all the risks that we talked about. The NG tube
16 helps to decompress to a greater degree the small bowel.
17 But you can prevent that fluid going down into that area
18 distending that anastomosis and putting tension on it and
19 possibly increase the risk of it leaking.

20 And so for a couple of reasons with her I think the
21 NG tube would have been a critical intervention that he
22 should have done to manage what she thought was a bowel
23 obstruction. That's what he thought that she had a bowel
24 obstruction, not a perforation. So he didn't institute an
25 NG tube that he needed. And then more importantly -- I

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1 mean what do you do with post-op small bowel obstructions?
2 They will many times result from adhesion formation.
3 That's the most likely cause of post-operative small bowel
4 obstruction, adhesions that form inter operatively can kink
5 the bowel, can oppress the bowel and make it so it's
6 mechanically obstructed, stuff won't go through it.

7 Now, there are many situations where that kink can
8 improve on it's own, just spontaneously. Studies have
9 looked at this. There's a large number of reports in the
10 literature that examine the management of post-operative
11 small bowel obstructions and they suggest of the people in
12 whom the bowel obstruction was spontaneously resolved on
13 it's own with this NG tube, NPO, liquid nutrition, of those
14 that were resolved with that regimen on there own without
15 surgery, 75 percent were resolved within the first one
16 week; 25 percent more -- well wait 20 percent more were
17 resolved in the second week. So 95 percent of people that
18 will resolve their post-operative small bowel obstruction,
19 particularly from adhesion formation, 95 percent will get
20 better with this regimen of the NG tube, NPO and liquid
21 nutrition in two weeks. 95 percent. The percentage of
22 them that get better after that is vanishingly small. And
23 I realize we're getting into this horrible window when you
24 don't want to be operating on people after that two week
25 window, two week to roughly two months. You want to stay

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1 out of that, but -- so I think he had options to manage
2 this in a very different way. The NG tube would have been
3 an important part of the management that he did not
4 institute and we got out of that two -- when he should have
5 operated on her before that two weeks if he was going to.
6 He thought with the KUB, the x-ray on post-op day seven
7 suggested small bowel obstruction, on post-operative day 8,
8 he said she had a small bowel obstruction. You're still 6
9 days away from that magical point that you don't want to go
10 inside her. You've got 6 days and if she's not getting
11 better and she's got issues, she's got pain, she's got
12 nausea, she's got vomiting. I've got a small bowel
13 obstruction, I need to go in and do something now if I'm
14 going to do it or if you had left it, don't do it, keep her
15 on the liquid nutrition, get her through that horrible time
16 when you don't want to operate on her and then revisit it
17 at two months, two-and-a-half months, see has hers gone
18 away. Is she better? You can do a study and CT scan to
19 see if it's gone away. If it has, you don't need to
20 operate on her. If it hasn't, it's going to be a much
21 safer surgery at that point, much less morbid at that point
22 than operating on her at the time he did, post-op day
23 number 33.

24 Q Dr. Irvin, after two weeks, 14 days, you mentioned
25 the studies, 95 percent if they're going to resolve without

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1 surgery will do so in the first two weeks. After that, a
2 patient has -- there's a 95 percent chance a patient would
3 require surgery to resolve the bowel obstruction?

4 A Only 5 percent that will resolve spontaneously with
5 the interventions that we discussed will do so after two
6 weeks.

7 Q Odds are pretty low?

8 A Pretty low.

9 Q The amount of bowel removed -- and Plaintiff's
10 Exhibit No. 29 is a summary from the records of the amount
11 of bowel that was removed from Ms. Atkinson's body?

12 A 48.7 centimeters in the second surgical procedure.

13 Q For a total of 51 centimeters in the second
14 surgical procedure.

15 A Right.

16 Q How would you describe to the jury removing 51
17 centimeters of Faye's bowel during that second surgery?
18 How would you describe that?

19 A Well, again, the small bowel is very critical for
20 absorbing nutrients and for helping people to stay
21 nutritionally fortified from the food stuffs that we eat.
22 We need the small bowel, the jejunum absorbs the nutrients,
23 the ileum absorbs important, critical things, vitamins and
24 bile salts, et cetera. So both components on the small
25 bowel are critical for helping people to absorb what they

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1 eat to stay alive.

2 Now, the more small bowel you take out, the less
3 there is to go from the stomach to the colon, where it
4 empties into the colon. And if you take out so much small
5 bowel, you're going to reach a point where there's not
6 enough left even to absorb nutrients, and so people need to
7 be on liquid nutrition for their lifetime. But if you take
8 out enough small bowel -- if you take out so much -- they
9 still have enough to live on but it's just a really small
10 amount, what you eat from your stomach goes through that
11 really quickly. There's not enough to absorb it and it all
12 dumps into your colon. And then your colon gets all this
13 solid material into the colon that draws water out of the
14 colon that makes this stuff very liquidy and you have
15 problems, unrelenting diarrhea. So it's called short gut
16 syndrome. So you want to be very careful about how much
17 small bowel you take out if you have the option because A,
18 you could make it where they can't even absorb nutrients
19 and they need to be on liquid nutrition for life; or if not
20 that extreme, you greatly increase the risk of this short
21 gut syndrome and this incredibly horrible unrelenting
22 problem of diarrhea.

23 Q According to hospital chart, 51 centimeters is
24 what Dr. Williams cut out during the second surgery.
25 That's about 2 feet?

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1 A Yes.

2 Q And of course, if you look at the medical records
3 to determine from the records how much bowel he took out
4 the first time, do you know?

5 A It wasn't sent to the pathologist, so we really
6 don't know.

7 Q Unknown?

8 A Right.

9 Q Answer any questions Mr. McDow might have.

10 THE COURT: Mr. McDow? What's your pleasure.

11 MR. MCDOW: Mr. Corbin went a little longer than
12 anticipated. But I'll go. I think we can do that --

13 THE COURT: Does that suit everybody on the jury?

14 MR. MCDOW: Of course, I'll do -- I'm not going to
15 be that long so if they want to go to lunch, I'll -- but --
16 so we can get him on the road back to the University of
17 Virginia too.

18 THE COURT: All right. You can continue. If you
19 want to reach a stopping point, I'll allow you to do that.

20 MR. MCDOW: Thank you, Judge.

21 THE COURT: Yes, sir.

22 **CROSS-EXAMINATION**

23 **BY MR. MCDOW:**

24 Q Dr. Irvin, I'm Bill McDow. I represent Dr.
25 Williams in this case.

Dr. William Irvin - Cross-Examination by Mr. McDow

1 You understand that Ms. Atkinson is not on liquid
2 nutrition for the rest of her life, correct?

3 A That's correct.

4 Q Doctor, surgical complications can occur without
5 malpractice being committed, correct?

6 A That's correct.

7 Q And you would agree that a medical outcome is
8 never guaranteed, correct?

9 A That's correct.

10 Q Complex surgeries have complications and
11 imperative risks, correct?

12 A That's correct.

13 Q That includes bowel perforations, bowel leakage
14 and possible reoperation, correct?

15 A That's correct.

16 Q It's possible that even in the best circumstances
17 with complex abdominal surgery that you could have those
18 complications, correct?

19 A You can, yes.

20 Q And you are not testifying that Dr. Williams was
21 not qualified to perform either surgery, are you?

22 A No.

23 Q Doctor, you were first contacted in this case in
24 January of 2012; is that right?

25 A That's correct.

Dr. William Irvin - Cross-Examination by Mr. McDow

1 Q And if I understood you at your deposition, you
2 listed out a number of records that you had reviewed. Did
3 those records include all the Palmetto Health records?

4 A As far as I'm aware. I'm not sure exactly how
5 extensive they were, but I was given the records that I
6 thought were appropriate to evaluate the issues for which I
7 was being sought to make an opinion.

8 Q Okay. Well, I'm just a little curious about that
9 because again, we've had marked as Plaintiff's Exhibit 18,
10 four notebooks of Palmetto Health records. Does this size
11 look familiar to you?

12 A It does.

13 Q Okay. And that's the only reason I ask is for
14 clarification because in your deposition you listed out
15 various things, but you didn't say the whole chart, so I
16 just wanted to know whether you looked at the whole chart
17 or not?

18 A I did.

19 Q Okay. And back when your deposition was taken on
20 August 2nd of this year, you had read the depositions of
21 Dr. Reynolds, Dr. Bailey, and Dr. Williams; is that
22 correct?

23 A That's correct, yes.

24 Q You had not read the deposition of Dr. Parker; is
25 that correct?

Dr. William Irvin - Cross-Examination by Mr. McDow

1 A That's correct.

2 Q Have you read Dr. Parker's deposition since the
3 time of your deposition in August?

4 A I have.

5 Q So you have been presented with Dr. Parker's
6 deposition since then?

7 A Yes.

8 Q Okay. Did you ever look at the radiology films
9 themselves?

10 A I did not.

11 Q Doctor, you mentioned some of your background that
12 you do cancer research. Did I understand that correctly?

13 A That's correct.

14 Q Does that involve clinical trials?

15 A That's correct.

16 Q So you go through the institutional review board
17 at your facility --

18 A We do.

19 Q -- to present those?

20 A We do.

21 Q An institutional review board is a board that
22 basically serves to look after human rights and one of
23 those is consents; isn't that correct?

24 A That's correct.

25 Q Doctor, if I understood you correctly 1.4 or 1.5

Dr. William Irvin - Cross-Examination by Mr. McDow

1 percent of women will develop ovarian cancer; is that
2 right?

3 A The late-time risk of developing ovarian cancer is
4 1.4 to 1.5 percent, correct.

5 Q And I've often heard that ovarian cancer is known
6 as a silent killer; is that correct?

7 A Not really. I mean it's interesting that it has
8 been labeled as such, but as we have gone back and looked
9 at women that were diagnosed with ovarian cancer, it's
10 clearly not silent. They will typically have symptoms for
11 6 to 8 months prior to their diagnosis, but the symptoms
12 are not specific, whereas for example, endometrial cancer
13 will present with post-menopausal bleed as a specific
14 symptom of endometrial cancer. Ovarian cancers typically
15 present with more vague, often gastrointestinal symptoms
16 that will mislead people in terms of what's going on, but
17 they clearly are symptomatic several months prior to their
18 diagnosis.

19 Q All right. Doctor. You are aware that
20 Ms. Atkinson was admitted to the hospital over in
21 Hartsville in March of 2007 through the emergency room
22 department due to pain, correct?

23 A Yes.

24 Q And it was at that hospitalization where the mass,
25 the 13 centimeter by 9 centimeter mass was discovered via

Dr. William Irvin - Cross-Examination by Mr. McDow

1 CT scan; isn't that correct?

2 A That's correct.

3 Q And it was at that hospitalization where her
4 regular OB GYN referred her over to Dr. Williams for
5 further followup; isn't that correct?

6 A That's correct.

7 Q And did you note, Doctor, in the records that you
8 reviewed the radiologist report from a stone search -- a
9 kidney stone search, right ovarian mass, no distal ureteral
10 stones or dilated ureters are seen. There is a large
11 cystic mass in the right adnexa, measuring 12.8 by 9
12 centimeters. Did you see that report?

13 A I did.

14 Q And that report goes on to say that mass contained
15 acceptations and peripheral calcifications, did you see
16 that?

17 A I did.

18 Q This mass should be considered an ovarian neoplasm
19 until proven otherwise. Left ovary is unremarkable except
20 for a 2.2 centimeter cyst. The uterus is not seen. The
21 urinary bladder looks unremarkable. Did you see that?

22 A I did.

23 Q Of course, her uterus is gone because she had a
24 prior hysterectomy; is that right?

25 A Correct.

Dr. William Irvin - Cross-Examination by Mr. McDow

1 Q And Doctor, what are septations?

2 A Septations are thin bands of tissue that will
3 extend from one side of the wall of a cyst to the other
4 side of the wall of the cyst.

5 Q And those are indicative for carcinoma, are they
6 not?

7 A No, not at all. Septations can commonly be found
8 in benign tumors as well as malignant tumors. There are
9 things called morphologic scoring tests that allow us to
10 get an idea of how worrisome septation, for example, is.
11 One of the more commonly used morphologic index tests is
12 the deep freeze morphologic induction scoring test and it
13 looks at three components of a cyst because many times
14 radiologists will say this looks like this, this, this,
15 clinical correlation advised. Which doesn't help you if
16 you're trying to avoid operating on somebody. So the nice
17 thing about the deep freeze morphologic index score is they
18 take what is a subjective radiologist opinion. This could
19 be X, Y, Z, and give you an objective number to allow you
20 to get an idea of what the malignant risk for that
21 particular mass is.

22 Now, there are three components of that score. One
23 is the size, you get a number for that. The bigger, the
24 higher the number. One is the internal components which
25 such is septum. The thicker the septa, the more vas

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1 vascular the septa, the higher the number you get for that.
2 And the third is the wall structure. The thicker the wall
3 structure, the more irregular, the more solid, the higher
4 the number. And so then you take your number, it can be
5 anywhere from 0 to 12 and see what your risk of cancer is.
6 0 to 5, invariably benign tumors. These are benign
7 neoplasms. Just as this ended up being a benign steatoma.
8 If the numbers are 6, 7, and 8, you start to worry about
9 malignancy; 9, 10, 11 or 12, 12 being the highest score you
10 get, those are cancerous. You can almost guarantee it
11 without operating on them.

12 So you kind of know what you're dealing with before
13 you go inside. So just the presence of septa alone does
14 not confirm the fact that that mass is malignant at all.

15 Q Doctor, did you note the impression on the
16 radiology report as being a large cystic mass, right
17 adnexa, worrisome for ovarian carcinoma?

18 A Right.

19 Q Carcinoma is cancer, correct?

20 A It is.

21 Q And the peripheral calcifications, that would be
22 where the calcium shows up on the CT scan; is that right?

23 A Correct.

24 Q And that's one of the --

25 **MR. MCDOW:** I'm sorry, Your Honor.

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1 **THE JUROR:** The TV just keeps blinking or moving.

2 **THE COURT:** Could you just go ahead and cut that
3 off?

4 **MR. CORBIN:** Yes, sir.

5 **THE COURT:** Thank you.

6 **THE JUROR:** Thank you.

7 **BY MR. MCDOW:**

8 **Q** It is calcium on the CT scan that the radiologist
9 looks at or reports it and reports; is that correct?

10 **A** That is one component that the radiologist will
11 comment on, among others in the mass, but, yes.

12 **Q** But that calcium shows up and can that be
13 worrisome for cancer?

14 **A** It can be, yes.

15 **Q** Okay. Because that's what a lot of times when
16 mammograms are done, they see a spiculated or dense or a
17 piece of calcium in there and that's what shows up and that
18 is, in the best times, can be worrisome for cancer as well,
19 correct?

20 **A** Both kind of suggests the areas of rapid growth and
21 subsequent necrosis of tissue, so, yes.

22 **Q** Doctor, there's a 50 percent chance, I think I
23 understood you to say that the cytology, the CA-125 is
24 wrong.

25 **A** If a CA-125 is drawn in a patient that has an add

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1 adnexal and that CA-125 is normal, it doesn't rule out the
2 possibility that that might be a malignant tumor. Roughly
3 50 percent of women that present with stage one ovarian
4 cancer will have a normal CA-125 preoperatively.

5 Q Doctor, you are critical of Dr. Williams for
6 failing to offer the serial ultrasounds, but you are not
7 critical of him for discussing the other risks that would
8 be associated with this surgery, correct?

9 A I think I -- I'm critical of the fact that he --
10 that there wasn't any further testing done to really
11 evaluate the malignant potential of this mass because a CT
12 scan is a very poor test to evaluate the malignant
13 potential in ovarian mass. A very poor test. An
14 ultrasound is much better because it gives you much more
15 detail, exquisite detail, not only that there's a mass
16 there, it will tell you how thick the wall of the mass is.
17 It will tell you what's inside it and how thick those septa
18 are. It will describe that there are neuro nodules, all of
19 which would be worrisome for cancer. And at the same time,
20 you can do something called doppler flow studies to see if
21 there's vascular flow and if it's worrisome; bone peaks
22 flow or normal high peaks flow.

23 So all of these are pieces of information you can
24 get from an ultrasound, none of which are available, in a
25 basic CT scan. So I think the next logical step when you

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1 diagnose a mass on a CT scan, particularly in a patient
2 with whom surgical intervention might be difficult, is to
3 get more information with an ultrasound and flow studies.
4 Now, if that had kind of suggested that there's a really
5 high likelihood this is cancer, you're stuck. You've got
6 to go operate on her regardless. But that was never done.
7 So you don't really know what it would have shown. And
8 ultimately this was found to be a benign process.

9 Q Doctor, you remember what my question was?

10 A No. You want the repeat it?

11 Q I do. Because you didn't answer my question. My
12 question was, Dr. Williams -- you are not critical of him
13 because he did discuss with her the various risks that
14 would be involved with the surgery?

15 A So I'm not critical of him because he discussed the
16 risks involved with the surgery; that is correct.

17 Q Thank you. And you even noted that she reviewed
18 and signed the consent form in the hospital records,
19 correct?

20 A That is correct.

21 Q And if the option would have been given to
22 Ms. Atkinson as you've described, you don't know what her
23 response would have been?

24 A That is correct.

25 Q Doctor, the first operative note that was

Dr. William Irvin - Cross-Examination by Mr. McDow

1 dictated, you believe seemed to be an appropriate dictation
2 note, correct?

3 A I do.

4 Q And was the second operative note an appropriate
5 dictation as well?

6 A I think it was.

7 Q And again, for the second surgery -- well the
8 first surgery, you're not offering the opinion that the
9 technical aspect fell below the standard of care, it's
10 rather you've got the criticism of the component of taking
11 down the adhesions; is that correct?

12 A I think he had to take those adhesions down to some
13 extent to get to the mass. I just don't know from his
14 description of the operative report what percentage of
15 those adhesions were actually involved with the mass and
16 what percentage were separate from the mass. My suggestion
17 would be that in that situation to perform as minimal of
18 adhesiolysis as possible to accomplish what your goal is
19 for that surgery and that's to get that mass out. And it
20 seems like two hours was an extensive period of time to
21 expose the right adnexa.

22 Q Doctor, do you have the summary of the chart that
23 Mr. Corbin prepared before you, relative to the drains? Do
24 you have that still with you up there?

25 A I do not.

Dr. William Irvin - Cross-Examination by Mr. McDow

1 (WHEREUPON the document was handed to the witness.)

2 BY MR. MCDOW:

3 Q Doctor, after the two pages of summaries?

4 There are then attached portions of hospital records. And
5 the first page there is PHR 527; do you see that?

6 A This the sheet that you're talking about?

7 Q I'm not sure. There are two pages here that
8 describe post-operative course and then -- that has the
9 wound drainage on it?

10 A I've got that page, yes.

11 Q Okay. Right. And the first part of the records
12 is page 527?

13 A I have it.

14 Q Okay. And that first document is entered at 10:31
15 a.m. on April 26, correct?

16 A Correct.

17 Q And that's part of the systems review and that
18 shows the three drains that were present, correct?

19 A Correct.

20 Q Okay. And part of that shows serous sanguineous
21 drainage, correct?

22 A Correct.

23 Q Okay. And then if you flip it to page 427 at 7:50
24 p.m., it continues to give a description, correct?

25 A Correct.

Dr. William Irvin - Cross-Examination by Mr. McDow

1 Q Okay. And that's under systems review in the
2 op -- in the hospital records, correct? If you look at the
3 top it says systems review.

4 A Correct.

5 Q Correct?

6 A Correct.

7 Q There is a separate -- then the next page, page
8 370, do you see that?

9 A Got it, yes.

10 Q Okay. And that's a separate part of the hospital
11 chart where there's documentation to wounds, dressings and
12 drains, correct?

13 A Correct.

14 Q All right. Under the wounds dressing and drains
15 on page 370 at 5 a.m. performed by a Nurse Cheryl Dodgen on
16 April 27th, there is an entry there that says drainage bag,
17 draining green, brown, foul smelling. Comment: Leaking.
18 Patient prefers not to have drainage bag changed at this
19 time. Do you see that?

20 A I do.

21 Q And is that the entry that you're relying upon for
22 your opinion that there was a small bowel perforation at
23 that time?

24 A That is one of many entries I'm relying upon that
25 suggest the possibility that there might be a small bowel

Dr. William Irvin - Cross-Examination by Mr. McDow

1 perforation. It clearly points out a post-operative
2 finding that is not normal at this point and requires some
3 form of further evaluation. That is the entry.

4 Q All right. Did you see any other references
5 relative to a description of green, brown, foul smelling?

6 A Specific, green, brown in the subsequent days, no.
7 Purulent, yellow, yes. Not green, brown.

8 Q Okay. Doctor, would your opinions change in any
9 way if that entry was incorrect? If she didn't have a bag
10 and that was an incorrect patient -- on the wrong chart,
11 something like that?

12 A If that were the only reference that was made to
13 the possibility of a small bowel perforation post
14 operatively in this post-operative course, yes. My opinion
15 might change. This was one of many, many different
16 post-operative findings that collectively, taken in
17 concert, suggest a very high likelihood that she had a
18 post-operative perforation. This is only one of many.

19 Q All right. Doctor, I don't see in this set of
20 records and you can flip through and correct me if I'm
21 wrong, but I don't see page 534. Do you see a page 534 in
22 the hospital records within this particular collection of
23 documents?

24 A If they run numerically, no.

25 Q Well, they don't run numerically, but that's not

Dr. William Irvin - Cross-Examination by Mr. McDow

1 surprising for a hospital chart, is it?

2 THE COURT: Does this have a number on it?

3 MR. MCDOW: Page 5 --

4 THE COURT: I'm talking about this exhibit he's
5 looking at. Is this --

6 MR. CORBIN: It does, Your Honor.

7 THE WITNESS: Number 10.

8 THE COURT: All right Plaintiff's 10.

9 THE COURT REPORTER: Six.

10 THE COURT: Plaintiff's 6. Okay.

11 BY MR. MCDOW:

12 Q Doctor, I didn't see it yesterday?

13 MR. MCDOW: May I approach the witness?

14 THE COURT: Yes, sir.

15 BY MR. MCDOW:

16 Q So I pulled a copy out, page 534 and I've
17 highlighted it for your easy reference. That's an entry on
18 April 17th around 7:56 a.m.; if I recall correctly.

19 A Okay.

20 Q And what is the description of the drains on that
21 particular document?

22 A On that specific day, none at 7 a.m.

23 Q Okay. How do we go from brown, green, foul
24 smelling at 5 a.m. in the morning to looking pretty good,
25 no entries, no drain problems at 7:56?

Dr. William Irvin - Cross-Examination by Mr. McDow

1 A There could have been a pocket of fluid that was
2 expressed as she was moving or rolling over and in some
3 fashion applied pressure on the wound that evacuated at
4 that moment in time and there was no other collection over
5 that two-hour short period of time.

6 Q Okay. May I have my exhibit back, please? Thank
7 you.

8 Doctor, let me now turn your attention to the
9 radiology reports.

10 MR. MCDOW: May I have this marked as Defendant's
11 Exhibit 1.

12 THE COURT: For ID or --

13 MR. MCDOW: As an -- I don't think Mr. Corbin has
14 any objections.

15 MR. CORBIN: No objection, Your Honor. Any records
16 can come in.

17 THE COURT: Defendant's No. 1 is in.

18 (WHEREUPON Defendant's Exhibit No. 1 was marked and
19 entered into evidence.)

20 MR. MCDOW: Okay.

21 BY MR. MCDOW:

22 Q Doctor, what I've done is we've collected the
23 radiology reports in a different format. I think those are
24 what we call bate stamped down at the bottom, PHR Radiology
25 01 through wherever the final one is and they're actually,

Dr. William Irvin - Cross-Examination by Mr. McDow

1 I believe in reverse chronological order. So you turn to
2 the last two pages of the exhibit, which should be pages 31
3 and 32?

4 A I have that.

5 Q That is the upper GI small bowel follow through
6 for May 2nd, 2007, correct?

7 A Correct.

8 Q Okay. And it was this small bowel follow through
9 that was performed with barium where the patient sipped it
10 down through a straw and then various films were taken as a
11 result of that procedure, correct?

12 A That's correct.

13 Q And that small bowel follow through does not
14 mention anything about any leaking of barium or a leak from
15 any site, does it?

16 A No, it does not.

17 Q Now, if you go forward to pages 24 and 25, that is
18 the -- what is called a KUB from May 12th, 2007, correct?

19 A That is correct.

20 Q Okay. And it was that finding there, that
21 collection of contrast left lower quadrant which has
22 somewhat angular margins. The possibility that this is an
23 extraluminal focus of contrast is not entirely excluded but
24 this is felt less likely as this collection appears smaller
25 than on the previous exam. Therefore, it is more likely

Dr. William Irvin - Cross-Examination by Mr. McDow

1 within abnormal segment of bowel; do you see that?

2 A I do.

3 Q So in the impression by that particular
4 radiologist was a small collection of contrast with
5 somewhat angular margins in the left lower quadrant appears
6 less prominent than on previous exams, continue followup is
7 suggested. You see that?

8 A He raises that possibility for consideration
9 because he isn't managing the patient. So he does raise it
10 as a possibility but doesn't clearly say that she has a
11 perforation because this is not the test that would show
12 you that.

13 Q None of the KUB's and followup showed any leaking
14 of barium, did they?

15 A They did not.

16 Q Doctor, did the second surgery where you believe
17 there was barium that was extravasated and found, was that
18 in the pelvis?

19 A No, that was at the base of the jejunum, mesentery.

20 Q I believe you testified in your deposition that
21 you thought the findings were of barium in the pelvis?

22 A Well, there's a true anatomic pelvis, there's the
23 pelvis that's defined as basically below the spines and the
24 true anatomic pelvis, no. It was felt to be in the mid
25 abdomen, upper pelvis, so it's a semantic distinction about

Dr. William Irvin - Cross-Examination by Mr. McDow

1 where it is. It wasn't up under the stomach and it wasn't
2 in the lower pelvis. It was in the root of the mesentery
3 of the small bowel, which is in the mid abdomen.

4 Q Doctor she did not show any signs of frank sepsis
5 in associated instability between the two surgeries; did
6 she?

7 A She did not.

8 Q Okay. And she also showed tachycardia after some
9 of Dr. Parker's surgeries as well, correct?

10 A She did.

11 Q She was not floridly septic?

12 A I don't think she ever was actually septic as
13 defined by vascularly compromise requiring lucent pressers,
14 intubation, ICU admission, et cetera. She was never in
15 that sense septic, no. Bacteriamic, probably, yes, but not
16 septic.

17 MR. MCDOW: Beg the Court's indulgence. I may be
18 about finished.

19 THE COURT: All right.

20 BY MR. MCDOW:

21 Q Doctor, your depositions that you give are 60
22 percent for the plaintiff and 40 percent for the defendant;
23 is that right?

24 A I have no choice. I simply review things that are
25 asked of me to be reviewed. I don't choose who sent it to

Dr. William Irvin - Cross-Examination by Mr. McDow

1 me. I would just as happy review for the defendant as the
2 plaintiff. I don't have a choice. I don't select those.

3 Q And you charge \$4,500 a day for trial since you're
4 out of your office today?

5 A For the full day, yes.

6 Q Okay. And deposition is \$2,000 with \$500 hour
7 after the first two hours, correct?

8 A Also compensating the time away from work, yes.

9 Q And the cases where you've given depositions
10 included Georgia; is that correct?

11 A That's correct.

12 Q Arkansas?

13 A That's correct.

14 Q Connecticut?

15 A That's correct.

16 Q Ohio?

17 A Correct.

18 Q Virginia?

19 A Correct.

20 Q New York?

21 A Correct.

22 Q Alabama?

23 A Correct.

24 Q And I also have one from Colorado; is that
25 correct?

Dr. William Irvin - Redirect Examination by Mr. Corbin

1 A Correct.

2 Q Doctor, did you note in the hospital records where
3 Dr. Williams spoke with the patient and the daughter on May
4 the 18th?

5 A I'm sure I reviewed that. I don't have an
6 independent recollection of it at this moment.

7 Q That's fine. I don't have any further questions.
8 Thank you very much.

9 THE COURT: Anything else?

10 MR. CORBIN: Just a short one, Your Honor.

11 THE COURT: All right.

12 **REDIRECT EXAMINATION**

13 **BY MR. CORBIN:**

14 Q Informed consent. You teach medical students
15 about informed consent?

16 A Yes.

17 Q In your opinion, under the standard of care, if a
18 patient signed an informed consent form, does that give a
19 doctor the right to provide negligent care?

20 A Absolutely not.

21 Q Georgia, Arkansas, Connecticut, Ohio, Virginia,
22 New York, Alabama Colorado and now South Carolina. Have
23 all these courts accepted you as an expert witness?

24 A They have.

25 Q Thank you, sir.

1 **THE COURT:** All right. You can step down. Thank
2 you, sir.

3 Can I see the lawyers up here for just a moment?

4 **MR. CORBIN:** Your Honor, may the doctor leave.

5 **THE COURT:** Yes, sir.

6 Doctor, you can be excused if you would like.

7 **THE WITNESS:** Thank you.

8 **MR. CORBIN:** Thank you, Dr. Irvin.

9 (WHEREUPON, there was a bench conference out of the
10 hearing of the jury and the Court Reporter.)

11 **THE COURT:** Ladies and gentlemen, we're going to
12 break now, of course, for lunch. It's almost quarter after
13 one. If you would please be back in your jury room at
14 2:30, we'll begin at that time. Of course, you know what
15 I'm going to tell you next, you may not discuss this case
16 with anyone on the this earth; even amongst yourselves and
17 we'll see you back at 2:30. Thank you.

18 (WHEREUPON the jury left the courtroom at 1:12
19 p.m.)

20 **THE COURT:** Mr. Corbin?

21 **MR. CORBIN:** Yes, sir.

22 **THE COURT:** The doctor typically has a two or three
23 page summary of his financial --

24 **MR. CORBIN:** He does.

25 **THE COURT:** Is he going to testify as to both

1 plaintiffs or just --

2 MR. CORBIN: No, no.

3 THE COURT: Just Ms. Atkinson?

4 MR. CORBIN: Yes, sir. And I've got one question,
5 Your Honor, since the jury's not here, about Mr. Atkinson
6 and I respect Your Honor's ruling about nothing being
7 mentioned about him having cancer and -- terminal cancer.
8 My only issue about that is, we have a lady who is
9 depending on somebody to care for her and that person who
10 has been caring for her has been her husband. That's why I
11 brought the consortium claim. I didn't have any idea that
12 he had terminal cancer when we brought this case.

13 THE COURT: Right.

14 MR. CORBIN: And now, he's going to die, but she
15 can't say that my husband has been caring for me for the
16 last four or five years because I need someone to care for
17 me, he's not going to be here anymore.

18 THE COURT: How about that Mr. McDow?

19 MR. CORBIN: Somebody's got to do it.

20 THE COURT: It can be prejudicial as long as it's
21 not unduly prejudicial. That's the key and that's my
22 decision to make. So what's your position on that?

23 MR. MCDOW: I think you've already heard my
24 position. I'll remain the same. I think it would be
25 unduly prejudicial to let the jury hear that because I

1 think that invokes more sympathy than what may be
2 necessary.

3 THE COURT: I guess one of the ironic things about
4 that is if he's going to pass away, he doesn't have a
5 claim.

6 MR. CORBIN: But he's not passed away yet.

7 THE COURT: I know that's not what you're talking
8 about.

9 MR. CORBIN: You know, ironically, that would help
10 their side.

11 THE COURT: I understand that, but going back to
12 your question, I'll wrestle with it and I think you're
13 right, probably some -- she is entitled to have some
14 explanation for the jury why the person she lives with is
15 not going to be there.

16 MR. CORBIN: And cares for her, yeah.

17 THE COURT: I don't know whether Mr. McDow will
18 object on hearsay grounds that he's going to die or some
19 prejudicial grounds or both, obviously on the prejudice
20 part, but I'll just have to --

21 MR. CORBIN: Yes, sir.

22 THE COURT: -- struggle with that. One thing you
23 might want to do is just make an offer of proof on it and I
24 can figure something out from there. She's going to be
25 your last witness this afternoon.

1 **MR. CORBIN:** I think so, Your Honor.

2 **THE COURT:** Okay. I'm not going to hold you to it.

3 **MR. CORBIN:** Yes, sir.

4 **THE COURT:** You got the deposition of Dr. Reynolds.
5 He typically would take 30 or 45 minutes.

6 **MR. CORBIN:** He would be quick. I would like to
7 get Faye up before he testifies, Your Honor. And so the
8 deposition part, Faye Atkinson, and then Dr. Reynolds.

9 **THE COURT:** All right. See y'all back at 2:15
10 then.

11 **MR. CORBIN:** Yes, sir.

12 **THE COURT:** In case you have anything else:

13 (WHEREUPON there was a recess for lunch.)

14 (WHEREUPON Court's Exhibit No. 2 was marked for
15 evidence.)

16 **NOTE FROM JUROR**

17 **THE COURT:** All right. Court's Exhibit No. 2,
18 gentlemen y'all don't know anything about this, it was just
19 handed to me. Actually it's extremely rare, it's another
20 note from a juror. And I obviously am duty bound to tell
21 you what it says and it -- there's a notation Juror 184, I
22 don't know who that is. Mr. Marrone, M-a-r-r-o-n-e. It
23 says, 1995 surgery on Faye, how many feet of bowel removed
24 at that time, question mark. Next line, Dr. Williams, 58
25 centimeters -- I thought it was 51, total -- Dr. Williams

1 58 centimeters total removed from both procedures, question
2 mark.

3 Obviously, what I'm going to do is tell the jury
4 that really at this stage of the proceedings, there is no
5 need to send out any note about any ongoing presentation of
6 evidence and that evidence will be presented and that's
7 what they will base their verdict on and there's no reason
8 to fire a shot off on that and try to find things out in
9 that respect.

10 Mr. Corbin, from the plaintiff, any -- of course,
11 you gentlemen can come up and look at this if you'd like
12 and show it to your clients. Is there anything from the
13 plaintiff on that issue?

14 MR. CORBIN: No, sir.

15 THE COURT: Mr. McDow?

16 MR. MCDOW: No, sir. I think you've outlined how
17 it should be handled.

18 THE COURT: Okay.

19 MR. MCDOW: It's a little premature for those kind
20 of notes at this point.

21 THE COURT: And the unspoken thing to be honest
22 with you, I would hope that the juror is not discussing
23 those questions with other jurors -- his fellow jurors.
24 That would be 180 degrees opposite from what I've
25 instructed them to do. Is there any -- either side wish me

1 to inquire into that? If I do that, I will bring the juror
2 out on his own initially.

3 MR. CORBIN: I think doing it that way would be the
4 appropriate way. If we have somebody back there expressing
5 opinions or raising questions before Your Honor tells the
6 jury to deliberate, I think we need to know and if he is, I
7 think he ought to be replaced.

8 THE COURT: All right. Mr. McDow?

9 MR. MCDOW: (No response).

10 THE COURT: I guess on the bright side, he's paying
11 attention.

12 MR. MCDOW: He's paying attention.

13 THE COURT: On the bad side, if he's -- the writing
14 the note, I don't have a problem with because he just may
15 not know. But if he's talking to other jurors about it
16 saying, Hey, how about if I find these things out.

17 MR. MCDOW: Yeah, but --

18 THE COURT: That's a problem.

19 MR. MCDOW: -- that's a potential problem.

20 THE COURT: I'll bring him out and see what he says
21 and then we'll take it from there. How about that?

22 MR. CORBIN: Yes, sir.

23 MR. MCDOW: I'll agree with that.

24 THE COURT: All right. And -- my law clerk said
25 you're going to call Dr. Reynolds first?

1 **MR. CORBIN:** No, sir, it's going to be deposition
2 publication of Dr. Smith, followed by Dr. Reynolds.

3 **THE COURT:** And then --

4 **MR. CORBIN:** Ms. Atkinson.

5 **THE COURT:** Ms. Atkinson.

6 **MR. CORBIN:** Yes, sir.

7 **THE COURT:** All right. So I think I'm -- I know
8 what I'm going to be doing about what you can say about her
9 husband.

10 **MR. CORBIN:** Yes, sir.

11 **THE COURT:** And we'll get to that later.

12 **MR. CORBIN:** Yes, sir.

13 **THE COURT:** Okay. Would you bring Mr. Marrone on
14 out, please.

15 **THE BAILIFF:** Yes, sir.

16 (WHEREUPON the juror entered the courtroom.)

17 **THE COURT:** Mr. Marrone? Is it Marrone?

18 **THE JUROR:** Yes, sir, it is.

19 **THE COURT:** I did receive your note identified by
20 your juror number.

21 **THE JUROR:** Thank you.

22 **THE COURT:** Let me ask you this first. Have you
23 had any discussions with your fellow jurors about these
24 points at all.

25 **THE JUROR:** No, sir.

1 **THE COURT:** Okay. This is your own inquiries?

2 **THE JUROR:** Yes, sir, they are.

3 **THE COURT:** Okay. Well, I guess the best way to
4 put it -- and I'm glad of that obviously, that you haven't
5 talked to your fellow jurors about it and I would certainly
6 ask you to continue to follow my instruction in that
7 regard. Just to answer your question immediately is that
8 during the course of the trial would not be the time where
9 you would pose questions to me in writing. Evidence is
10 going to be presented over the course of time as it has
11 been in the last day and the witnesses will testify as to
12 things within their knowledge and certain points made --
13 some certain questions may be answered in your mind,
14 certain other questions may not be answered and the jurors
15 do not have the right to ask those questions. And I'm not
16 fussing at you because you've probably never been on a
17 jury, you just don't know.

18 **THE JUROR:** That's right.

19 **THE COURT:** But that -- I will not be answering
20 those questions and nor will anything be done immediately
21 to respond to any inquiries from you. And if you would,
22 number one, don't discuss this with your jurors -- fellow
23 jurors; and number two, there's no need to send anymore
24 questions out --

25 **THE JUROR:** Okay.

1 **THE COURT:** -- at this stage, all right?

2 **THE JUROR:** Yes, sir. Thank you.

3 **THE COURT:** And I hate to put you on the spot. I
4 just wanted to bring you out so we could get that straight.

5 **THE JUROR:** That's totally fine, Your Honor. Thank
6 you.

7 **THE COURT:** All right. Thank you.

8 **THE JUROR:** Thank you, sir.

9 (WHEREUPON the juror left the courtroom.)

10 **THE COURT:** Okay. Any objection or observation
11 from the plaintiff?

12 **MR. CORBIN:** Neither, Your Honor.

13 **THE COURT:** Mr. McDow, for the defendant?

14 **MR. MCDOW:** Let's proceed, Judge.

15 **THE COURT:** Okay. You can bring in the jury.

16 (WHEREUPON the jury entered the courtroom at 2:37
17 p.m.)

18 **THE BAILIFF:** Jury is present, Your Honor.

19 **THE COURT:** Okay. Thank you.

20 Okay. Ladies and gentlemen, thank you for your
21 patience. We're now ready to move on forward.

22 Mr. Corbin, you can call your next witness or
23 present your next piece of evidence.

24 **MR. CORBIN:** Thank you, Judge. At this time we'd
25 like to publish parts of the deposition testimony taken of

1 Sidney T. Smith, M.D. on August 13, 2012.

2 THE COURT: All right. Ladies and gentlemen, as I
3 mentioned to you earlier, a deposition is something that's
4 taken, obviously, typically during pretrial phase of the
5 case. Mr. Corbin's made reference to a deposition or
6 excerpts to a deposition that he's going to publish, which
7 means read.

8 Mr. Corbin, who's going to be reading the answers?

9 MR. CORBIN: My paralegal Christina Stewart, Your
10 Honor.

11 THE COURT: Okay. All right. Do y'all have an
12 oath for her or...

13 MR. CORBIN: She's going to do that, Your Honor.

14 THE COURT: Your name, please, ma'am.

15 THE WITNESS: Christina Stewart.

16 THE COURT: Just raise your right hand.

17 CHRISTINA STEWART,

18 having been duly sworn, testified as follows:

19 THE COURT: Thank you. Have a seat.

20 The way the rules work in civil cases is that a
21 party can offer these excerpts an the other side, Mr. McDow
22 in this instance can offer excerpts as well. The way it
23 will work in this particular case is that Mr. Corbin will
24 publish those excerpts and then Mr. McDow will be permitted
25 to publish excerpts that he has identified as well. Some

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 of the excerpts identified by Mr. Corbin have kind of been
2 jointly offered, if you will, but we'll approach it in that
3 fashion. The important thing for you to remember is that
4 the witness, Dr. Smith, was sworn at the time of the
5 deposition to tell the truth just as the witness would be
6 here live in court.

7 All right. Any objection to those comments, Mr.
8 Corbin?

9 MR. CORBIN: No, Your Honor.

10 THE COURT: Mr. McDow?

11 MR. MCDOW: No, sir.

12 THE COURT: Okay. You can begin and if you would
13 kindly let us know what page number and line number and
14 I've got the original, that will be Court's Exhibit No. 3
15 at the appropriate time.

16 THE COURT REPORTER: Yes, sir.

17 THE COURT: Thank you.

18 **READING OF DEPOSITION EXCERPTS OF**

19 **SIDNEY T. SMITH**

20 MR. CORBIN: Your Honor, we're going to start on
21 page 4, please, line 11.

22 Dr. Smith, would you please state your complete
23 name for the record?

24 THE WITNESS: Sidney, that's S-i-d-n-e-y, Terrell,
25 T-e-r-r-e-l-l, Smith.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Dr. Smith, how long have you been a
2 doctor?

3 **THE WITNESS:** I finished medical school in 1975,
4 finished residency in 1979, so I guess 1979.

5 **MR. CORBIN:** Dr. Williams is your medical partner?

6 **THE WITNESS:** He is indeed.

7 **MR. CORBIN:** How long has Dr. Williams been your
8 medical partner, roughly speaking?

9 **THE WITNESS:** Its a bad guess, but I would guess
10 about fifteen years.

11 **MR. CORBIN:** Have you reviewed the medical records
12 in this particular case?

13 **THE WITNESS:** I reviewed the records from Richland
14 Memorial Hospital.

15 **MR. CORBIN:** Is that also Palmetto Health Richland?
16 Is it all considered the same thing, Richland Memorial
17 Hospital?

18 **THE WITNESS:** Yes, sir, it is.

19 **MR. CORBIN:** Yes, sir, and based upon your review
20 of the medical records involving Dr. Williams' care of
21 Ms. Atkinson, are you prepared to render opinions as to
22 whether or not Dr. Williams met the standard of care?

23 **THE WITNESS:** Yes, I am.

24 **MR. CORBIN:** Have, in fact, you reached those
25 opinions.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **THE WITNESS:** Yes, I have.

2 **MR. CORBIN:** In general would you agree that your
3 opinion would be that Dr. Williams violated no standard of
4 care? Would that be your opinion?

5 **THE WITNESS:** My opinion would be that the standard
6 of care has not been violated by Dr. Williams.

7 **MR. CORBIN:** Are you prepared to testify to your
8 opinions to a reasonable degree of medical certainty.

9 **THE WITNESS:** I am, indeed.

10 **MR. CORBIN:** You anticipate testifying at trial
11 about your opinions?

12 **THE WITNESS:** If I'm called upon to do so, then I
13 will.

14 **MR. CORBIN:** The next reference starts on page 19.

15 All right. Line 8: Would you agree that if
16 Ms. Atkinson did have extravasated dye outside of her
17 intestine that it had to get there by a leak?

18 **THE WITNESS:** Yes, I would agree with that.

19 **MR. CORBIN:** Would you agree that Dr. Williams did
20 not treat Ms. Atkinson for a bowel perforation.

21 **THE WITNESS:** We're talking about from the 25th of
22 April to the 20th of May?

23 **MR. CORBIN:** Yes, sir.

24 **THE WITNESS:** No, he did not specifically treat her
25 at all for a perforation.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** In fact, was his diagnosis between the
2 first -- in fact, what was his diagnosis between the first
3 and second operations?

4 **THE WITNESS:** A small bowel obstruction, partial or
5 small bowel obstruction secondary to -- and he said
6 disease.

7 **MR. CORBIN:** Would you agree that Ms. Atkinson,
8 after her first operation, given the fact that she had a
9 bowel perforation during the first operation, she had a
10 bowel resect where part of the bowel was actually
11 surgically removed; given the fact that that bowel was sewn
12 back together, would you agree that she was in danger, more
13 than in a regular operation, of having a post-operative
14 perforation or abscess?

15 A There is no doubt that if a bowel is resected and
16 then reanastomosed, this is great -- there is a greater
17 risk than there would be if the bowel was completely
18 intact. This bowel, by the way, was stapled, as far as I
19 know, not sutured.

20 **MR. CORBIN:** Would you agree that Dr. Williams'
21 initial operation was difficult?

22 **THE WITNESS:** Yes, I would.

23 **MR. CORBIN:** Would you agree that the fact that Dr.
24 Williams indicates in his operative report he spent about
25 two-and-a-half hours removing adhesions, that would be

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 considered a long lysis adhesion removal procedure?

2 **THE WITNESS:** Given the fact that it took
3 two-thirds of the operative time, I would say yes, it was
4 difficult and that was long.

5 **MR. CORBIN:** Do you believe that Dr. Williams
6 removed any adhesion that was not necessary to gain access
7 to Ms. Atkinson's ovaries?

8 **THE WITNESS:** He lysed the entire small bowel and
9 one might believe that there is an excessive amount of
10 adhesiolysis, just to get to the ovary. I think the
11 caveat, however, is there was a bowel injury in the process
12 and you have to lyse enough bowel to know that you're
13 putting the thing back together. Well, that you're not
14 creating a problem in the process. So the answer, if you
15 stick it just to the ovary, complete adhesiolysis might be
16 excessive depending upon the situation. Would you then add
17 a hole --

18 **MR. CORBIN:** Would you please read it correctly?

19 **THE WITNESS:** When you have a hole in the bowel,
20 you then have to increase the amount you're doing in order
21 to be able to fix that injury.

22 **MR. CORBIN:** Would you agree that the primary goal
23 to have a lysis procedure is to remove only what is
24 necessary?

25 **THE WITNESS:** I think I agree.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Page 24, Your Honor.

2 Would you agree that Ms. Atkinson -- in
3 Ms. Atkinson's -- that Ms. Atkinson's case, her first
4 surgery, the purpose of that surgery was to gain access to
5 the mass and remove it, correct.

6 **THE WITNESS:** That's correct.

7 **MR. CORBIN:** Would you agree that Ms. Atkinson had
8 no prior history of troubles from adhesions before the
9 first surgery?

10 **THE WITNESS:** I know that she had two episodes of
11 bowel obstruction that required surgical therapy prior to
12 that. I am not privy to the reasons for those, so they may
13 have been adhesive disease. I do not know that.

14 Q Since those prior operations I think were in the
15 1990's, well more than a decade before she saw Dr.
16 Williams, would you agree that the records indicate she had
17 no troubles from adhesions at least in the decade?

18 **THE WITNESS:** As far as I can read the record, that
19 is true.

20 **MR. CORBIN:** Would you agree in Ms. Atkinson's case
21 since she had no troubles with adhesions before seeing Dr.
22 Williams for at least a decade that his goal should have
23 been to remove the mass and to take down the least amount
24 of adhesions that we could to get access to the mass.

25 **THE WITNESS:** I would regard that as unreasonable,

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 yes.

2 MR. CORBIN: Would you agree that the reason you
3 minimize taking down adhesions is because when you take
4 them down -- in Ms. Atkinson's situation -- there's a good
5 chance they're going to come back.

6 THE WITNESS: Oh, no, they will come back.

7 MR. CORBIN: Would you agree that if you cut out
8 scar tissue through the lysis procedure and the person
9 wasn't having troubles with adhesions before the operation,
10 you're increasing the chance that you'll have troubles in
11 the future from those adhesions?

12 THE WITNESS: That is a reasonable assumption.

13 MR. CORBIN: In other words, if Ms. Atkinson was
14 having no troubles with adhesions and did not have the
15 perforation caused by Dr. Williams in that procedure, can
16 you think of any reason to run the entire bowel or remove
17 all of those adhesions?

18 THE WITNESS: Again, because I'm not there, you
19 really don't know what the mass -- what kind of bowel was
20 involved with the mass. And to sit here today and say that
21 you -- that you should have taken down half the adhesions
22 or a fourth of the adhesions is to have a piece of data
23 that we don't have. There's no doubt that you want to take
24 down as few adhesions as possible. You want to get to the
25 mass or whatever it is and get out of there. But at the

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 time if three-fourths of the bowel was laying on top of the
2 mass, you're going to have to --

3 **MR. CORBIN:** It goes down --

4 **THE WITNESS:** That goes down, that becomes part of
5 the decision made by the operator at the time and I'm not
6 sure how you walk that back to a statement that's real.

7 **MR. CORBIN:** But the bottom line is remove the
8 least amount of adhesions that you can to get access to
9 that particular mass?

10 **THE WITNESS:** Yes. I agree.

11 **MR. CORBIN:** What is the danger to a patient like
12 Ms. Atkinson if the lysis procedure is too aggressive?

13 **THE WITNESS:** Well, there are -- I guess you can
14 find two major ones. And one of those would be the
15 production of other enterotomies in the process of taking
16 that adhesion down. A second of those would be the fact
17 that you have already -- that you had already brought up,
18 that adhesion to reform. They will probably reform within
19 an hour of taking these things down.

20 The first would be -- and this is not in this case
21 at all -- but if the timing of the surgery required a
22 tremendous amount of time, if you're at six or seven hours,
23 you would increase morbidity by virtue of time. So these
24 are the three things that you think of. One of these being
25 immediate, the others obviously a bit not.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** The two-and-a-half hours of lysis
2 procedure and the fact that Dr. Williams, when you say he
3 ran the bowel, he removed all of the adhesions on the
4 bowel, is that what you're talking about?

5 **THE WITNESS:** As best I can tell from his operative
6 note, I think he uses the word complete adhesiolysis. Now,
7 I would have to see the operative note to make certain that
8 is accurate.

9 **MR. CORBIN:** Complete adhesiolysis means if he saw
10 an adhesion, he took it down or cut it out.

11 **THE WITNESS:** It would generally mean that. What
12 it actually means is that if you can trace the bowel and
13 you can follow the bowel from one end to another and notice
14 it is completely open, there can certainly be adhesions in
15 the mesentery that you would not take down and there can be
16 some little interloop adhesions that you would not take
17 down. What you're doing is saying that the bowel is in
18 total, free.

19 **MR. CORBIN:** Page 29.

20 Okay. Would you agree that an aggressive lysis
21 procedure, taking down adhesions that are not necessary to
22 get access to a mass increases a patient's risk of a
23 perforation, peritonitis, or an abscess.

24 **THE WITNESS:** There's no doubt that the longer the
25 surgery goes, the more adhesions you take down, the greater

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 is the likelihood of some complication. Be that your
2 abscess, be that a leak or something of that nature, so it
3 is related to the amount of adhesiolysis that you do.

4 **MR. CORBIN:** Next page, Your Honor, is starting on
5 page 35.

6 Should Dr. Williams have clearly stated in the
7 records the source of especially the thick and yellow and
8 brown or green drainage from the drains?

9 **THE WITNESS:** Generally things are numbered
10 drains -- drains are numbered. When I say things. Then
11 you say drain one and drain two are here and drain three is
12 there. That is lacking in the description and there's no
13 way to go back from the nurses notes or from any other
14 notes and define which one is which.

15 **Q** Do you believe Dr. Williams, that anywhere in his
16 records --

17 (WHEREUPON there was an interruption.)

18 **MR. CORBIN:** Shall I continue, Your Honor.

19 **THE COURT:** Yes, sir.

20 **MR. CORBIN:** Starting line 18:

21 Do you believe Dr. Williams, that anywhere in his
22 records should have noted the locations of the drainage?

23 **THE WITNESS:** I believe it is a prudent thing that
24 you put it in -- that you put in where drains go.

25 **MR. CORBIN:** Is it important in treating a patient

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 knowing the source of the drainage?

2 **THE WITNESS:** That's why you would number the
3 drains.

4 **MR. CORBIN:** Why is that important to know the
5 source of the wound leakage?

6 **THE WITNESS:** Well, you would want to know whether
7 this was coming from the abdomen. You would want to know
8 whether this was coming from the subcutaneous tissue,
9 exactly where it's coming from. Now, he may well have
10 known by virtue of the kind of drains or where the drains
11 were. I simply cannot reconstruct that from the record. I
12 just cannot do that. So basically she does wound
13 infection.

14 **MR. CORBIN:** How quickly do you think she had the
15 wound infection.

16 **THE WITNESS:** I believe that she probably developed
17 the wound infection within five or six days of the surgery
18 and it probably came from contamination of the bowel being
19 resected.

20 **MR. CORBIN:** Did Dr. Williams ever diagnose
21 Ms. Atkinson of having any type of wound infection?

22 **THE WITNESS:** As I sit here right now, I do not
23 remember. That's not a good answer, but...

24 **MR. CORBIN:** If a patient like Ms. Atkinson, post
25 surgical, at a higher risk of having abscesses,

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 perforations, bowel leaks, if she had a wound infection, do
2 you think it should have been diagnosed and in the record?

3 **THE WITNESS:** Well, anything that happens post
4 operatively needs to be in the record and so the answer is
5 yes. If somebody has a wound infection, then it ought to
6 be in the record somewhere.

7 **MR. CORBIN:** Do you know why Dr. Williams in his
8 medical reports, if it's not there and I -- if it's not
9 there and I can indicate -- let me finish the question --
10 and you don't recall seeing a diagnosis wound infection,
11 neither do I. So my question is do you know why there was
12 no diagnosis of the wound infection?

13 **THE WITNESS:** No, sir.

14 **MR. CORBIN:** You indicated that not only there was
15 no diagnosis of a wound infection, but you believe she had
16 some post operatively day five or six, there never even was
17 a culture done of the drainage; is that correct?

18 **THE WITNESS:** That is correct.

19 **MR. CORBIN:** Can you state to a reasonable degree
20 of medical certainty something more than a guess of what
21 type of infection she had from post-operative day five or
22 six on?

23 **THE WITNESS:** One would believe that it's a mixed
24 flora, representing in part bowel contaminants, as well as
25 the potential for some type of skin contaminant.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** What else could it have been?

2 **THE WITNESS:** You asked for my best guess as to
3 what it was and that's what it would be.

4 **MR. CORBIN:** No, sir, would it just be a guess.

5 **THE WITNESS:** Yes.

6 **MR. CORBIN:** Okay. Let me be more precise. Can
7 you state to a reasonable degree of medical certainty most
8 probably what kind of infection she had from post-operative
9 day five or six on?

10 **THE WITNESS:** Without --

11 **MR. CORBIN:** Without a culture.

12 **THE WITNESS:** Without a culture you're not going to
13 be able to say that.

14 **MR. CORBIN:** Next page, Your Honor, is starting on
15 page 42.

16 **THE COURT:** All right.

17 **MR. CORBIN:** Was she draining pus?

18 **THE WITNESS:** The nurses notes record pus. I do
19 not see that any in the physician record.

20 **MR. CORBIN:** Could the doctor have missed it and
21 the nurses caught it? Is that possible?

22 **THE WITNESS:** All things are possible.

23 **MR. CORBIN:** Please continue.

24 **THE WITNESS:** Do I believe that for a period of 30
25 days the doctor would miss pus draining out of the wound,

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 the answer is no, I don't. But is it possible? Sure.

2 **MR. CORBIN:** Is there any big deal about pus coming
3 out of a drain?

4 **THE WITNESS:** Again, to my mind, what it says is we
5 have a wound infection, so yes, that's a big deal.

6 **MR. CORBIN:** Is it a big enough deal to do a
7 culture of the pus?

8 **THE WITNESS:** Again, I think the pus will come out
9 to be a mix flora from which I would get no information
10 other than that there are bacteria in there; and frankly, I
11 knew that before I sent it.

12 **MR. CORBIN:** Your review of the medical records,
13 you certainly saw the references, but the nurses, they felt
14 like Ms. Atkinson's wounds were draining pus, correct?

15 **THE WITNESS:** Correct.

16 **MR. CORBIN:** You saw no reference by Dr. Williams,
17 given his examination of the wound, if, in fact, it did
18 occur, that he saw any evidence of pus, correct?

19 **THE WITNESS:** That's correct.

20 **MR. CORBIN:** So would you agree either the nurses
21 were wrong or Dr. Williams is wrong?

22 **THE WITNESS:** Intuitively, the answer to that, I
23 suppose is yes.

24 **MR. CORBIN:** Your review -- you reviewed Dr.
25 Williams' records. Did he indicate anything at all that

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 had any resemblance of pus?

2 THE WITNESS: I did not see anything, no, sir.

3 MR. CORBIN: Page 51, Your Honor.

4 Would you at least agree -- and I assume that you
5 have read the medical literature about small bowel
6 obstructions; is that true?

7 THE WITNESS: Yes.

8 MR. CORBIN: And if someone were to say that the
9 medical journal peer review literature is a bunch of junk,
10 what would you say?

11 THE WITNESS: I would say that's not true.

12 MR. CORBIN: Okay. And peer review articles, that
13 means that other doctors have reviewed the article, made
14 certain that it's reasonably reliable before it's published
15 to the journal; is that correct?

16 THE WITNESS: That's correct.

17 MR. CORBIN: Would you agree that if you look at
18 the peer review medical literature from these prominent
19 journals that you mentioned, and other prominent journals,
20 like the American College of Surgeons and those kinds of
21 things, that it falls in line with experience that if you
22 have a small bowel obstruction patient, post operatively
23 and the patient does not get better with conservative
24 medical management for 10 to 14 days or so, probably that
25 patient will not get better unless you intervene

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1 surgically?

2 **THE WITNESS:** That is generally our feeling, yes.

3 **MR. CORBIN:** For example, the Pickleman Study, are
4 you familiar with that one?

5 **THE WITNESS:** You'd have to show it to me.

6 **MR. CORBIN:** Okay. Some of your experts have
7 produced the Pickleman Study, but in that particular study
8 and in numerous others, it indicates in the first week,
9 early post operative small bowel obstruction like
10 Ms. Atkinson, in the first week about 75 percent of the
11 patients, if they're going to resolve nonsurgically do so
12 with conservative management. Is that a fair statement?

13 **THE WITNESS:** That's a fair statement.

14 **MR. CORBIN:** 70 percent of the patients during the
15 first week with conservative medical treatment,
16 nonsurgical, if they're going to resolve without surgery,
17 they do so within the first week, has that been your
18 experience.

19 **THE WITNESS:** I would say so, yes.

20 **MR. CORBIN:** If you go into the second week, by the
21 end of the second week, about 95 percent of the patients,
22 if they're going to resolve without an operation with a
23 small bowel obstruction, do so.

24 **THE WITNESS:** That is, again, reasonable.

25 **MR. CORBIN:** So would you agree that Ms. Atkinson,

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 during the first two weeks, there was a 95 percent chance
2 that she would resolve without surgery.

3 **THE WITNESS:** Statistically, that's true.

4 **MR. CORBIN:** Would you agree that after two weeks
5 there was a 95 percent chance that she would not resolve
6 without surgery.

7 **THE WITNESS:** That is the reverse of those numbers,
8 yes.

9 **MR. CORBIN:** Okay. If somebody were to tell you
10 that using NG tubes in early small bowel obstruction cases
11 is no longer the standard, what would you say?

12 **THE WITNESS:** I would generally regard it still as
13 being the standard of care. Now, I'll also admit to you
14 that I use a nasal gastric tube a lot more than other
15 people do.

16 **MR. CORBIN:** Next page starting at 62, Your Honor.
17 So at trial, we can show you the KUB reports and
18 you can tell me how many obstructions Ms. Atkinson had.

19 **THE WITNESS:** No.

20 **MR. CORBIN:** Okay. Do you know of anybody who can
21 look at those KUB reports and state under oath to a
22 reasonable degree of medical certainty she had X number of
23 obstructions?

24 **THE WITNESS:** No, sir.

25 **MR. CORBIN:** Can somebody state to a reasonable

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 degree of medical certainty that in fact those KUB's are
2 obstructions and nothing else.

3 **THE WITNESS:** If KUB only gives you a look at what
4 the bowel is looking like and how it seems to be
5 functioning. I'm not hearing a question. What something
6 else is supposed to mean.

7 **MR. CORBIN:** For example, can peritonitis cause an
8 ileus or an obstruction?

9 **THE WITNESS:** Yes, it can.

10 **MR. CORBIN:** Can an abscess cause what appears to
11 look like a small bowel obstruction on plain films?

12 **THE WITNESS:** They can create a small bowel
13 obstruction.

14 **MR. CORBIN:** Could a bowel leak, just using plain
15 films look like Ms. Atkinson's KUB's.

16 **THE WITNESS:** Yes, with a caveat and the caveat
17 would be this: She could certainly -- anybody could
18 certainly have a small area of leak and produce the look of
19 a small bowel obstruction. The commonality in everything
20 that you have just presented is things that affect the
21 mortality of the bowel, be that adhesion, be that abscess,
22 be that potentially a leak, it depends on how well walled
23 off the leak is. It may not -- peritonitis certainly can.

24 The KUB does not define anything other than the
25 status of the gas and the bowel and it gives you a hint of

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1 how it's functioning. Now, by that, I mean this: If
2 you've got that x-ray that shows multiple-air-fluid-levels
3 and you listen to someone's abdomen and it is quiet as a
4 church mouse, that person has an ileus: That may be an
5 abscess. If you listen and there are growls and gurgles
6 and all sorts of things, that person has a mechanical
7 obstruction and the bowel is working as hard as it can.
8 The KUB did not give you the information. It told you
9 simply the status of the bowel and that's all it ever does.

10 **MR. CORBIN:** Dr. Smith, would you agree that the
11 KUB's are consistent with a small bowel obstruction,
12 peritonitis, abscess and a bowel leak.

13 **THE WITNESS:** No. I would agree that it is
14 consistent with a small bowel obstruction. It says nothing
15 about the origin.

16 **MR. CORBIN:** Do the KUB's rule out peritonitis and
17 abscess or a bowel leak.

18 **THE WITNESS:** No, they do not.

19 **MR. CORBIN:** Okay. Would you agree that given the
20 fact that Ms. Atkinson was in the higher risk of
21 peritonitis, abscess and a bowel leak and the KUB does not
22 rule out those conditions, why not take the CT scan.

23 **THE WITNESS:** That's a critical judgment based on
24 what the patient looks like and the critical scenario at
25 the time. I can't answer it any differently than that. In

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1 the individual that I think -- because of the presence of
2 fever -- the presence of a change in their bowel, whatever
3 it happens to be, I believe the CAT scans and those sorts
4 of things are -- are very valuable and it's the critical
5 situation, not the KUB that dictates to me.

6 **MR. CORBIN:** If Ms. Atkinson during those 32 or 33
7 days, especially after post-op day 5 or 6, if in fact she
8 did have an abscess, would a CT scan most probably show it?

9 **THE WITNESS:** Probably, yes.

10 **MR. CORBIN:** A CT scan is certainly more sensitive
11 than a plain film in showing an abscess, correct?

12 **THE WITNESS:** Correct.

13 **MR. CORBIN:** Would you agree that if a patient has
14 a condition suggestive of an abscess and the plain films
15 are imprecise, the standard of care indicates a CT scan
16 should be taken?

17 **THE WITNESS:** If that individual has the clinical
18 setting of an abscess, the KUB is of little value at that
19 point in time. So as a matter of fact, a CAT scan would be
20 a very reasonable thing to do at that time, yes.

21 **MR. CORBIN:** Would it be the standard of care?

22 **THE WITNESS:** I think it would.

23 **MR. CORBIN:** You think it would be the standard of
24 care?

25 **THE WITNESS:** It would be the standard of care, but

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 again, it is not the KUB that has anything to do with that.

2 It's a clinical presentation at the time.

3 **MR. CORBIN:** So in your opinion, if the KUB comes
4 back and it really does not rule out -- can peritonitis
5 kill a patient?

6 **THE WITNESS:** Yes.

7 **MR. CORBIN:** Can an inter abdominal abscess in a
8 patient like Ms. Atkinson kill her?

9 **THE WITNESS:** Yes.

10 **MR. CORBIN:** Would a bowel leak in a patient like
11 Ms. Atkinson cause her to dye if untreated.

12 **THE WITNESS:** It's possible, yes.

13 **MR. CORBIN:** Would you agree that a small bowel
14 obstruction, peritonitis, abscess or a bowel leak, the
15 least dangerous, in general, would be a small bowel
16 obstruction?

17 **THE WITNESS:** Correct.

18 **MR. CORBIN:** A differential diagnosis is where if a
19 patient has signs and symptoms consistent with more than
20 one condition, the doctor is supposed to come up with a
21 list of differential or potential conditions the patient 0
22 to rule out the most dangerous ones first, agreed?

23 **THE WITNESS:** That is a reasonable thought, yes.

24 **MR. CORBIN:** Is that the standard of care?

25 **THE WITNESS:** That's a reasonable thought, yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Would you agree that if a patient like
2 Ms. Atkinson has a condition consistent with something else
3 besides just a plain small bowel obstruction, a condition
4 that could kill her, not ruling out the condition that
5 could kill the patient first would be a violation of the
6 standard of care?

7 **THE WITNESS:** In a hypothetical situation, in an
8 individual who has signs and symptoms that is consistent
9 with an abscess, consistent with a leak, consistent with
10 peritonitis, then to not look at those is below the
11 standard of care.

12 **MR. CORBIN:** Next page 73.

13 **THE COURT:** Come up, please, just a moment. Mr.
14 McDow?

15 (WHEREUPON there was a bench conference out of the
16 hearing of the jury and the court reporter.)

17 **THE COURT:** All right. You're on page 73, correct?

18 **MR. CORBIN:** Yes, sir, page 73.

19 **THE COURT:** Well, actually -- yeah, 73.

20 **MR. CORBIN:** Yes, sir.

21 Do you think Ms. Atkinson should have had that
22 discussion with Dr. Williams after a certain length of
23 time, that Ms. Atkinson, you have two choices. You can
24 either sit and wait and hope it's going to open up with
25 time or I can go in and surgically try to correct the

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1 problem.

2 **THE WITNESS:** I believe, to be honest about it,
3 that everybody has the right to talk, to go to other things
4 present, those sorts of things; and so, yeah, there's no
5 doubt that the patient has got to have a place in the
6 decision making of what is done. Now, there are certain
7 times in which there is an emergency, you really don't have
8 a choice.

9 **MR. CORBIN:** We're talking about Ms. Atkinson.

10 **THE WITNESS:** Yes, I know that. But in this kind
11 of case, it's a matter of sitting down and talking. Does
12 it have to be a formal conversation? When you've got a
13 relationship with somebody that you see every day and as
14 that conversation evolves many times discussion comes out
15 of that. Now, I'll be honest with you, I like to talk so I
16 will have a formal sit down, let's collect everybody and
17 talk session. There are times in which the decision is
18 made before then, but yes, I think as a rule for everybody,
19 the patient has a right and ought to take part in what's
20 done or not done.

21 **MR. CORBIN:** Your Honor, starting on page 75, line
22 14.

23 Do you think in Ms. Atkinson's situation that a
24 doctor should have had a discussion with her after
25 post-operative day 10, 11, or 12 or so and told her what

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1 you just told us a few minutes ago if your small bowel
2 obstruction is going to resolve without surgery, 95 percent
3 of the time, it's going to happen within the first 2 weeks.
4 If it doesn't, 95 percent of the time, it's not going to
5 resolve without surgery. Do you think she had a right to
6 have that much information.

7 **THE WITNESS:** I think she has a right to have as
8 much information as you can reasonably give her.

9 **MR. CORBIN:** Page 75, Your Honor.

10 I'm sorry, that's not the page.

11 **THE COURT:** Yes, sir, page 84.

12 **MR. CORBIN:** Yes, sir.

13 **THE COURT:** Excuse me, I'm sorry, not page --
14 page --

15 **MR. CORBIN:** 81.

16 **THE WITNESS:** 81.

17 **THE COURT:** Yes.

18 **MR. CORBIN:** Starting with line 5. Page 81,
19 starting on line 5.

20 If you want to refute this, that's fine, but is it
21 your testimony that over time if the operation would have
22 been done, like I said post-operative day 6, 7, 8, 9 or 10,
23 is it your testimony that the adhesions would have been
24 just as bad then as they were post-operative day 33.

25 **THE WITNESS:** The adhesions that were there on day

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1 33 were there on day 15. They are not as tenacious on day
2 15 as 33, but you would have still run into a ball of glue
3 on day 15. You don't grow new adhesions. Those adhesions
4 form within a couple of hours to a day of the original
5 surgery. What happened was they do become more dense over
6 time. That is true.

7 **MR. CORBIN:** More dense, more dangerous.

8 **THE WITNESS:** They become harder.

9 **MR. CORBIN:** More difficult to operate on.

10 **THE WITNESS:** Yes, more difficult.

11 **MR. CORBIN:** More dense means more dangerous to
12 cause perforations?

13 **THE WITNESS:** That means that they have to be
14 removed surgically with scissors or a knife. They cannot
15 be divided by blunt dissection so that increases the
16 possibility of having holes in the bowel or whatever your
17 talking about.

18 **MR. CORBIN:** Page 83, Your Honor, lines 11 through
19 22.

20 Do you have any criticism that Dr. Williams never
21 ordered an NG tube for Ms. Atkinson between the first and
22 second operations given her condition?

23 **THE WITNESS:** I would have placed an NG tube.
24 However, if he feels -- if he felt like he was getting
25 decent bowel decompression without it, I cannot fault him

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 for not doing that. Like I told you before, at least on
2 one occasion, maybe on another, she actually refused to
3 have an NG tube placed and I think -- and that I think
4 colored what was done later.

5 **MR. CORBIN:** Page 84, lines 8 through 25.

6 **MR. CORBIN:** Yes, sir, yes, sir. And is it your
7 position under the standard of care that if a patient
8 expresses concerns, I really don't want to have an NG tube
9 on post-operative day 5 or 6 that it's okay for the next 25
10 days not to do an NG tube?

11 **THE WITNESS:** No. I did not say that at all.

12 **MR. CORBIN:** Okay. You're not blaming the patient.
13 If she needed an NG tube, the physician should have
14 expressed that to her, correct.

15 **THE WITNESS:** Correct.

16 **MR. CORBIN:** The nausea and vomiting, does an NG
17 tube decompression treat or lessen the nausea and vomiting?

18 **THE WITNESS:** The nausea and vomiting of a bowel
19 obstruction is lessened by an NG tube, yes.

20 **MR. CORBIN:** Do you know how often Ms. Atkinson,
21 during those 33 days had nausea and vomiting without the NG
22 tube?

23 **THE WITNESS:** I can tell you that it was multiple,
24 but I can't tell you otherwise, I did not count.

25 **MR. CORBIN:** If Ms. Atkinson had 64 episodes on at

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1 least 23 separate days of nausea and vomiting, do you
2 believe she would have benefitted from an NG tube?

3 **THE WITNESS:** I would have placed an NG tube
4 because I think she would have benefitted from it, yes.

5 **MR. CORBIN:** Do you know of any reason under the
6 standard of care if Ms. Atkinson had 64 episodes of nausea
7 and vomiting on 23 separate days why it would be
8 appropriate not to give her an NG tube?

9 **THE WITNESS:** Save the inability to pass the NG
10 tube because of an anatomic defect, then the answer is no.
11 And she did not have that as far as I know.

12 **MR. CORBIN:** Does it make it even worse or more
13 critical that a patient have an NG tube decompression if
14 you have 64 episodes on 23 separate days of nausea and
15 vomiting despite medications to prevent nausea, does that
16 make it worse?

17 **THE WITNESS:** From my perspective, the need for the
18 NG tube exists. And whether that amounts to 4 big episodes
19 of nausea and vomiting or 64, the need is still there.

20 **MR. CORBIN:** Page 86, Your Honor, I think we
21 exclude lines 20 through 24.

22 **THE COURT:** Correct.

23 **MR. CORBIN:** Yes, sir. Page 86.

24 Did you carefully review the nausea and vomiting
25 records?

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **THE WITNESS:** No, sir, I must admit I did not.

2 **MR. CORBIN:** Does it make any difference if a
3 patient like Ms. Atkinson is throwing up large amounts of
4 vomit that is feculent?

5 **THE WITNESS:** Does it make a difference?

6 **MR. CORBIN:** In terms of treatment.

7 **THE WITNESS:** No, it does not change treatment.
8 What it basically says is there's a loop of bowel sitting
9 there and that bacteria are growing in it. It still speaks
10 to the need for an NG tube.

11 **MR. CORBIN:** If a patient is throwing up thick,
12 foul-smelling, yellow vomit, does that have any medical
13 significance?

14 **THE WITNESS:** Again, there's material that's been
15 sitting in the bowel long enough for bacteria to grow, it
16 produces odor, so again, it is a sign of the bowel
17 obstruction.

18 **MR. CORBIN:** Page 87, Your Honor, line 7 through
19 15.

20 Would you agree under the standard of care, a CT
21 scan should have been given during those 32 or 33 days,
22 given her condition?

23 **THE WITNESS:** Given the fact that she had what was
24 believed to be a small bowel obstruction, secondary to
25 adhesive disease, the CAT scan, in my opinion would have

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1 offered nothing except dye in her bowel. So, no, it is not
2 a violation of the standard of care not to get it.

3 **MR. CORBIN:** The next page, 90, lines 18 through
4 23.

5 If you had the suspicions of an abscess or a small
6 bowel leak in Ms. Atkinson, would it be violation of the
7 standard of care not to get a CT scan?

8 **THE WITNESS:** If indeed you have those suspicions
9 up front, then it would be a violation not to look.

10 **MR. CORBIN:** Next reference, Your Honor, page 94,
11 lines 21 through 25.

12 Ms. Atkinson's situation, and you indicated the KUB
13 where it talked about -- well, have we talked about the KUB
14 post-operative day 15 -- post-operative day 12, I think, the
15 KUB that indicated possible leakage of barium. You recall
16 saying that?

17 **THE WITNESS:** Yes, I do.

18 **MR. CORBIN:** Is that what you call -- is that what
19 you recall, possible leakage of barium.

20 **THE WITNESS:** There was, I think what it basically
21 said was that there was a stellate area in the left lower
22 quadrant that could potentially represent, but may also
23 represent material in the bowel within itself.

24 **MR. CORBIN:** Yes, sir.

25 **THE WITNESS:** Yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Would you agree that the possibility
2 was raised that it could be evidence of a bowel leak with
3 dye coming out of her intestines?

4 **THE WITNESS:** The possibility is raised.

5 **MR. CORBIN:** Okay. If a doctor in Ms. Atkinson's
6 situation is given notice by the radiologist that your
7 patient could have, it's possible, that the report shows
8 that there's a leak in the small bowel and barium is
9 coming -- or getting outside the intestine, should the
10 physician do anything to rule it out?

11 **THE WITNESS:** I think it depends on the quality of
12 the report. Now, here's what I mean. If the radiologist
13 called and says we have an obviously leak of bowel, we can
14 see it squirting out and it's in the peritoneal cavity,
15 that has to be investigated. Quite frankly, that gets you
16 back to the operating room. On the other hand, if what you
17 get is something like this, which is little stellate area
18 that just sits there, it doesn't go into the peritoneal
19 cavity, it just sits there, do you pay attention to it? Do
20 you like -- do you look at it again? You see what it does,
21 but I don't think that warrants going back into the
22 abdomen.

23 I don't think it warrants another set of x-rays at
24 that point in time. You're going to get back to the CAT
25 scan. No it doesn't warrant the CAT scan it's a localized

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1 little spot as best you can tell. So the repeat -- so you
2 repeat the film and see what it does. Now, that again,
3 depends upon the clinical picture of the patient at the
4 time. If she is simply -- if she has suddenly gotten ill,
5 she's febrile, she has a white count, she's reacting to
6 something at that point in time, then that's a different
7 situation.

8 **MR. CORBIN:** Next page, Your Honor, page 99
9 starting online 16.

10 Would you agree that if, in fact, it was barium
11 leaking outside of the intestine, that he had missed that
12 diagnosis earlier?

13 **THE WITNESS:** If indeed there was barium sitting at
14 the base of the mesentery and we had been able to prove
15 that that's the case and there was a leak there that we did
16 not see, that's correct.

17 **MR. CORBIN:** And if that leak were there, the lower
18 left quadrant, a CT scan would have picked it up earlier.

19 **THE WITNESS:** No, we're talking about two different
20 things. Left lower quadrant is the -- is that little
21 speculated thing and his thing is that that thing at the
22 base of the mesentery, so you're talking about two
23 different things. Would a CAT scan have picked up that
24 little tiny stellate thing down in the pelvis, I would
25 almost bet you that it wouldn't. It was so small and was

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1 getting smaller -- well, stellate less obviously all along.
2 So I don't think it would have seen that. Would it
3 necessarily have seen that little collection at the base of
4 the mesentery, as I remember it was about 2 and-a-half
5 centimeters big or something. It may have -- it may have
6 seen that, but again, we don't have any evidence that there
7 was barium at the base of the mesentery. The question was
8 in the left lower quadrant.

9 **MR. CORBIN:** Next page 103, lines two through 15.

10 If a patient has a small bowel perforation and is
11 given barium, would you agree with the statement made by
12 somebody else that the barium becomes like cement when it's
13 retained like that in Ms. Atkinson's system for 26 or 27
14 days?

15 **THE WITNESS:** Now, you just asked two separate
16 things. The barium that moves outside, barium will with
17 time become more concrete. It is after all, clay. So as a
18 matter of fact, if it's outside of the bowel, that's why we
19 said if it washes away it cannot be outside the bowel.

20 **MR. CORBIN:** Yes.

21 **MR. MCDOW:** Your Honor, I need to object. I think
22 we missed a question leading into that on page 102.

23 **THE COURT:** 102, line 19.

24 **MR. MCDOW:** Line 19 through the bottom.

25 **THE COURT:** If you could start over there, please.

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1 **MR. CORBIN:** Starting --

2 **THE COURT:** 102, line 19.

3 **MR. CORBIN:** Yes, sir.

4 **THE COURT:** And 103 --

5 **MR. CORBIN:** Go back to page 102, line 19.

6 If it were 26 days of retained barium in her
7 system, do you think Dr. Williams should have done
8 something to investigate by using a CT scan to see what was
9 going on with her bowel?

10 **THE WITNESS:** No, you've already got an
11 obstruction: The obstruction is the cause of it. The CT
12 scan that says Gee, there's barium in your bowel, simply
13 adds to what you already know.

14 **MR. CORBIN:** If a patient has a small bowel
15 perforation and is given barium, would you agree with a
16 statement made by somebody else that the barium becomes
17 like cement when it's retained like that in Ms. Atkinson's
18 system for 26 or 27 days?

19 **THE WITNESS:** Now, you've just asked two separate
20 things. The barium that moves outside, barium will with
21 that time become more concrete. It is, after all clay. So
22 as a matter of fact, if it's outside the bowel, that's why
23 we said if it washes away it cannot be outside the bowel.
24 As it sits in the bowel, yes, it becomes much more -- it
25 becomes hard. It becomes stone like, so the answer, I

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1 think, is yes.

2 **MR. CORBIN:** Next page 116, lines 2 through 12.

3 If a CT scan would have been taken and it showed a
4 perforation in the lower left quadrant, you indicated
5 earlier that a perforation can cause a paralytic ileus, a
6 long term effect on the bowel; is that correct.

7 **THE WITNESS:** I did.

8 **MR. CORBIN:** Okay. And if a CT scan would have
9 been taken and if she had a perforation, lower left
10 quadrant that could be causing the obstruction, correct?

11 **THE WITNESS:** Yes.

12 **MR. CORBIN:** Page 117, lines 6 through 20.

13 Was her operation urgent on that day?

14 **THE WITNESS:** No.

15 **MR. CORBIN:** Would you agree that the operation on
16 that particular day, the second operation was elective?

17 **THE WITNESS:** Actually, I would, yes.

18 **MR. CORBIN:** Would you agree that if Dr. Williams
19 wanted to take a CT scan, he certainly had time to do it
20 before the operation?

21 **THE WITNESS:** Yes.

22 **MR. CORBIN:** Would you agree that the options
23 available to Ms. Atkinson on that day that Dr. Williams
24 decided to do surgery was surgery or continuation of TPN?

25 **THE WITNESS:** Yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Page 118, starting with line 14
2 through 18.

3 Watched her with TPN?

4 **THE WITNESS:** Oh, yes. You know, you've got to
5 feed her.

6 **MR. CORBIN:** Would you agree that watching her like
7 Dr. Strickland says and you say would be the safer route
8 compared to an operation that day?

9 **THE WITNESS:** There is little doubt that
10 complications associated with doing nothing and doing a TPN
11 is going to be less than going back to the operating room.
12 It comes down to, again, to the decision made of, have I
13 had enough of this vomiting and do all the things I'm doing
14 with the abdominal distension and everything else, can I go
15 on living that way or is this now time to do something. It
16 depends on the weight that is put on those set of scales.

17 You know from the medical standpoint, it certainly
18 would be easier to watch. There would be less complications
19 to watch, but the patient has to be willing to accept
20 nausea, vomits, the abdominal distension, the whole what
21 she'd been going through up until now.

22 **MR. CORBIN:** Do you think Dr. Williams, since he
23 had not given her NG tube decompression before going to the
24 operating room, he should have given her that option? We
25 can continue with TPN and to treat the nausea and vomiting,

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1 we can try an NG tube decompression, or we can do the
2 surgery with all those risks of those horrible
3 complications. Do you think she should have been given
4 that choice?

5 **THE WITNESS:** I think those choices always have to
6 be discussed.

7 **MR. CORBIN:** Did you see any evidence in the
8 medical record that Ms. Atkinson was given a choice between
9 continuation of TPN and perhaps NG tube therapy to treat
10 the chronic nausea and vomiting as compared to doing the
11 risky surgery?

12 **THE WITNESS:** I did not see a note to that effect
13 one way or the other.

14 **MR. CORBIN:** Can you explain why that documentation
15 is missing?

16 **THE WITNESS:** No.

17 **MR. CORBIN:** Would you agree that documentation
18 ought to be there?

19 **THE WITNESS:** Yes.

20 **MR. CORBIN:** Because we're talking about
21 potentially horrible consequences of surgery, correct.

22 **THE WITNESS:** That is the weight on the other side.
23 That is correct.

24 **MR. CORBIN:** On post-operative day 33, the day
25 before the surgery, assume you were -- instead of Dr.

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1 Williams, we know that you would recommend TPN. What would
2 you do if the reason for doing surgery is to get
3 Ms. Atkinson out of this horrible nausea and vomiting, what
4 would you recommend to treat that?

5 **THE WITNESS:** Had I been there then, we would have
6 done a discussion regarding several options. One option
7 would be is put an NG tube in, continue the TPN and see how
8 we did. Another option would be to put the NG tube in. If
9 it got better then we consider a gastrotomy tube, if it
10 could be placed in TPN. And this the third option would be
11 to go into the operating room with all of it's intended
12 complications. Now, the point in all of this otherwise is
13 this: And you have used these numbers before and they're
14 real. If we make the decision to do nothing, the
15 likelihood is this: Is -- this is how she would live her
16 life. Then the question comes as to whether she would
17 choose to do that or not because, again, the likelihood of
18 it spontaneously getting better at that point in time is
19 not zero, but it is close.

20 So as a matter of fact, that's the decision that
21 has to be made at that point and I would give her those
22 choices and we would put them all over the chart.

23 **MR. CORBIN:** Well you certainly agree out of those
24 three potential options, Ms. Atkinson should have been --
25 should have been given all three.

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1 **THE WITNESS:** I think that the patient needs to be
2 given as much information as possible with the intended
3 complications and the long term things, so the answer is
4 yes.

5 **MR. CORBIN:** Under the standard of care, all three,
6 correct?

7 **THE WITNESS:** Yes.

8 **MR. CORBIN:** Would you agree that of those three,
9 the surgery would be the riskier option?

10 **THE WITNESS:** The short answer is yes. The one
11 with the greatest chance of making her better is also the
12 one that is riskier. It is like most things in this world.
13 That which has the greatest -- usually that has the
14 greatest benefit and that's what you have to weigh.

15 **MR. CORBIN:** Page 123, lines 5 through 12.

16 Can you think of any good reason of how
17 Ms. Atkinson could benefit by Dr. Williams not giving her
18 those three options before doing the second surgery.

19 **THE WITNESS:** No. I think information always
20 benefits the patient. I don't know whether that discussion
21 was held intermittently through that time or not. It does
22 not appear in the record.

23 **MR. CORBIN:** Would you agree with this statement,
24 that most obstructions in post-operative patients like
25 Ms. Atkinson are caused by adhesions which form within 72

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1 hours of surgery, then become very dense and vascular after
2 two weeks?

3 **THE WITNESS:** Yes.

4 **MR. CORBIN:** Would you agree that between two weeks
5 and two months post-op, adhesions become thick, vascular
6 and little bit more tangled, making surgery more difficult
7 and prone to complications.

8 **THE WITNESS:** As time goes on, the adhesions become
9 harder and they do indeed make the procedure -- so, yes, I
10 would agree.

11 **MR. CORBIN:** Page 125, lines 11 through 14. And 17
12 through 25.

13 Do you agree that, quote, management of the stable
14 patient involves fluid and electrolyte replacement, bowel
15 rest, nasal gastric tube drainage and a nutritional
16 evaluation.

17 **THE WITNESS:** I would agree with parts of it and
18 parts of it I would not. Nutrition evaluation after seven
19 days, a patient needs TPN. I don't care what you believe
20 because at that point in time, they're anabolic. Secondly,
21 the use of NG tube depends upon whether the patient is
22 doing relatively well or not. You can make a point for not
23 putting the NG tube in if that person is not vomiting and
24 that person is otherwise relatively stable and can keep
25 their stomach empty. I like NG tubes. I use them a great

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1 deal and I use them more than my partners do.

2 **MR. CORBIN:** Page 127, lines 9 through 12.

3 The second operation, would you agree that that is
4 considered an operation of a hostile abdomen.

5 **THE WITNESS:** Yes.

6 **MR. CORBIN:** Page 128, lines 21 through 23.

7 Have you ever done an operation like Ms. Atkinson's
8 second operation?

9 **THE WITNESS:** Yes.

10 **MR. CORBIN:** Page 129, starting on line 20.

11 Would you agree that Dr. Williams doing that
12 particular procedure instead of causing numerous
13 enterotomies at that point in time after the first or the
14 second or the third enterotomy, he had a decision to make,
15 should I continue or stop?

16 **THE WITNESS:** There's always that clinical
17 decision, yes.

18 **MR. CORBIN:** We do know that Dr. Williams made the
19 decision to continue with the operation and caused numerous
20 enterotomies and removed a significant part of her bowel,
21 correct.

22 **THE WITNESS:** Correct.

23 **MR. CORBIN:** How much bowel did he remove?

24 **THE WITNESS:** It's hard to tell, but it looks like
25 he removed at least 60 percent of it, but I'm not real

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1 clear on that.

2 **MR. CORBIN:** Next page 133, starting on line 21.

3 Let me ask you two questions.

4 **THE WITNESS:** Yes.

5 **MR. CORBIN:** If you remove a portion of a patient's
6 bowel, should that bowel be sent to pathology or just
7 discarded?

8 **THE WITNESS:** No, sent to pathology.

9 **MR. CORBIN:** Under the standard of care, that body
10 part needs to be sent to pathology, correct?

11 **THE WITNESS:** Correct.

12 **MR. CORBIN:** Page 138, Your Honor, starting on line
13 15.

14 Would you agree that a CT provides superb
15 anatomical detail and diagnostic specificity by directing
16 imaging -- by directly imaging the intestinal wall,
17 detecting secondary signs of bowel disease within the
18 surrounding mesentery and depicting even small amounts of
19 extraluminal air or oral contrast leakage into the
20 peritoneal cavity?

21 **THE WITNESS:** In the face of a normal cavity
22 otherwise, that is absolutely true.

23 **MR. CORBIN:** Small bowel perforation can be caused
24 by the inflammatory process.

25 **THE WITNESS:** True.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** When Dr. Williams decided to do the
2 second operation and he opened her abdomen up, did he find
3 massive inflammatory changes?

4 **THE WITNESS:** He found massive adhesions. I'm not
5 clear that I would refer to it as massive inflammatory
6 processes.

7 **MR. CORBIN:** Would you agree that a massive
8 inflammatory process in Ms. Atkinson would be peritonitis.

9 **THE WITNESS:** By definition that is probably true.

10 **MR. CORBIN:** Do you have any way to testify how
11 long Ms. Atkinson had the massive inflammatory changes of
12 peritonitis before the second operation?

13 **THE WITNESS:** I'm unaware that she had massive
14 inflammatory changes or peritonitis before the second
15 surgery. She had bowel obstruction. She had massive
16 adhesion, but I think the other is a leak.

17 **MR. CORBIN:** The other is what?

18 **THE WITNESS:** I don't believe she had peritonitis.

19 **MR. CORBIN:** Page 140, line 2.

20 Would you agree that if in fact she had massive
21 inflammatory changes that would be peritonitis?

22 **THE WITNESS:** By definition, massive inflammatory
23 changes are peritonitis.

24 **MR. CORBIN:** Okay. So the question is, if Dr.
25 Williams, when he opened up her abdomen the second time, he

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1 discovered massive inflammatory changes or peritonitis by
2 definition. Can you testify when that began?

3 **THE WITNESS:** No.

4 **MR. CORBIN:** Would you agree that leaking barium
5 outside the intestine can cause massive inflammatory
6 changes.

7 **THE WITNESS:** If indeed the barium leaked over the
8 entire cavity of the abdomen, the answer is yes.

9 **MR. CORBIN:** What in the world would be causing
10 Ms. Atkinson's massive inflammatory changes before the
11 second operation?

12 **THE WITNESS:** Would you let me see the operative
13 note a moment of the second surgery because I'm unaware of
14 massive inflammatory changes, where those words being used.

15 **MR. CORBIN:** Page 141. If I may, Your Honor, the
16 next reference is for ease of reference. Mr. McDow showed
17 Dr. Smith the report and the witness says okay.

18 **THE WITNESS:** Okay.

19 **THE COURT:** Okay.

20 **MR. CORBIN:** Next question.

21 Is it in the first sentence?

22 **THE WITNESS:** It is in the very first sentence.

23 **MR. CORBIN:** Would you read the first sentence to
24 us?

25 **THE WITNESS:** Massive inflammatory changes in the

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1 abdomen. Pocket of possible extravasated dye along
2 posterior peritoneum in the pocket at the base of the
3 mesentery.

4 **MR. CORBIN:** So in the very first sentence, And you
5 reviewed this before your testimony today?

6 **THE WITNESS:** Yeah.

7 **MR. CORBIN:** And you reviewed, especially the
8 second operative report carefully before your deposition
9 testimony, correct?

10 **THE WITNESS:** I thought I had, but obviously, I
11 didn't see that sentence.

12 **MR. CORBIN:** And when you look at the very first
13 sentence under findings, it says massive inflammatory in
14 the abdomen. That's peritonitis, isn't it?

15 **THE WITNESS:** By definition that would be construed
16 as being it, yes.

17 **MR. CORBIN:** And your testimony earlier that she
18 did not have a massive inflammatory change in her abdomen,
19 which would be peritonitis, when you said it didn't happen,
20 do you stand corrected? Do you believe that statement is
21 true?

22 **THE WITNESS:** Which statement is that?

23 **MR. CORBIN:** That when he opened up her bowel, he
24 found massive inflammatory changes in the abdomen.

25 **THE WITNESS:** That's what the statement says and so

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 we have to stand by that, yes.

2 **MR. CORBIN:** So the question is, even though you
3 don't believe she had peritonitis, if you believe this
4 statement of Dr. Williams, the very first sentence under
5 findings, massive inflammatory change, by definition
6 peritonitis, can you testify when the peritonitis began?
7 Are you willing to state she didn't have peritonitis?

8 **THE WITNESS:** Given what that says, I cannot make
9 that statement.

10 **MR. CORBIN:** You also stated earlier that you saw
11 no evidence that Ms. Atkinson had a small bowel leak before
12 the second operation, true?

13 **THE WITNESS:** True.

14 **MR. CORBIN:** The very second sentence, explain to
15 me what this means to you as a surgeon, quote, pocket of
16 probable -- read the second sentence to me verbatim,
17 please.

18 **THE WITNESS:** Pocket of probable extravasated dye
19 along the posterior peritoneum and a pocket at the base of
20 the mesentery.

21 **MR. CORBIN:** The only way that probable dye could
22 get outside of Ms. Atkinson's intestine would be a leak,
23 correct?

24 **THE WITNESS:** That is the only way dye would be
25 outside, yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** So if the second sentence is true,
2 would you stand corrected too when you stated there was no
3 evidence of a bowel leak before the second operation?

4 **THE WITNESS:** No, I will not. He says probable. I
5 think he was wrong. I think he did not see it on -- when
6 the KUB's were done that area is not what showed up --
7 showed as having barium in it. I think that is a pocket of
8 peritoneal fluid, but it is not barium. And again, I make
9 that statement not because of what she said, but because of
10 what the KUB did not show.

11 **MR. CORBIN:** Dr. Smith, I want you to assume that
12 this statement was true. Would you agree that if the
13 statement is true that means there was a bowel leak.

14 **THE WITNESS:** If that statement is true, then that
15 is what it means.

16 **MR. CORBIN:** Would you agree if that statement is
17 true that Ms. Atkinson did, in fact, have a small bowel
18 leak? Dr. Williams missed it before the second operation?

19 **THE WITNESS:** If that statement is true, then that
20 follows as being correct, yes.

21 **MR. CORBIN:** Lines 9 through 14.

22 Would you agree that if Dr. Williams' second
23 statement under the findings as true, that in fact,
24 Ms. Atkinson had a small bowel leak? That's consistent
25 with the radiographic report. The KUB where the

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 radiologist said possible barium leak, is that consistent?

2 **THE WITNESS:** No because it's in a different
3 location of the abdomen.

4 **MR. CORBIN:** Do you have an opinion based upon a
5 reasonable degree of medical certainty that if Dr. Williams
6 would have decided to take a CT scan before the second
7 operation it most likely would have shown that small bowel
8 leak.

9 **THE WITNESS:** The answer is no. I do not believe
10 she had a small bowel leak.

11 **MR. CORBIN:** I'm asking you to believe the second
12 sentence to be true. And you say that the second sentence
13 is true, if the second sentence is true, she had a small
14 bowel leak. The question was, accepting that as true, do
15 you have an opinion based upon a reasonable degree of
16 medical certainty that if Dr. Williams would have taken a
17 CT scan before the second operation, it probably would have
18 shown that perforation?

19 **THE WITNESS:** If there was a perforation, then the
20 CAT scan would probably have shown it, yes.

21 **MR. CORBIN:** Doctor, would you agree that if a
22 patient post surgery is at an increased risk of a
23 perforation of the small bowel, that it is better to use a
24 water soluble contrast study than use the barium?

25 **THE WITNESS:** The answer is yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** Why so, please?

2 **THE WITNESS:** Only because it doesn't distend the
3 bowel as much. The water soluble contrast will wound
4 through more rapidly and won't set itself up later in the
5 bowel.

6 **MR. CORBIN:** The barium in Ms. Atkinson's system
7 set itself up in the barium later on?

8 **THE WITNESS:** It retained itself over in the bowel.
9 So the answer is yes.

10 **MR. CORBIN:** Next page 149, starting on line 24.

11 So if Ms. Atkinson were your patient you would have
12 used barium instead of a water soluble contrast?

13 **THE WITNESS:** I didn't say that. I said we would
14 have ordered the upper GI small bowel follow through and
15 then the radiologist kind of decides which one he's going
16 to use in the process. I don't necessarily specify I want
17 barium or I want the gastrografin.

18 **MR. CORBIN:** Would you have that right?

19 **THE WITNESS:** Oh, sure. I have the right to
20 specify anything. So the answer is we don't necessarily do
21 that, but certainly we have a right to do it.

22 **MR. CORBIN:** So if Dr. Williams wanted to avoid
23 barium, he certainly had the right to tell the radiologist,
24 I want to use a water soluble contrast, correct?

25 **THE WITNESS:** Yes, he does.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **MR. CORBIN:** And you would agree that should have
2 been -- and you would agree that would have been safer?

3 **THE WITNESS:** Yes.

4 **MR. CORBIN:** It would have been better, that's what
5 you would prefer?

6 **THE WITNESS:** That's what I'd prefer.

7 **MR. CORBIN:** But you're not willing to go as far as
8 to say that's the standard of care, correct?

9 **THE WITNESS:** I don't know of anything out there
10 that necessarily says that is the case, but that brings it
11 to a new level of thought, so no, I am not.

12 **MR. CORBIN:** You talked earlier about bowel sounds
13 and you mentioned hypoactive bowel sounds. What are
14 hypoactive bowel sounds?

15 **THE WITNESS:** Those which are not as active as one
16 would normally expect.

17 **MR. CORBIN:** What are absent bowel sounds?

18 **THE WITNESS:** Just what it says, no bowel sounds at
19 all.

20 **MR. CORBIN:** Is there anything medically
21 significant if Ms. Atkinson had absent bowel sounds?

22 **THE WITNESS:** Long term obstruction can produce
23 basically the exhaustion of bowel sounds, so you can get
24 absent bowel sounds, but you go through a period in which
25 they're hyperactive -- hypoactive and then they're absent.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 So the answer is that can certainly happen. Point of
2 obstructions will usually have hyperactive bowel sounds and
3 then they'll go through the same evolution.

4 **MR. CORBIN:** Page 156, lines 5 through 7, 10 and 12
5 through 25.

6 Would you agree CT has been reported to be
7 usefully -- would you agree CT has been reported to be
8 useful specifically for the diagnosis of strangulation of
9 the bowel?

10 **THE WITNESS:** Yes.

11 **MR. CORBIN:** Did Ms. Atkinson ever have any kind of
12 ischemia of the bowel?

13 **THE WITNESS:** There was in my mind a history of
14 that in the past. One of the reasons for her laparotomies
15 in the past as far as I'm aware, there was not one in this
16 case.

17 **MR. CORBIN:** If something was ischemic in the
18 bowel, would you expect to see in a pathology report,
19 evidence of necrotic tissue?

20 **THE WITNESS:** Yes.

21 **MR. CORBIN:** In general, what is necrotic tissue?

22 **THE WITNESS:** Dead tissue. Tissue that is
23 otherwise not viable.

24 **MR. CORBIN:** Would you agree that if a doctor
25 decides to wait instead of doing an operation to address a

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 small bowel obstruction, namely waiting 33 days, if the
2 pathology reports that there is necrotic tissue of the
3 bowel, would you agree the doctor waited too long.

4 **THE WITNESS:** Yes.

5 **MR. CORBIN:** Page 159, lines 16 through 19, 22, 23
6 and 25.

7 Would you agree with the statement that NG tube
8 decompression, quote, provides almost immediate symptomatic
9 relief from nausea and vomiting?

10 **THE WITNESS:** It would relieve the nausea and
11 vomiting.

12 **MR. CORBIN:** Almost immediately?

13 **THE WITNESS:** Essentially, yes.

14 **MR. CORBIN:** Would you agree it often relieves
15 nausea and vomiting to a significant degree?

16 **THE WITNESS:** Yes.

17 **MR. CORBIN:** Would you agree it can also relieve
18 abdominal pain?

19 **THE WITNESS:** Yes.

20 **MR. CORBIN:** Page 175, starting on line 17.

21 How did it come about that you were providing
22 medical care and treatment to Dr. Williams' patient,
23 Ms. Atkinson?

24 **THE WITNESS:** That was the time that I was on call.

25 **MR. CORBIN:** What do you mean by on call?

Dr. Sidney T. Smith - Deposition Excerpts by Mr. Corbin

1 **THE WITNESS:** Basically at that point in time, the
2 two of us were the only two there, so he would take all of
3 the calls for a week which would mean the week and the
4 weekend and then I would take the next one, so we would see
5 each other's patients.

6 **MR. CORBIN:** How many members were in the practice
7 at that time?

8 **THE WITNESS:** As far as GYN is concerned, only two.

9 **MR. CORBIN:** Would you agree that Ms. Atkinson was
10 a patient of your medical group?

11 **THE WITNESS:** Well, yes.

12 **MR. CORBIN:** In other words, primarily, she was Dr.
13 Williams' patient, but because she was being treated by
14 your medical group, if he couldn't be available, you would
15 cover for him; is that correct?

16 **THE WITNESS:** That's correct.

17 **MR. CORBIN:** And that's the publication part.

18 **THE COURT:** All right. Everybody on the jury okay?
19 Anybody need to take a break?

20 Is she going to read your part too.

21 **MR. MCDOW:** I guess I'll have my law partner that's
22 going to do that.

23 **THE COURT:** Okay. Y'all switch places.

24 **THE WITNESS:** Do I need to take an oath?

25 **THE COURT:** Yes, sir, raise your right hand and

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 state your name, please.

2 THE WITNESS: Shelton Haile, H-a-i-l-e.

3 THE COURT: All right.

4 SHELTON HAILE,

5 having been duly sworn, testified as follows:

6 THE COURT: All right. Thank you, sir. You can
7 have a seat.

8 All right. Mr. McDow?

9 MR. MCDOW: Page 4, line 11 through line 20.

10 Do belong to any medical boards or community groups
11 or other types of community organizations?

12 THE WITNESS: I am a member of the American board
13 of OB GYN, the American College of OB GYN now called the
14 congress. I'm a member of the Society of Gynecological
15 Oncologists. The South Atlantic Association of
16 Obstetricians and Gynecologists, the South Carolina
17 Obstetrical and Gynecological Society.

18 MR. MCDOW: Have, in fact, you taught medical
19 students before?

20 THE WITNESS: When I finished my fellowship at the
21 ND Anderson Hospital, I came back and worked with the
22 Department of Obstetrics and Gynecology at the University
23 of South Carolina School of Medicine from 1981 until about
24 12 years ago, roughly 19 and a half years. So, yes, I did.

25 MR. MCDOW: Do you have current hospital privileges

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 at Palmetto Health?

2 THE WITNESS: I have privileges at Palmetto Health
3 as well as in Lexington.

4 MR. MCDOW: Page 12.

5 Okay. Do you believe that any time between
6 Ms. Atkinson's first and second surgeries that she had a
7 perforation of the small bowel?

8 THE WITNESS: I do not.

9 MR. MCDOW: Page 17.

10 What leads you to believe that Ms. Atkinson did not
11 have a small bowel perforation?

12 THE WITNESS: There are several reasons and one can
13 look at it in prospect or retrospect. In prospect, there
14 is an extra evaluation, which reveals a slow transit time.
15 An upper GI small bowel follow through does not show a
16 leak. There are several flat and upright abdomens which
17 are done. There is a stellate area of barium in the left
18 lower quadrant and as those x-rays progressed that stellate
19 area becomes less obvious, it becomes diluted out. If
20 something is in the peritoneal cavity, i.e. barium, one
21 would expect, first of all, it's not going to dilute out.
22 In fact, it may actually become a bit more radiopaque
23 because as a matter of fact fluid is going to be taken from
24 it so it will actually get worse.

25 What you saw for her was that the area became less

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 over time. A radiologist at the original time said it
2 could represent extravasation of dye but did not make the
3 diagnosis of same. So that's one of them.

4 Secondly, in retrospect, when she is operated on
5 the second time, there is an area of fluid found at the
6 root of her mesentery. The root of the mesentery sits in
7 the mid abdomen slightly to the right. The area in
8 question on the scan was actually the left lower quadrant.
9 Those are different creatures, different areas. So I
10 really believe that although Dr. Williams surgical report
11 kind of throws doubt to what that is, it is in a different
12 part of the abdomen and I have run into little pockets of
13 fluid after taking down adhesions that look for all the
14 world like the inside of a piece of bowel and what they
15 turn out to be loculated, small loculated fusion. So I
16 think that's what he found.

17 So in prospect the x-rays get progressively better
18 and in retrospect, the area in question, i.e. that area
19 that Dr. Williams talks about at the base of the mesentery
20 is not the area that is seen on flat and upright abdomen.

21 **MR. MCDOW:** Page 50.

22 **MR. CORBIN:** Which page, please?

23 **MR. MCDOW:** Page 30. Beginning at line 6.

24 That's why I'm asking, wouldn't you at least agree
25 that spending at least two and a half hours doing this

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 lysis procedure if he was utterly aggressive, that he
2 understood he was increasing her risk of having a
3 perforation, peritonitis, or an abscess.

4 **THE WITNESS:** Well, I think you weigh that risk
5 against what you think you're trying to accomplish and it
6 is in the balance of that that you make that determination
7 because if you have all of this bowel that is stuck
8 together, you can't free it enough to get to the mass or to
9 do what you have to do. You say, okay. The best way to do
10 this is the adhesiolysis. Now, it's one other example and
11 that is when you find multiple loops of bowel stuck down to
12 the mass, how is it that you get to it swiftly. And one of
13 the ways sometimes is to start at the Ligament of Treitz
14 and come down to it and you can't get it off otherwise.

15 What you've got is this conglomerate of small bowel
16 sitting on top of something and you say to yourself, you
17 know what, I don't know where the end is or where the
18 beginning is. And sometimes the best way to do that is to
19 come up to the ligament or go into the colon, something you
20 know and you come down onto it and then you know you've
21 safely removed it. I have had periods of time in which you
22 get in there and you see the bowel sitting there and you
23 say, okay, I am going to try over there. Over here. That
24 doesn't work and so you try over there and that doesn't
25 work.

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1 So finally you go back to an area you know, the
2 ligament or the colon, and you start to work back. Now,
3 sometimes that amounts to a full adhesiolysis. I'm not
4 sure. You've used the word aggressive a whole bunch of
5 times. I think it is better to simply say that it was a
6 complete adhesiolysis. The word aggressive perhaps doesn't
7 give the best connotation to it.

8 **MR. MCDOW:** Page 32.

9 If you don't like the term aggressive --

10 **THE WITNESS:** Huh huh, okay.

11 **MR. MCDOW:** -- can you think of a better term,
12 medically speaking, to describe if a physician is taking
13 out two big adhesions, unnecessary adhesions, he took out
14 too much, how do you describe that?

15 **THE WITNESS:** I think the better word is extensive.
16 It's an extensive adhesiolysis because I'm not certain that
17 anybody in this room or outside of an operating room can
18 necessarily say too many were taken down because we just
19 don't -- we're not there. We don't know how much it
20 requires to be able to accomplish the goal, which was to
21 remove the mass. You can start to make assumptions, but
22 the truth is, we weren't there to see that. You don't know
23 that.

24 **MR. MCDOW:** Page 33.

25 **MR. CORBIN:** Mr. McDow, please -- please read

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1 through lines 23 on page 33 when you publish that.

2 MR. MCDOW: I'm sorry, say that again, please?

3 MR. CORBIN: Please read through line 23 on page 33
4 when you publish.

5 MR. MCDOW: I'm on page --

6 THE COURT: Page 32, line 19 through page 33, line
7 23.

8 MR. CORBIN: No, sir, he's on page 33, line 8
9 through 15. I asked him to include lines 167 through 23 --

10 THE COURT: I see.

11 MR. CORBIN: On the same page.

12 THE COURT: All right. You didn't publish that Mr.
13 Corbin?

14 MR. CORBIN: No, sir.

15 THE COURT: Okay.

16 MR. MCDOW: All right. I'll add it.

17 Page 33, line 8, question by Mr. Corbin.

18 So in your opinion there could be no violation of
19 the standard of care in any situation where a surgeon is
20 too extensive in his lysis procedure.

21 THE WITNESS: That would be my opinion, yes.

22 Again, that opinion is based on the fact that we don't know
23 what it requires. So the ability to say it was too
24 extensive is beyond our scope.

25 MR. MCDOW: We get to line 16.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 There can never be too much.

2 **THE WITNESS:** We don't know that. Certainly you
3 can see an example in which there are a few little
4 adhesions down here and all these things up here and I
5 can't have to take these down to get to it. Is this too
6 much? Probably it is, but we're not there to know that.
7 Therein lies my problem with the statement.

8 **MR. MCDOW:** Page 38, beginning at line 22.

9 Do you believe that it is important in a patient
10 like Ms. Atkinson if you see drainage from wounds and you
11 believe she has a wound infection to at least culture or
12 send that drainage to the laboratory to find out precisely
13 what it is?

14 **THE WITNESS:** Although on the surface of it, it
15 sounds like that's what you really ought to do in the
16 person that's immediately post-op. The wound can generally
17 be managed either by opening or maintaining drainage of it
18 and then with general antibiotics. For that reason, I have
19 been let down more by cultures than I have been helped by
20 cultures because most of them come back, as I told you a
21 second ago, as mixed processes; and as such, it's not a
22 pure culture. It's not like a blood culture that comes
23 back and shows staff or strep. They're usually a mixture
24 of organisms both from bowel and from skin and for that
25 reason, generally speaking, no, I don't culture them.

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1 I will open the wound if I need to, allow it to
2 drain. Even if frank pus comes out of the wound a culture
3 at that point in time doesn't help me. I simply open the
4 wound and we treat with general antibiotics.

5 **MR. CORBIN:** Is it your opinion that it meets the
6 standard of care if Ms. Atkinson had 28 days of wound
7 drainage and 19 of those days the wound drainage was yellow
8 or purulent, that it meets the standard of care not to
9 culture the wound drainage?

10 **THE WITNESS:** If I believe there is wound
11 infection, not something more, and I would believe in this
12 case that's what it is. I do not believe that a culture is
13 necessary. So it is not out of the standard of care if
14 that is your diagnosis not to have culture.

15 **MR. CORBIN:** Well, what if your diagnosis is wrong.
16 By virtue of opening the wound by treating with a general
17 antibiotic, you will then see how somebody does. Again, it
18 is the experience that says when I culture these things, I
19 get back a mixed culture and what happens when a mixed
20 culture comes back, the laboratory reports back mixed
21 culture and it stops. You don't get back any notification
22 of anything. You don't get back a sensitivity, they simply
23 say it's a mixed culture. The same is true of a lot of
24 things. Urine cultures, for instance, if they come back as
25 mixed, you won't get anything back. It's considered to be

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 a contaminant. So to be honest about it, wound cultures
2 don't help us nearly as much as you believe they should.

3 **MR. MCDOW:** Do they help at all?

4 **THE WITNESS:** I don't think they do.

5 **MR. MCDOW:** Page 44 -- excuse me, page 46 beginning
6 at line 2.

7 Would wound drainage for 28 days, 19 being yellow
8 or purulent be consistent with a small bowel perforation?

9 **THE WITNESS:** No, it would not be. One would
10 expect small bowel contents to be draining from the wound
11 if that were the case.

12 **MR. MCDOW:** Would the wound drainage for 28 days be
13 consistent with an abscess?

14 **THE WITNESS:** I would regard it as consistent with
15 an abscess in the wound, a secondary wound infection. As
16 far as I have reviewed the record, the fascia was intact
17 and that goes even to the time of the second surgery. What
18 that means is that all of the drainage that we're seeing
19 after that first, I think 5 days in which we have jackson
20 pratts in place, it's coming from the wound itself because
21 as I understand it, the jackson pratt drainage were removed
22 on or about the 30th.

23 **MR. MCDOW:** In your opinion, did Ms. Atkinson ever
24 have an ileus?

25 **THE WITNESS:** That was obviously the discussion

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 that occurred very early on and the reason that you sit and
2 that is -- does this represent a post operative ileus or
3 does it represent a partial small bowel obstruction. The
4 difference, obviously, being that the ileus will, with time
5 resolve itself. The small bowel obstruction, partial bowel
6 obstruction may, but it is less liable to do so. So, yes,
7 sir, at least in that first 5 or 6 days, ileus is a
8 perfectly good and workable diagnosis and would normally be
9 the diagnosis given.

10 **MR. MCDOW:** After the first 5 or 6 days, is it your
11 opinion that she had nothing else besides a small bowel
12 obstruction and a superficial wound infection?

13 **THE WITNESS:** That is not an unreasonable
14 statement. Ileus could still be part and parcel of it.
15 Keep in mind that every little bit of her bowel was touched
16 and what that does is produce an edema in -- edema in the
17 bowel wall and that is, in part, what produces the ileus.
18 I've got a lady in the hospital right now that we washed
19 mucinous fluid out of her abdomen for two hours. As a
20 matter of fact, her bowel is not yet awake. It's an ileus.
21 We're now 6 days post, but that's what I expect because I
22 touched every piece of her bowel. So at what point in time
23 does an ileus go away in this obstruction is almost
24 impossible to say.

25 **MR. MCDOW:** Are you going to wait 33 days with your

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 current patient before you do an exploratory while the
2 ileus continues?

3 **THE WITNESS:** If I do an x-ray of her bowel and her
4 bowel is open except for various low transit, I will sit
5 for a very long time?

6 **MR. CORBIN:** Excuse me, please. Add lines 10
7 through 20.

8 **MR. MCDOW:** 10 through 20. Okay. Keep reading.
9 We didn't publish that before.

10 **THE WITNESS:** I was told one time by a very smart
11 man the Charleston that if you're willing to sit forever
12 and a day the bowel will always open up. Now, I don't
13 believe that. I honestly believe that if I have an
14 obstruction I will give it some 10 days to 2 weeks and then
15 I'll go do something about it. But that is in an otherwise
16 uncomplicated person and that's obviously not who this lady
17 was.

18 **MR. MCDOW:** She was complicated.

19 **THE WITNESS:** She was complicated.

20 **MR. MCDOW:** Page 49, beginning on lines 9.

21 Question, so after 10 or 14 days diagnosed it as a
22 small bowel obstruction; 10 to 14 days have lapsed.
23 Patient hasn't gotten better, what do you do.

24 **THE WITNESS:** Well, it's going to depend on the
25 patient herself. If the patient is otherwise

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 uncomplicated -- and let's look at the lady I have in the
2 hospital now. If 10 days from now her bowel is still not
3 working and I've got evidence of an obstruction, we're
4 going to go back and do something about it because she's
5 otherwise not complicated.

6 In the individual, however, who is complicated and
7 unfortunately, this lady fits that bill, the price of going
8 back is considerable. This case shows you the considerable
9 cost of going back, the holes and everything else that
10 occurs. So am I willing to sit longer? The answer is yes,
11 in somebody like that, yes. The other thing that is
12 striking about Ms. Atkinson is this: She would go along
13 for a while, have nausea, vomiting and have distension and
14 then suddenly she would have bowel function. And let's be
15 very honest, the doctor wants people to get -- wants
16 somebody to get better as well as anybody else does and
17 when that starts to happen, you go phew (sound), she's
18 getting better. So I'm willing to wait a little bit
19 longer.

20 Unfortunately, as all things in this world, when we
21 don't set an absolute time, we kind of slowly move past the
22 time and all of a sudden it's been a huge amount of time;
23 and in part that's what happens here. So she's
24 complicated. She's had big time adhesive disease. You
25 know it will be worse when you go back and the price of

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1 going back is considerable. She's been very ill during
2 this period of time and then on top of that when you get
3 yourself edged up to the point of doing something, suddenly
4 her bowel works. You know, she just had large bowel
5 movements and wants to go home.

6 With enemas --

7 **THE WITNESS:** Or something of that nature. Not
8 necessarily. Some of these actually -- after her upper GI,
9 if you remember, I think she had four large bowel movements
10 and on that day voiced the statement that I want to go home
11 now. And the next day, the KUB basically says, no you're
12 still obstructed. So all of that plays into the process of
13 time.

14 **MR. MCDOW:** I think this gets us up to page 56.

15 **MR. CORBIN:** Excuse me, Mr. McDow, please, would
16 you start on line 9?

17 **THE COURT:** Have y'all not --

18 **MR. CORBIN:** We have.

19 **MR. MCDOW:** Yes. Your Honor, he designated.

20 **THE COURT:** Just a second. Don't argue with each
21 other. Come up here and argue to me. Okay. Come on up.

22 (WHEREUPON, there was a bench conference out of the
23 hearing of the jury and the Court Reporter.)

24 **THE COURT:** All right. Page 56, right?

25 **MR. MCDOW:** Page 56. Starting on line 9.

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1 Well, the purpose of the NG tube is to relieve the
2 patients distension and nausea and vomiting, correct?

3 **THE WITNESS:** On the surface, the answer is yes.
4 The real reason for its use is to try to decrease the
5 pressure against the bowel against the area of obstruction.
6 If you think about it, the obstruction is simply a kink or
7 something of that nature usually and if the bowel is trying
8 to push material by it then it produces swelling. The
9 notion of bowel rest then is to remove that pressure, and
10 hopefully by virtue of that remove the swelling.

11 Now, the one thing you have to be careful of in the
12 data you quoted is that in that, there's also that group of
13 people that actually have an ileus that is not related to a
14 mechanical obstruction so as we start to look at
15 progression through that thing, we're also looking at those
16 people who have the ileus. The vast majority of those
17 people will, as a matter of fact, resolve in that time
18 frame. So it is not a clean population that you're looking
19 at. It's a mixed population. You just presented it as
20 only obstructions.

21 Well, it's people whose bowel haven't worked. Part
22 of those are the ileus people, part of those are those who
23 have mechanical obstruction. The hard part sometimes is
24 trying to figure out which ones those are. Again, I would
25 say to you this -- and we've used this analogy before, but

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1 we'll use it again, and that is -- we're trying to strike a
2 balance and that balance says this is the cost of doing
3 something and this is what I get back for it and it is that
4 that medicine struggles with all the time.

5 **MR. MCDOW:** Go to page 80, I believe is the next
6 one.

7 **THE COURT:** Page -- that one has been taken care
8 of. Page 102?

9 **MR. MCDOW:** Yes, Your Honor, page 102, beginning on
10 line 6.

11 What was causing the barium to remain in
12 Ms. Atkinson's system for weeks between the first and
13 second operations?

14 **THE WITNESS:** The bowel simply would not pull it
15 along. So either that was the ileus, but we believe it
16 could be a small bowel obstruction. Remember that the
17 bowel pulls stuff through by changing size and if things
18 are blocking and it can't do that, the barium simply sits
19 there.

20 **MR. MCDOW:** Then we go to 102 starting at lines 19.

21 **MR. CORBIN:** Line 15.

22 **MR. MCDOW:** No, you want to start at 15, okay.

23 **MR. CORBIN:** Yes, sir, thank you. Continue that.

24 **MR. MCDOW:** Do you know how long the KUB's
25 indicated that Ms. Atkinson had retained barium in her

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1 system between the first and second operations?

2 THE WITNESS: I do not.

3 MR. CORBIN: Keep going.

4 MR. MCDOW: If it were 26 days retained barium in
5 her system, do you think Dr. Williams should have done
6 something to investigate by using a CT scan to see what was
7 going on with her bowel.

8 THE WITNESS: No. You've already got an
9 obstruction. The obstruction is the cause of this. A CAT
10 scan that says there's barium in your bowel simply adds to
11 what you already know.

12 MR. MCDOW: And then to page 118.

13 THE COURT: Page 122.

14 MR. MCDOW: No, that's been taken care of. Yeah,
15 page 122. Page 122, line 2.

16 Would you have done the CT scan?

17 THE WITNESS: Again, the answer is no. The
18 clinical situation I see looks like bowel obstruction,
19 period. I don't think the other things are there, so the
20 answer is no.

21 MR. MCDOW: Okay. 146 is the next page.

22 MR. CORBIN: Page 146 or 145?

23 THE COURT: Page 146.

24 MR. MCDOW: Eight.

25 THE COURT: Yeah, must be going off something else.

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1 Just let me know.

2 **MR. MCDOW:** Page 148, beginning on line 10.

3 Question: If the massive inflammatory changes in
4 Dr. Williams findings were not caused by barium, then what
5 in the world caused them?

6 **THE WITNESS:** I think, frankly taking down all of
7 the adhesions and all of the manipulation of the bowel
8 produced in the inflammatory process in part drove the
9 adhesions. So I think it's part and parcel of the process
10 of the original surgery.

11 **MR. MCDOW:** Nothing to do with leaking barium,
12 correct?

13 **THE WITNESS:** That is my contention, yes.

14 **MR. MCDOW:** That gets us to page 152 -- yeah, 152
15 in response to the question from the previous page, will
16 you publish that answer, lines 1 through 11.

17 **THE WITNESS:** I suspect that the reason for
18 Ms. Atkinson is that as time went along and the bowel wall
19 thickened then the bowel sounds were essentially lost by
20 virtue of that.

21 **MR. MCDOW:** You're aware that she had several --
22 several days of absent bowel sounds?

23 **THE WITNESS:** Yes.

24 **MR. MCDOW:** That would have not prompted you to
25 change the diagnosis or course of treatment, the absence of

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 bowel sounds for several days?

2 **THE WITNESS:** No, sir, it would not.

3 **MR. MCDOW:** 153, line 12.

4 The fact that Ms. Atkinson had 28 days out of the
5 33 days with either hypoactive or absent bowel sounds, that
6 would not change your course of treatment for her if you
7 would have been there.

8 **THE WITNESS:** That would not change my diagnosis or
9 my course of treatment.

10 **MR. MCDOW:** Would it change your differential
11 diagnosis?

12 **THE WITNESS:** No.

13 **MR. MCDOW:** The differential diagnosis would be
14 what, please?

15 **THE WITNESS:** The differential diagnosis at that
16 point in time is that a bowel obstruction, secondary to
17 adhesive disease. I find nothing in the record that I
18 reviewed that changes that for me.

19 **MR. MCDOW:** If you accept the second operative
20 report as being true, are you going to stick with your one
21 and only diagnosis, it had to be a small bowel obstruction
22 and nothing else?

23 **THE WITNESS:** Yes.

24 **MR. MCDOW:** 182.

25 **THE COURT:** 182, line 7?

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 **MR. MCDOW:** All right. Mr. Corbin is telling me to
2 go to page 181, lines 1 through 14.

3 **THE COURT:** All right.

4 **MR. MCDOW:** 181, line 1 through 14.

5 And if I understood you correctly earlier, subject
6 to your exact words, if there was a -- tissue on the
7 pathology report that you would agree that it was too long
8 a wait for the surgery. Do you agree the wait was too long
9 for the surgery based on the pathology report.

10 **THE WITNESS:** There is indeed an area of dead
11 bowel, although it seems to be very localized, it is,
12 nonetheless there.

13 **MR. MCDOW:** Does that pathology report indicate to
14 you that there was a waiting period too long to take
15 Ms. Atkinson back to surgery after the first surgery?

16 **THE WITNESS:** It would suggest that.

17 **MR. MCDOW:** Page 182, line 7.

18 Doctor, do you believe that Dr. Williams violated
19 any standard of care by not placing the NG tube after the
20 first surgery?

21 **THE WITNESS:** No, I do not.

22 **MR. MCDOW:** Question: Based on your review of the
23 record and your deposition today, is it still your opinion
24 to a reasonable degree of medical certainty that Dr.
25 Williams complied with all general accepted standards of

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 care in the care that he rendered to Ms. Atkinson?

2 THE WITNESS: That remains my opinion.

3 THE COURT: All right. That conclude it gentlemen?

4 MR. CORBIN: Yes, sir.

5 MR. MCDOW: All right.

6 THE COURT: You can step down. Thank you, sir.

7 All right. Ladies and gentlemen, we'll take a
8 break at this time. Please do not discuss the case, we'll
9 have you back out momentarily. Thank you.

10 (WHEREUPON the jury left the courtroom at 4:17
11 p.m.)

12 THE COURT: All right. We'll recess for a minute.

13 I see Dr. Wood's here. We'll begin his at 4:30.

14 MR. CORBIN: Yes, sir.

15 THE COURT: And depending upon the time, we may not
16 be able to do any other witnesses today.

17 MR. CORBIN: We understand, yes, sir. Thank you.

18 THE COURT: Thank you.

19 MR. CORBIN: Yes, sir.

20 (WHEREUPON a recess was observed.)

21 THE COURT: Mr. Corbin, you ready to proceed?

22 MR. CORBIN: The plaintiffs ready, Your Honor.

23 MR. MCDOW: I'm ready, Judge. I've got those --

24 Dr. Reynolds got my homework.

25 THE COURT: Yes.

Dr. Sidney T. Smith - Deposition Excerpts by Mr. McDow

1 **MR. MCDOW:** Okay.

2 **THE COURT:** Let's go ahead and make the original
3 transcript of the deposition we just published and that
4 will be the next court's exhibit. There's an errata sheet
5 he didn't read and sign, did he? Dr. Smith?

6 **MR. CORBIN:** I don't think so.

7 **THE COURT:** Okay. And you can hand that up at your
8 leisure.

9 **MR. CORBIN:** I'll do that right now because I
10 certainly don't want to forget it.

11 **THE COURT:** Okay. You ready otherwise, Mr. McDow?

12 **MR. MCDOW:** Yes, sir.

13 **THE COURT:** Okay. You can bring in the jury.

14 (WHEREUPON the jury entered the courtroom at 4:33
15 p.m.)

16 **THE BAILIFF:** Jury is present, sir.

17 **THE COURT:** All right. Thank you, sir.

18 Okay. Ladies and gentlemen, we'll have one more
19 witness this afternoon.

20 And Mr. Corbin, you can call that person.

21 **MR. CORBIN:** Yes, sir, Your Honor. At this time,
22 we'd call doctor Oliver G. Wood, Jr. to the witness stand,
23 please.

24 **OLIVER G. WOOD,**

25 having been duly sworn, testified as follows:

Faye Atkinson - Direct Examination by Mr. Corbin

1 **THE COURT:** Mr. McDow?

2 **MR. MCDOW:** Yes, Your Honor.

3 **THE COURT:** Okay. You can call your next witness.

4 **MR. CORBIN:** Your Honor, at this time, we'd call
5 Ms. Faye Atkinson.

6 **DORIS FAYE ATKINSON,**
7 having been duly sworn, testified as follows:

8 **THE CLERK:** Have a seat in the witness box and
9 state your full name for the record, please.

10 **THE WITNESS:** Doris Faye Atkinson.

11 **DIRECT EXAMINATION**

12 **BY MR. CORBIN:**

13 **Q** Faye, have you ever testified in your life?

14 **A** No, sir.

15 **Q** In your life have you ever brought a lawsuit
16 against anybody?

17 **A** No, sir.

18 **Q** You a little bit nervous today?

19 **A** Yes, sir.

20 **Q** Faye, where do you live, please?

21 **A** Hartsville, South Carolina.

22 **Q** How long have you lived in Hartsville?

23 **A** All my life.

24 **Q** All your life. How old are you, please?

25 **A** 64 years old.

Faye Atkinson - Direct Examination by Mr. Corbin

- 1 Q 64 years old. Are you married?
- 2 A Yes, sir, I am.
- 3 Q Do you work?
- 4 A No, sir.
- 5 Q Did you ever work?
- 6 A Yes, sir.
- 7 Q What was your last employment, please?
- 8 A I was a long-term substitute teacher in special
9 needs with the Darlington County School District.
- 10 Q About how many years?
- 11 A Three years in long term and several other years as
12 substitute and as a special needs assistant.
- 13 Q Special needs teacher -- did you love your job?
- 14 A Yes, sir.
- 15 Q Do you miss your job?
- 16 A Yes, sir, very much.
- 17 Q I know testimony is going to be tough at some
18 times, but we're going to get through this.
- 19 Are you married?
- 20 A Yes, sir.
- 21 Q How long?
- 22 A A little over 47 years.
- 23 Q Your husband's name?
- 24 A William M. Atkinson, Jr.
- 25 Q He goes by the name of Bucky?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A Yes, sir.

2 Q Now, Bucky is not here?

3 A No, sir.

4 Q Bucky supports your claim?

5 A Yes, sir.

6 Q Bucky has his own claim in this lawsuit?

7 A Yes, sir.

8 Q But Bucky is not here?

9 A No, sir.

10 Q Do you believe he would want to be here?

11 A Oh, yes, sir.

12 Q Do you believe he would support you in this

13 courtroom?

14 A Yes, sir.

15 Q Do you think he would physically help you in and

16 out of this courtroom if he could?

17 A Yes, sir.

18 Q Now, we're only allowed to go certain areas in

19 this respect, but --

20 MR. MCDOW: Your Honor.

21 THE COURT: Yes, sir?

22 MR. MCDOW: I hate to interrupt, but I would object

23 to this line of testimony pursuant to my previous

24 objection.

25 THE COURT: And note -- that's overruled, but don't

Faye Atkinson - Direct Examination by Mr. Corbin

1 go into anything accept the question about --

2 **MR. CORBIN:** I understand, Your Honor.

3 **THE COURT:** Don't discuss any parameters with your
4 witness.

5 **BY MR. CORBIN:**

6 **Q** Yes, sir.

7 **THE COURT:** You just ask the question.

8 But Mr. McDow, your objection is noted and it's
9 overruled.

10 **BY MR. CORBIN:**

11 **Q** If Bucky could physically be here, would he be
12 here?

13 **A** Yes, sir.

14 **Q** Bucky has a medical condition that does not allow
15 him to be here, correct?

16 **A** Correct.

17 **Q** Bucky has a condition from which he will not
18 survive, correct?

19 **A** Correct.

20 **Q** Ms. Atkinson, let's talk a little bit about your
21 physical health before you came up under Dr. Williams' care
22 in 2007. In general how was your health in 2007 -- you
23 were about 59 years old or so -- how were you doing?

24 **A** Very good.

25 **Q** In 1995 -- now, we're backing up 12 years. Let's

Faye Atkinson - Direct Examination by Mr. Corbin

1 back up 12 years from the time that you saw Dr. Williams.

2 Did you have a bowel issue in 1995?

3 A Yes, sir.

4 Q Were you hospitalized for that?

5 A Yes, sir.

6 Q Did you receive treatment for it?

7 A Yes, sir.

8 Q Was part of your bowel removed in 1995?

9 A Yes, sir.

10 Q In addition, before 1995 -- and we're going to go
11 back to the 70's or 80's -- besides -- well, how many --
12 you had two procedures in 1995?

13 A Yes, sir.

14 Q Before then, did you have any other types of
15 stomach or abdominal or gynecologic surgeries?

16 A Yes, sir.

17 Q What were those, please?

18 A I had a hysterectomy.

19 Q The three surgical procedures -- the one
20 hospitalization involved two resections, correct?

21 A Correct.

22 Q Tell this jury how you did for the next 12 years
23 after your hospitalization in 1995 where a portion of your
24 bowel was removed. How did you do?

25 A I did very well. I had no problems with my bowel.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Short bowel syndrome, you know that very well.

2 A Yes, sir.

3 Q Between 1995, for the next dozen years, knowing
4 what you know about that short bowel syndrome, did you have
5 it back in those days for that dozen years?

6 A No, sir.

7 Q Big difference?

8 A Yes, sir.

9 Q After the surgeries in 1995, did it put you where
10 your life was out of control in '95?

11 A No, sir.

12 Q The surgeries in 1995 -- we'll come back to that
13 in a minute.

14 Tell the jury how it came about that you came under
15 Dr. Williams' care in Columbia.

16 A I was referred to Dr. Williams by Dr. Michelle Cray
17 in Hartsville.

18 Q Michelle Cray, your gynecologist?

19 A She's a gynecologist.

20 Q Why did you go see Dr. Williams? For what
21 condition, please?

22 A I had a mass in the right side of my abdomen.

23 Q 59 years of age, 12 years no troubles after your
24 surgeries at Carolina Pines. Did you have any troubles
25 with any kind of ovarian cysts or mass before that date and

Faye Atkinson - Direct Examination by Mr. Corbin

1 time? Did you know that you had a mass?

2 A No, sir, not until I went to the hospital.

3 Q How did you learn you had a mass? What test was
4 performed on you at the hospital in Hartsville?

5 A They did a CT scan.

6 Q A CT scan?

7 A (Witness nodded head.)

8 Q For pain in your belly?

9 A Yes, sir.

10 Q The CT scan showed you had a mass in your belly.
11 You were referred to Dr. Williams. Do you recall your
12 initial meeting with Dr. Williams in Columbia?

13 A Yes, sir.

14 Q Who was with you?

15 A My husband and my daughter.

16 Q Bucky and Angie, correct?

17 A Correct.

18 Q Tell the jury what you remember about your initial
19 meeting with Dr. Williams.

20 A I did paperwork. He examined me in the presence of
21 his nurse. Then he talked with me, my husband, and my
22 daughter after the examination.

23 Q What did he tell you that you needed?

24 A I needed the mass removed. I needed surgery.

25 Q When Dr. Williams said you needed surgery, did you