

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 3 of 3; Pages 801 - 1016)

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SC Court of Appeals

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Matthew Kohler - Cross-Examination by Mr. Corbin

1 Q Which is in contradiction to Dr. Williams'
2 handwritten note?

3 A Well, I would agree there is some contradiction
4 there, but I think one has to know that with the object of
5 findings of the abdominal radiograph and the written
6 opinion of the expert general surgeon which clearly
7 indicated that the patient had a partial small bowel
8 obstruction.

9 Q And she had feculent vomiting at that time, too?
10 Right? Did you read that?

11 A I -- at one point she had feculent vomiting. I
12 don't know if that was on the 21st or not.

13 Q Continue with your Op Note that you wrote
14 involving the problems. Problem number one, the four star
15 problem.

16 A Talking about the no description of bowel
17 reanastomosis. I believe we've laid that to rest
18 because --

19 Q We did?

20 A -- this was corrected. And then number two, why
21 not simply overflow the enterotomies as opposed to
22 resecting.

23 Q Now the purpose of that is, if the goal is to
24 preserve as much bowel as you can, in general, it's better
25 to sew the hole shut than to cut out or resect the bowel?

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A Well, that completely depends on many factors. It
2 depends on the condition of the surrounding bowel; if the
3 hole is very large and ragged, if it's near the mesenteric
4 or blood supply site of the bowel or over something that's
5 technically impossible or difficult; if the surrounding
6 bowel is dusky or ischemic looking, then it may very well
7 be completely appropriate to remove that section of the
8 bowel instead of risking a leak from a poor job of sewing
9 or breakdown over sewing.

10 Q Was there a very large perforation or a very
11 ragged perforation that prompted Dr. Williams to do the
12 resection instead of over-sewing?

13 A I don't know that that is described. I believe --
14 I believe the terminology that was used was an enterotomy
15 that's been encountered. Let me just double-check that.
16 An enterotomy was encountered and large massive adhesions
17 that adhered to the intraabdominal wall.

18 Q Did you ever get the answer to this question that
19 you had? Why not simply over-close the enterotomy as
20 opposed to resecting it? Did you ever get an answer?

21 A Again, I have had no communication with Dr.
22 Williams.

23 Q The next problem you have on that page is a five
24 star problem. Please read it.

25 A We skipped some text in there, just so we're clear.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 One of the things that was skipped was the fact that Dr.
2 Williams actually took additional measures to try to
3 prevent a post-operative small bowel obstruction, which is
4 to say the placement of seprafilm. Seprafilm is a membrane
5 that's been shown to reduce post-operative adhesions and
6 bowel obstruction that was deliberately placed by Dr.
7 Williams as an additional measure to try to prevent this
8 scenario from unfolding. But, moving on to the, as you
9 say, the five star problem. Bowel resection, where's the
10 bowel? Not on Path Report only ovaries, which showed
11 serious just abnormalities --

12 Q Missing bowel apparently is the big issue?

13 A Well --

14 MR. MCDOW: I object to the statement.

15 THE COURT: Sustained.

16 Rephrase the question. Or ask a question.

17 MR. CORBIN: Let me just -- we can move on.

18 BY MR. CORBIN:

19 Q The missing bowel you rated four -- rated five
20 stars as a problem, correct?

21 A Again, on the first pass, but when I looked back at
22 the Op Note, which clearly describes hooking up the bowel
23 and I know what happened, actually, and that is that in the
24 throws of the 3-and-a-half-hour surgical procedure, Dr.
25 Williams would have handed that loop of bowel off and it

Matthew Kohler - Cross-Examination by Mr. Corbin

1 got misplaced --

2 Q Doctor, are you speculating or --

3 A I am.

4 Q -- do you know?

5 A I'm speculating.

6 Q Okay.

7 A But yeah.

8 Q Doctor, when you give opinions like that, please
9 make them based on a reasonable degree of medical certainty
10 that you feel comfortable testifying under oath. Something
11 probably happened. Would you do that please?

12 A I would be willing to say that actually we -- it's
13 sad to say, but on occasion, specimens get lost in the
14 operating room because they get passed to the scrub nurse
15 and then to the circulating nurse and they get lost
16 somewhere between the OR and the Pathology Department. It
17 happens not infrequently, unfortunately. And it's my
18 opinion that that's what happened in this case.

19 Q And when that happens, you follow up and you
20 correct the problem, because that's a problem, isn't it?

21 A We backtrack and we start with pathology and we
22 move backwards and sometimes we find the specimen and
23 sometimes we don't. It's very disappointing when that
24 happens.

25 Q But if you lose feet of bowel, the proper

Matthew Kohler - Cross-Examination by Mr. Corbin

1 backtracking is to go to the pathology lab, find out what
2 happened to your patient's bowel; correct?

3 A I believe that that's reasonable, although in this
4 case, there was no reason to suggest or to speculate that
5 there would be any intrinsic underlying pathology of the
6 bowel itself. Very different from the ovarian cancer cases
7 that we do where that piece of tissue that we're sending
8 off is actually the site of the cancer. So backtracking
9 findings, it is really important.

10 In this case it was a -- it was a section of bowel
11 that was sort of eat up and it had a hole in it and it was
12 intrinsically normal. It wasn't a cancer operation; it was
13 nothing to suggest that there was intrinsic pathology of
14 the bowel.

15 Q How much was it, you don't know, correct?

16 A I can't -- I can't say.

17 Q But you can tell this jury that you know, you
18 can't tell us how much was removed, but you can testify
19 that it was intrinsically not diseased and didn't need to
20 go to pathology; is that your testimony?

21 A My testimony is that I presume -- I wasn't here for
22 Dr. Williams' testimony, but I'm assuming that you asked
23 him under oath how much bowel that he removed at the first
24 surgery; did you do so?

25 Q Uh-huh. He doesn't know.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A And --

2 Q Do you know?

3 A I do not.

4 Q Okay. If you do not know how much was removed,
5 how in the world can you know what's inside of that bowel
6 portion removed?

7 A I believe Dr. Williams to be professional enough
8 and knowledgeable enough to know that the section of bowel
9 that he removed was intrinsically pathologic; had a mass;
10 had swelling; had abnormal induration in the wall that that
11 would have prompted him to consider that there was
12 underlying pathology that would have been deserving of
13 backtracking where the specimen had gone.

14 Q Any evidence he backtracked?

15 A I have no evidence in that regard.

16 Q We're on the Post-Operative Care page; you see
17 that?

18 A Yes, I do.

19 Q For time constraints, if you want to read the
20 whole thing, that's fine.

21 A Sure.

22 Q But I just want to focus on the problems.

23 A Fair enough.

24 Q And I understand that you think nothing was done
25 inappropriately in this case, but I just want to focus on

Matthew Köhler - Cross-Examination by Mr. Corbin

1 the problems.

2 A Yes, sir.

3 Q And on this particular page, if you look at,
4 towards the bottom, you had a star in front of a phrase
5 followed by four stars, followed by three question marks.
6 Can you read that?

7 A Is this about midway down -- a quarter.

8 Q Yes, sir. The four stars, three question marks,
9 and another star.

10 A Okay.

11 Q And an arrow. Or is that an arrow?

12 A I've got -- it says, Lab two, 5/29/07, post-op day
13 number 34 and then I've got, how were these multiple
14 enterotomies closed, question mark, question mark, four
15 stars. How many -- four stars.

16 Q Did you ever get an answer to those questions?

17 A I did not. Again, I've had no contact with Dr.
18 Williams verbally or otherwise.

19 Q Well, it must have been important to you because
20 you wrote the question down, put stars next to it, question
21 marks next to it?

22 A Uh-huh.

23 Q But you never got the answer; correct?

24 A I don't know that I was specifically seeing the
25 answer, merely presenting my objective assessment of this

Matthew Kohler - Cross-Examination by Mr. Corbin

1 case to the defense attorney, Mr. McDow.

2 Q Yes, sir. Next line. You have the word multiple
3 underscored twice; correct?

4 A Correct.

5 Q And next to that you have a question mark, how
6 many, two question marks, underscored twice and four stars.
7 Was that an important question?

8 A How many is not underscored. It's got question
9 marks, but it's not underscored.

10 Q Oh, I'm sorry. It's got question marks?

11 A Correct.

12 Q Three question marks and four stars; correct?

13 A Correct.

14 Q Was that important?

15 A I think it would have been helpful; it was
16 something that I would have liked to have known.

17 Q The next line. You have question mark, dyed
18 extravasation, double quote -- double question marks?

19 A I do.

20 Q Three question marks at that; is that important?

21 A It is.

22 Q If we could, let's go --

23 A Actually, I want to make one clarification if I
24 might. It was important on my initial perusal of this case
25 to know whether there truly had been dye extravasation or

Matthew Kohler - Cross-Examination by Mr. Corbin

1 not detected at the second surgery. I want to say for the
2 record, without implication that when I reviewed this case
3 in exhaustive detail, I became convinced and remained
4 convinced that the issue of dye extravasation of the second
5 surgery is a complete red herring. It is utterly,
6 clinically irrelevant because not only was it clearly not
7 making the patient sick, had it been detected, had a CT
8 scan been done and it had been detected, it would have been
9 either treated not at all or treated nonoperatively with a
10 drain.

11 Even in retrospect, even if we accept the
12 possibility that there was dye extravasation detected in
13 the second surgery, it was clinically a red herring and
14 virtually irrelevant. That is my medical opinion.

15 Q Yes, sir. You've done a lot of medical research
16 involving issues in this case. And you were kind enough to
17 send me, I think, 17 medical journal articles and textbook
18 sections and you cited some of those on the witness stand.

19 A Uh-huh.

20 Q You mind if I ask you a few questions about some
21 of that literature?

22 A Not at all.

23 Q Okay. First one, please. For example, you gave
24 to us a document entitled, Complications in Colorectal
25 Surgery by the American Society of Colon and Rectal

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Surgeries. And I just want to ask you about a quotation in
2 this article and see if you agree with it. On page 306,
3 last paragraph; are you with me, Doctor?

4 A I am.

5 Q Last paragraph, would you please read the first
6 sentence to the jury?

7 A CT scan of the abdomen-pelvis is probably the best
8 test for both diagnosis and evaluation of a patient with
9 small bowel obstruction.

10 Q Do you agree with that?

11 A It's interesting, you know, I read the deposition
12 of Dr. Strickland who specifically disagrees with that
13 statement and I would have to say that I disagree with that
14 statement as well.

15 Q Yes, sir. And then the very next sentence, could
16 you read that to the jury about CT scans; what the
17 literature says.

18 A The sensitivity of CT scan is not even 100 percent.

19 Q Disagree with that one?

20 A I have no knowledge to the contrary. The problem
21 with CAT scans is that it's a single point in time. So
22 when you do a CAT scan, you get cross-sectional imaging of
23 the tummy and the bowel, but you don't follow the contrast
24 through the gut with time with the passage of time as you
25 do with a barium swallow. So when you do a barium swallow,

Matthew Kohler - Cross-Examination by Mr. Corbin

1 you're watching that contrast go through with multiple time
2 sequenced radiographs. With a CAT scan, it's a single
3 point in time; and therefore, I agree with Dr. Strickland.
4 It's very common to see CAT scans overhaul and miscall
5 small bowel obstruction. That's been my clinical
6 experience.

7 Q Page 4, please?

8 A Yeah.

9 Q Second paragraph.

10 A Yeah.

11 Q Read the first sentence to the jury please.

12 A Small bowel obstruction occurring within one month
13 of abdominal surgery is a special situation.

14 Q Please continue.

15 A Re-operation in this patient should only be
16 undertaken in the event of uncontrollable sepsis or
17 ischemic bowel.

18 Q Now, we're talking about Faye's situation. She
19 had a small bowel obstruction within a month of abdominal
20 surgery. She's a special case. Fair?

21 A I agree that everybody in this courtroom today has
22 stated for the record that she is an unusually complex
23 case.

24 Q Okay.

25 A Yes.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Q And then the next sentence, it says, should --
2 operation should only be undertaken in a patient like Faye
3 if she has uncontrollable sepsis. Did she ever have that
4 between surgeries one and two?

5 A She did not.

6 Q Or ischemic bowel. Did she ever have that between
7 surgeries one and two?

8 A Not clinically diagnosed, no.

9 Q But it was found on the Path Report at the second
10 surgery; correct?

11 A There was some ischemic change, but I have
12 commentary on that, too.

13 Q Yes, sir. Please continue.

14 A Okay. To read?

15 Q Yes, sir.

16 A Otherwise, extreme patients should be the rule.
17 Laparotomy during the post-operative period can be
18 extremely difficult due to dense, inflammatory adhesions
19 and the risk of enterotomy mesenteric vascular injury
20 and/or fistula anastomosis small bowel obstruction are
21 significant. These patients can be managed with total
22 parenteral nutrition and a tube decompression --

23 Q If I may, please?

24 A Uh-huh.

25 Q Now, Faye was given the benefit of TPN and for

Matthew Kohler - Cross-Examination by Mr. Corbin

1 whatever reason, she didn't have tube decompression;
2 correct?

3 A Correct. Well, she had tube decompression just
4 prior to the second surgery.

5 Q And it worked?

6 A It provided, as you just heard Dr. Parker,
7 temporary relief of her symptoms.

8 Q Yes, sir.

9 A But no correction of the underlying
10 pathophysiology.

11 Q Yes, sir. Please read the next sentence.

12 A Most early post-operative small bowel obstructions
13 will resolve with conservative management, though it may
14 take several months.

15 Q Conservative management, TPN; correct?

16 A Correct.

17 Q Periodic NG tube decompression for the distention;
18 correct?

19 A Possibly. Although, again, the literature says
20 that we had failed to show any level one data that would
21 advocate --

22 Q Yes, sir.

23 A -- conclusively for that.

24 Q And this literature might take for months before
25 you can go back in and reoperate safely on a patient like

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Faye; correct?

2 A Well, again, the first line that I read talked
3 about small obstruction -- small bowel obstruction
4 occurring within one month. I mean, this patient was
5 beyond that. She was post-op day 33; she had a general
6 surgeon consulting. The general surgeon said that
7 conservative management's failing, she's going to need to
8 be reoperated. That is written in writing in the chart.
9 So -- so I think everybody recognized up from that Ms.
10 Atkinson was likely to be a very difficult case and she --
11 and she proved to be that.

12 Q Yes, sir. If we may continue with your
13 literature. You have another article called Early
14 Operational or Conservative Management of Patients with
15 Small Bowel Obstruction; the Fevang article. Do you have
16 it?

17 A Give me the author again.

18 Q Fevang?

19 A Might I take a --

20 Q Do you have it?

21 A Might I take a look at what you have so I can pull
22 it up.

23 MR. CORBIN: Your Honor, may I approach the
24 witness.

25 THE COURT: Yes, sir.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 BY MR. CORBIN:

2 Q If you don't have it, I can --

3 A Let's see if I've got it.

4 Q Doctor, if I may, you can read it off of my copy
5 of the article. All I want is one sentence.

6 A Fair enough.

7 Q If you could, page 476. That particular paragraph
8 starting with, all patients. Please read that sentence to
9 the jury.

10 A The reasons for operating were developmental
11 science; if symptoms of strangulation worsen or the
12 patient's general condition were failure to resolve a
13 conservative treatment.

14 Q The next sentence?

15 A All patients have nasogastric drainage.

16 Q All of the patients had been --

17 A With all due respect, I hardly think that that
18 provides an insight as to the -- as to the --

19 Q Next reference?

20 A -- proof that the NG suction is required.

21 Q The next reference, in that same article is a
22 paragraph on page 480. Can you read that starting with,
23 from this? What the conclusion was of this particular
24 study?

25 A From this we may conclude that the decision to

Matthew Kohler - Cross-Examination by Mr. Corbin

1 operate early must be based on clinical judgement and
2 diagnostic tools other than the plain abdominal
3 radiographs.

4 Again, I would point out this patient was not
5 operated on early. She was operated on only after over a
6 month of failure of conservative management and a
7 documented persistent partial small bowel obstruction only
8 on serial multiple flat plates, but also an area of the
9 contrast study.

10 Q The next paper is the author's Ellozy; Early
11 Post-Operative Small Bowel Obstruction. This is a study of
12 242 abdominal operations.

13 A I may have to look over your shoulder to read it.
14 I don't have the luxury of --

15 Q In this particular study, would you read for the
16 jury what the findings were? Which are highlighted there
17 for you.

18 A In the present study, 87 percent of the episodes of
19 what they say, E.P.S.B.O, or I'm assuming is early
20 post-operative small bowel obstruction, resolved entirely
21 with nasogastric suction, comma, all but one within six
22 days of diagnosis.

23 Q So if a patient has an NG tube, what percent was
24 it resolved?

25 A Eighty-seven percent.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Q Eighty-seven percent with an NG tube and IV's
2 resolved within what period of time?

3 A All but one within six days of the diagnosis.

4 Q Six days. Read the next thing on that page?

5 A So -- can I -- are you stating -- are you
6 speculating that this patient, had she had an NG tube would
7 it have been well within one week of developing her bowel
8 obstruction? I think that's fantastically unlikely,
9 truthfully.

10 Q Yes, sir.

11 A So the next highlighted area is 96 to 100 percent
12 of those patients whose conditions resolved without
13 exploration experienced resolution within two weeks of
14 diagnosis.

15 Q So 96 percent of those resolved during -- within
16 the first two weeks, according to that study?

17 A Well, you've picked one study of many.

18 Q We do have many that you sent to us, but in this
19 particular study, 96 percent --

20 A And I want to state for the record that, you know,
21 Ms. Atkinson was hardly the average patient that would have
22 shown up in the studies that you're -- that you're picking
23 here. She was a very complicated, complex patient; she had
24 multiple prior procedures. The state that she would have
25 gotten well within a week of putting an NG tube down

Matthew Kohler - Cross-Examination by Mr. Corbin

1 strains the boundaries of credibility in my opinion.

2 Q Yes, sir. In your deposition, you quoted the
3 Sarjah (phonetic) article. It talks about the hostile
4 abdomen. Do you have that one handy?

5 A I do have that one.

6 Q Please turn to page 689 on the right hand side of
7 the column, there's a section called hostile abdomen?

8 A Yes.

9 Q Would you please read that from the word, any, to
10 the word, death.

11 A Any mixed series of patients with early
12 post-operative small bowel obstructions; likely to include
13 a subgroup of patients in whom the index of operation has
14 disclosed a quote, hostile, end quote peritoneal cavity
15 suggesting that further surgery to relieve the obstructive
16 process would be hazardous and futile. This group includes
17 patients with extensive radiation, enteritis in whom
18 persisting obstruction can be defined as intestinal
19 failure. These patients are best managed with long term
20 parenteral nutrition, indiscriminantly operations on such
21 patients often leads to massive bowel resection, multiple
22 fistulas, and death.

23 Q Did Faye have a hostile abdomen? For the second
24 operation?

25 A I believe she was found to have massive adhesions

Matthew Kohler - Cross-Examination by Mr. Corbin

1 that could be -- could be called that.

2 Q Yes, sir. Do you agree with that particular
3 statement of literature about the hostile abdomen or not?

4 A Well, again, I think the -- by it's very
5 description, a hostile abdomen indicates that there are
6 patients, who no matter how they're managed are going to be
7 exceedingly complex and by virtue of multiple surgeries, by
8 virtue of extensive intraabdominal tumor, by virtue of
9 prior radiation. Whether you're going to treat them with
10 reoperation, whether you're going to treat them by sending
11 them home with TPN and NG tube or a gastrostomy tube, you
12 know, they're going to remain a challenge from that point
13 forward.

14 And it's been pointed out by Dr. Strickland earlier
15 this afternoon, there is very little expectation that this
16 patient would have improved or gotten better had she been
17 sent home on TPN and the nasogastric tube. She was still
18 obstructed 33 days out from surgery. What magic number
19 would have lead to her getting better down the road? And I
20 want to point out without question there are serious and
21 significant, indeed, life threatening complications to
22 maintaining patients on weeks and even months of TPN. In
23 my career, I've seen bacterial and fungal sepsis when you
24 get TPN and you've got to have a permanent indwelling --
25 semi-permanent indwelling IV; those lines are prone to

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1 infection; they're prone to thrombosis of the veins, the
2 axillary veins and so forth. They could clot off; the
3 lines could infect them. Chronic liver function,
4 abnormalities, and so forth. Not to mention, being hooked
5 up to an IV at home for somewhere between 8 and 12 hours a
6 day each and every day. Not to mention having an NG tube
7 down.

8 So to say that somehow sending patients home on TPN
9 is the magical solution, it is not and, you know, if Ms.
10 Atkinson had been placed on chronic TPN then sent home and
11 can come back to the hospital with fungemia and had died
12 from overwhelming fungal sepsis because of long term TPN,
13 we'd be arguing this case, but from a different cause of
14 action, unfortunately. So there are no easy solutions
15 here, unfortunately.

16 Q TPN's not the magical solution; was surgery Faye's
17 magical solution?

18 A There are no magical solutions --

19 Q The next one is a --

20 A -- unfortunately.

21 Q You reviewed that, sent that to us to support your
22 opinion.

23 Can you turn to the Pitman article?

24 A Actually, if I'm not mistaken, just to correct the
25 record, I believe that you all sent this one to us. If I'm

Matthew Kohler - Cross-Examination by Mr. Corbin

1 not mistaken. I believe that this one was sent to us by
2 you all.

3 Q In the Pitman article?

4 A Uh-huh.

5 Q Page 218, the paragraph at the bottom. Would you
6 please read that for the jury?

7 A This one.

8 Q Yes, sir?

9 A Okay. In the management of post-operative patients
10 with suspected early post-operative small bowel
11 obstruction, comma, all authorities believe that some form
12 of gastric or intestinal suction is required. Significant
13 disagreement exists, however, regarding the merits of each
14 kind of tube.

15 Q If we can -- you can read the whole article if you
16 wish. But the question about that particular sentence,
17 pretty straight forward, Faye had early post-operative
18 small bowel obstruction. That was her diagnosis by Dr.
19 Williams; correct?

20 A Correct.

21 Q This states all authorities agree that some form
22 of gastric or intestinal suction is required; isn't that
23 what it says?

24 A Uh-huh.

25 Q That's NG tubes; is it not?

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A No, and I'd like to point out that this article is
2 25 years old and I will tell you that when we first started
3 managing small bowel obstruction, actually, it goes back 40
4 or 50 years. There was an attitude in surgical literature
5 that became part of the training that quote, the sun should
6 never set on a small bowel obstruction.

7 Patients, it was understood, that they would have
8 to be whisked back to an operating room by the end of the
9 day. We now know that not to be true at all. When I was
10 early on in my training, we used to try to put these long
11 cantor tubes down; we'd sit at the bedside and pour mercury
12 into a balloon and we'd hook it up to a long tube and try
13 to feed it down the entire small bowel. That was the
14 prevailing standard of care then.

15 We now know that to be foolish. There have been,
16 in fact, multiple randomized trials that show advantage of
17 the long tube over the short tube. So medicine evolves
18 over time and we certainly have patients that have had
19 partial small bowel obstructions that we don't put
20 nasogastric tubes down; I've got a whole host of patients
21 with reoccurring ovarian cancer and low-grade small bowel
22 obstructions and those patients are managed as outpatients
23 without NG tubes.

24 So -- and again, we have no randomized data looking
25 at an NG tube versus no suction in a long trial in these

Matthew Kohler - Redirect Examination by Mr. McDow

1 patients. So again, this article is outdated. It's 25
2 years old.

3 Q Dr. Kohler, do you know any way to cure Faye's 20
4 inches of small bowel?

5 A I certain --

6 Q Do you know any way to cure her 20 inches of small
7 bowel at this point?

8 A I don't understand your --

9 Q Fix it?

10 A I would have to ask -- I would say that the length
11 of bowel that she has now is what she'll have.

12 Q Thank you, Doctor.

13 THE COURT: Redirect?

14 **REDIRECT EXAMINATION**

15 **BY MR. MCDOW:**

16 Q Dr. Kohler, just some clarification questions on
17 these records. Dr. Kohler, I want to show you a series of
18 letters. If -- I think you may have one, but if you could
19 just briefly summarize the date of that letter, who it was
20 from, who it was to, and what was transmitted in that
21 letter.

22 A I'd be delighted. So this date is dated May 17th
23 of 2010; it's originating from your office, which is to
24 say, the Richardson Plowden Law Firm. It is signed
25 personally by you, Mr. McDow. And it is re: The Doris

Matthew Kohler - Redirect Examination by Mr. McDow

1 Atkinson and William Atkinson versus James Williams civil
2 action. And I -- how much of this would you like for me
3 to --

4 Q Well, first off, what records, not the civil
5 action or the affidavit from anyone else --

6 A Okay.

7 Q -- but just what office records were you provided
8 initially?

9 A Okay. As such, I have attached for further review,
10 a copy of the following documents. Number one, the civil
11 action cover sheet, notice of an attempt to file suit. And
12 number two, office records of Dr. Williams and the SCOA,
13 which is to say is the South Carolina Oncology Associates.
14 And you will please note that I've attempted to arrange the
15 SCOA records in chronological order.

16 Q All right. Doctor, that was the first set of
17 records --

18 A Uh-huh.

19 Q -- that you were able to review; correct?

20 A Correct.

21 Q And then as a result of that initial review of
22 just the office records you prepared the notes that you've
23 been over; is that correct?

24 A Actually -- and I -- it's actually a routine that I
25 do. It consists of a list and in this are the operative

Matthew Kohler - Redirect Examination by Mr. McDow

1 notes, the pathology reports, I -- Dr. Parker's consult
2 note of May the 21st, and some x-ray or radiographic
3 reports and that's it. There are no progress notes, there
4 are no nurses' notes; it's just the tiniest subset of her
5 medical records.

6 Q All right. If I could have the letters back to
7 try to speed things up, just briefly. So your notes were
8 based solely on that set records from South Carolina
9 Oncology Associates?

10 A That's my recollection, yes.

11 Q And then it looks like I came down and met with
12 you on Tuesday July the 27th, 2010; do you recall that?

13 A I do.

14 Q You gave me your notes at that time?

15 A Uh-huh.

16 Q I believe you referenced I sent them back to you
17 on July the 28th, 2010. You got that letter there?

18 A Yes. We referenced that cover letter and returned
19 hand-written notes.

20 Q And it was sent by letter April the 26th, 2011
21 that I sent you -- stated we finally set the deposition
22 with Dr. Williams for May 25th, 2011. In reviewing the
23 file it appears I never sent you a copy of the Palmetto
24 Health Richland Medical Records. Accordingly, please find
25 enclosed for your review a disc of these records, which are

Matthew Kohler - Redirect Examination by Mr. McDow

1 Bates stamped PHR0001-1957; obviously, these are very
2 voluminous records, please give me a call to discuss these
3 records prior to your review; did I read that correctly?

4 A You did indeed; in fact, I still have that CD-Rom
5 in my possession.

6 Q Doctor, going back to the very first letter that I
7 sent to you on May the 17th, this letter follows our
8 telephone conference May the 17th, wherein I advised that I
9 represent the defendants in the above referenced, et
10 cetera, et cetera, and I did tell you on the back side of
11 that page, I do not need a written report; correct?

12 A Correct.

13 Q And in spite of that, you prepared the notes
14 anyway, which is fine; is that right?

15 A Yes.

16 Q Doctor, tell you what, I think that's all I need.
17 I'm not going to ask anything else. No further questions.

18 **THE COURT:** Mr. Corbin?

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

20 **THE COURT:** All right. Thank you, sir. You can
21 step down. All right, can I see the lawyers very quickly
22 up here?

23 **MR. MCDOW:** And I would ask that Dr. Kohler would
24 be excused so he can get back to Charleston?

25 **MR. CORBIN:** No objections.

Matthew Kohler - Redirect Examination by Mr. McDow

1 THE COURT: All right. Thank you, sir. You can
2 leave.

3 THE WITNESS: Thank you.

4 THE COURT: If you'd like.

5 THE WITNESS: Yes, sir.

6 MR. MCDOW: Now, don't -- let me make sure you
7 don't walk out with any exhibits; I see you've got a
8 sticker, so.

9 THE WITNESS: That's not mine, okay. Thank you.

10 (WHEREUPON there was a bench conference out of the
11 hearing of the jury and the court reporter.)

12 MR. MCDOW: Your Honor, at this time, the Defense
13 rests its case.

14 THE COURT: All right. Ladies and gentlemen, we're
15 going to stop for the day. We're going to allow you to go
16 on and go home. Please be back in your jury room tomorrow
17 morning -- I'm going to make it ten o'clock. Please be on
18 time. What we're going to do is get here a good bit
19 earlier than that -- the presentation of evidence may not
20 be over, but if there is addition -- for example, if there
21 is going to be a reply of the plaintiff, immediately after
22 that, we would have to take a break according to the rules
23 that I referenced before and I have to spend some time with
24 the attorneys going over the jury charge, the verdict
25 forms, and things of that nature.

1 That would necessarily take some time with you
2 sitting back in that room. So we're going to shift things
3 around. If there is reply, we're going to start that at
4 ten and between 9:00 or 9:15 and 10:00, we're be here alone
5 going over those things that we would have otherwise gone
6 over later in the morning. So that's why we're going to
7 start at 10:00.

8 But if you would please be back promptly at 10:00
9 or before and we'll get -- we'll resume at that time.

10 Thank you for your patience. You may not discuss the case
11 at all, just put it out of your mind as far as any research
12 or so forth is concerned. Thank you.

13 (WHEREUPON the jury left the courtroom at 5:35
14 p.m.)

15 **THE COURT:** All right. Anything before we break,
16 gentlemen?

17 **MR. CORBIN:** Nothing, Your Honor.

18 **THE COURT:** At 9:15, we're going to get together
19 and go over these jury charges so -- according to how -- I
20 need yours still.

21 **MR. MCDOW:** When should I renew my motions for --

22 **THE COURT:** Tomorrow morning. You can do it
23 tomorrow morning.

24 **MR. CORBIN:** Not today?

25 **THE COURT:** Correct.

1 MR. MCDOW: Your Honor --

2 THE COURT: Of course, if he's going to have his
3 reply, it'll -- there's some debate as to whether or not --
4 if they're closing the evidence yet.

5 MR. MCDOW: Oh, I understand.

6 THE COURT: I'll let you make it then and then you
7 can make it again.

8 MR. MCDOW: Yes, sir.

9 THE COURT: Okay. All right.

10 MR. MCDOW: I might have one or two more simple
11 ones in the morning --

12 THE COURT: Okay. Well, I -- I've been asking for
13 it --

14 MR. MCDOW: I know. Yes, sir.

15 THE COURT: So I'm not really going to entertain
16 much more.

17 MR. MCDOW: I got you.

18 THE COURT: Okay. Lawyers are going to come back
19 for just a minute and I'm going to talk to y'all in the
20 back about the length of your closing arguments because I
21 think I'm going to have to weigh in on that.

22 MR. MCDOW: Yes, sir.

23 THE COURT: All right. Thank you.

24 (WHEREUPON court was in recess until Friday,
25 October 12, 2012.)

1 * * * * * END OF VOLUME IV * * * * *
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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.)

Volume V

9)
10 James A. Williams, Jr., M.D. and)
South Carolina Oncology)
11 Associates,)
Defendant.)

12
13 October 8-12, 2012
Columbia, South Carolina
14

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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1 FRIDAY, OCTOBER 12, 2012

2 THE COURT: Defendant's motions, if you want to
3 make those, Mr. McDow.

4 MR. MCDOW: Yes, sir. I'll go ahead and do that
5 now in earnest and then I guess I'll just simply, after the
6 reply testimony, just renew them.

7 THE COURT: Okay.

8 MOTIONS

9 MR. MCDOW: In general without being so specific.

10 All right. Your Honor, may it please the Court?
11 The Defendant has rested their case and again, we renewed
12 their motion for a directed verdict on those grounds raised
13 in the prior motions for directed verdict, each of which
14 grounds incorporate, herein, by reference as if fully
15 restated.

16 One, the only reasonable inference from all
17 competent evidence is that the Defendants were not
18 negligent. Two, the only reasonable inference of all the
19 competent evidence is that no act or omission or part on
20 the Defendants was the approximate cause of any of the
21 plaintiff's injuries. The only reasonable inference from
22 all competent evidence is that no act or omission on the
23 part of any employee or agent of the Defendants was the
24 proximate cause of the plaintiff's injury.

25 The Plaintiff has failed to prove by preponderance

1 of the evidence that Dr. Williams violated the standards of
2 care, which were the approximate cause of the alleged
3 injuries or damages. Four, the only reasonable inference
4 from all the competent evidence is that the Plaintiff was
5 fully informed of risks of surgery.

6 The Defendants move for a directed verdict as
7 to any informed consent caused. Also, Defendant would
8 move again for directed verdict on the initial grounds that
9 the Plaintiff testified she wanted the surgery; the
10 objective standard would be that she would accept the
11 surgery. The Plaintiff failed to show a reasonable person
12 having been properly informed would elect to not have
13 either of the procedures performed and also failed to
14 prove proximate cause on this issue.

15 Five, the only reasonable inference of all the
16 competent evidence is that these Defendants did not act in
17 reckless, willful, or wanton fashion or conscious disregard
18 for the plaintiff's rights and safety. The plaintiffs
19 failed to prove by clear and convincing evidence that the
20 Defendants acted recklessly, willfully, wantonly; the
21 Plaintiff is not entitled to punitive damages against these
22 defendants or a charge relative to gross negligence for
23 purposes of potentially recovering damages above the
24 statutory capital damages.

25 Clear and convincing evidence is an elevated

1 standard of proof must be found to be credible. The facts
2 in which the witnesses testify must be distinctly
3 remembered. Testimony must be precise and explicit; the
4 witnesses must be lacking in confusion and the evidence
5 must be of such weight that it produces in the mind of the
6 trier a fact, a firm belief or conviction without hesitancy
7 as to the truth of the allegations sought be established.

8 Eight, that the awarding of punitive damages would
9 be in violation of the constitution and these Defendants
10 move for a directed verdict on punitive damages as plead in
11 their answer to the plaintiff's complaint; specifically
12 related to clear and convincing evidence. There's no clear
13 and convincing evidence that any lost bowel, as alleged by
14 the Plaintiffs during the first surgery was the approximate
15 cause of any injuries. There's no credible evidence to
16 testify Dr. Williams tried to hide or spoliage or in other
17 ways get rid of that particular specimen. The only
18 reasonable inference is that it was passed off and the
19 hospital itself must have lost it, which is different than
20 Dr. Williams not having the evidence.

21 Again, the testimony relative to any lost bowel
22 would be any proximate cause, any alleged injuries or
23 damages of Ms. Atkinson. The only reasonable inference
24 from the testimony in this stage of the proceeding is that
25 there was a difference of opinion in how to treat this

1 patient post-operatively or pre-operatively for that matter
2 and that goes into the judgement of whether Dr. Williams
3 would be a reasonable and prudent physician in what those
4 decisions were. The fact that the plaintiff's experts may
5 testify in each fork in the road, he took the wrong road,
6 doesn't add up to gross negligence such that they would be
7 entitled to receive a charge of punitive damages in that
8 respect. Not to breach a cap -- or breach a gap --

9 THE COURT: Which you've already covered.

10 MR. MCDOW: Which I've already covered. Again, Dr.
11 Bailey never used the terms proximate cause. I don't
12 believe Dr. Irvin did either and the directed verdict on
13 any allegations of NG tube on informed consent, experts did
14 not testify to this. I think that is based on --

15 THE COURT: All right. You also -- of course, you
16 incorporated all your prior motions by reference.

17 MR. MCDOW: Yes, sir.

18 THE COURT: You also earlier moved to strike or in
19 the alternative for directed verdict on the issue of
20 what -- that Dr. Williams was, quote, overly aggressive,
21 end quote, in removing the adhesions in the first surgery.

22 MR. MCDOW: That's correct.

23 THE COURT: And you included that?

24 MR. MCDOW: I included that.

25 THE COURT: Okay. Mr. Corbin, do you have any

1 response at all? And I know this is not the time for you
2 to make your motions, because we'll get to that in just a
3 moment.

4 MR. CORBIN: Yes, sir.

5 THE COURT: Do you have any response?

6 MR. CORBIN: Nothing new today, Your Honor. I
7 think the evidence is clear. At this stage, of the
8 proceeding, we did introduce sufficient evidence for the
9 jury to consider. Classic jury fact-finding mission.

10 THE COURT: All right. Does the Plaintiff have any
11 motions?

12 MR. CORBIN: You know Judge, I have one. And it's
13 a motion --

14 THE COURT: Directed verdict.

15 MR. CORBIN: Yes, sir. It's a motion for a
16 directed verdict. And I want to focus -- I want to focus
17 on the second operation. And if you focus on the second
18 operation, Dr. Williams even testified, he didn't give her
19 any alternatives. There's nothing in the record; there's
20 nothing in the record, documents, or testimony, that he
21 told Faye she had an option for surgery or no surgery.
22 There's nothing there.

23 And the case law is clear that he had a duty to
24 fully explain the surgery -- which he says he did -- fully
25 explain the surgery, but also, at a very minimum, he had a

1 duty to explain to her what's going to happen to you if I
2 don't do my surgery.. He doesn't do that. In addition,
3 he's got a duty to say, what other treatments are
4 available; which, he failed to do that. But just telling
5 her, what will happen to you if you don't have the surgery,
6 he's got to do that. He didn't do it. I don't think
7 there's any factual dispute of that. They could argue
8 about damages, but he violated the standard of care and I
9 just want to focus on that one point.

10 **THE COURT:** All right. According to my notes, I
11 believe this was concerning the second surgery, he
12 testified -- and this is on cross -- he informed her as to
13 the risk of bowel complications, but did not discuss
14 percentage chances of each specific bowel complication such
15 as a leak or obstruction or so forth. Is that what you're
16 talking about?

17 **MR. CORBIN:** Yes, sir. I'm saying he did that, but
18 under the standard of care, he has to do more than that at
19 a minimum. He has to do more than that. He talked -- he
20 said he talked about the surgery. I'm not going to dispute
21 that. He handled that part, but there's more than one
22 part. He also has to tell her -- give full information,
23 what will happen to you if I don't do my surgery. And
24 there's nothing in the record to that effect. Hospital
25 records are empty. His testimony was empty. He testified,

1 I warned her, if you let me go forward you could have all
2 these horrible things, but he didn't go the second step.
3 He didn't fully inform her -- a doctor has to tell a
4 patient, now if you don't let me do the surgery, this is
5 what can happen to you. And he never did that?

6 THE COURT: All right. Okay. Mr. McDow? Any
7 response?

8 MR. MCDOW: Your Honor, I think Dr. Williams
9 testified they had that conversation seven to ten days
10 earlier. That was the May 18th note and ongoing
11 discussions and that -- of what would happen if you don't
12 have surgery, that's what prompted the second opinion by
13 Dr. Parker. Dr. Parker had the same conversation with her.
14 So that also gets back into what options there were and I
15 think that's been covered enough. If I could --

16 THE COURT: Okay. Anything else on that point, Mr.
17 Corbin?

18 MR. CORBIN: Seven or eight days later, that
19 conversation was not talked about. If we don't do this,
20 this is what could happen to you.

21 THE COURT: All right. Okay. This gets into the
22 jury charge, but it's also going to get into a point Mr.
23 McDow raised the alternative motion to strike reflected the
24 issue of the loss of the bowel from the time it was
25 removed, Dr. Williams said he handed it off to a nurse and

1 doesn't know what became of it from that point. Of course,
2 I'm familiar with the Stokes case you e-mailed. I think it
3 was a part of what you handed up, too.

4 If there was some testimony, Mr. Corbin, you can go
5 from one extreme to the other that if there was evidence
6 that if Dr. Williams was the sole custodian and sole
7 responsible person for specimens removed, if that --
8 there's evidence of that or that was the law, I'd think
9 you'd have a great argument on spoliation.

10 The evidence -- the only evidence that I have heard
11 is that he removed whatever he removed; it was given to a
12 nurse and, like I said, standard of care -- he says the
13 standard of care required him to send the bowel to
14 pathology, passed off to a hospital employee who was to
15 accomplish delivering.

16 These spoliation cases talk about when the
17 Defendant itself or himself or herself sponsor -- either
18 sponsored, destroyed it, or was the one in constant custody
19 of it. And it somehow became lost -- lost honestly or not.
20 So in this case, how does Stokes even apply? That's -- of
21 course, it's against a hospital: Stokes versus something
22 Regional Hospital. So where -- how does that apply?

23 **MR. CORBIN:** Your Honor, it's my position that Dr.
24 Williams removed the specimen. Dr. Williams controlled
25 that specimen and he decided to send it to pathology. He

1 sent it to pathology. If it doesn't get there, then he's
2 the captain of the ship. He's in charge of that operating
3 room, number one. Number two, there was no testimony at
4 all that he did anything in the world to follow up. He got
5 the report back about the ovaries but he had to know the
6 bowel was missing. There's nothing in the record, he
7 didn't complain to the director of pathology. Nothing.

8 THE COURT: Okay. Okay. Let's assume all that's
9 correct. What would the -- what are you trying to
10 accomplish by having that charge given? What is the
11 evidence? What is the reasonable inference to the jury to
12 draw from that?

13 MR. CORBIN: Yes, sir.

14 THE COURT: As far as, number one --

15 MR. CORBIN: Yes, sir.

16 THE COURT: Negligence.

17 MR. CORBIN: Yes, sir. The inference is --

18 THE COURT: Number two --

19 MR. CORBIN: I'm sorry.

20 THE COURT: -- damages.

21 MR. CORBIN: Number one, negligence. This bowel
22 part, if it were here, even their expert witness, Dr.
23 Kohler, five stars, missing bowel. If it were here, number
24 one, we'd know how much it was and we could -- scientific
25 body parts we have here and it looks like -- could be 10 or

1 12 feet missing. We would know that, it'd be studied.

2 Number two, if the bowel were here, we would know
3 scientifically how ragged it was, how many perforations
4 there were. Dr. Kohler testified, he was concerned about a
5 nightmare during this. He was concerned about the missing
6 bowel; there could have been a nightmare there; could have
7 been a huge perforation; could have been a ragged
8 perforation. That -- if we had that and pathology looked
9 at it -- if it got to pathology and they looked at it and
10 said, oh by the way there's a -- you know, a large hole, a
11 ragged hole, there's whatever it is. And it's 6 or 8 or 10
12 feet long. That's material.

13 **THE COURT:** Mr. McDow, is there any dispute that
14 between the April surgery and the May surgery that, I think
15 what Dr. Parker (sic) took out -- how much did he say he
16 took out?

17 **MR. MCDOW:** He -- well, he said he doesn't know, he
18 just knows how much was --

19 **MR. CORBIN:** Sir, the important thing is, when he
20 got it and he looked at it and he said it was 70 to 80
21 centimeters, that's 2 and a half feet.

22 **THE COURT:** I understand that. So that's what Dr.
23 Parker took out?

24 **MR. CORBIN:** No, that's what he began with.

25 **THE COURT:** Okay. That's what he began with. So

1 how is the Defendant going to logically argue to this jury
2 that between April and when Dr. Parker got there that Dr.
3 Williams didn't remove a substantial portion of the small
4 intestine? Can you even dispute that? I mean, that's
5 the -- that's the reality.

6 MR. MCDOW: Right. I mean, I don't dispute that.

7 THE COURT: So the fact is --

8 MR. MCDOW: -- and I don't dispute that --

9 THE COURT: He claims -- Dr. Williams claims, yes;
10 I took it out, she was left with 2 and a half feet when Dr.
11 Parker opened her up, but what I did was in no way
12 negligent. So the evidence is indisputable.

13 MR. CORBIN: How --

14 THE COURT: That was from April to May --

15 MR. CORBIN: Yes, sir.

16 THE COURT: -- he took out a lot.

17 MR. CORBIN: How much -- excuse me, how much is a
18 lot? How much is significant? He says he doesn't know.

19 THE COURT: Well, how about the people at Byerly or
20 Carolina Pines? Did you get their pathology stuff?

21 MR. CORBIN: No.

22 THE COURT: See how much they took out?

23 MR. CORBIN: Those records don't exist.

24 THE COURT: Well, is he at fault for that?

25 MR. CORBIN: No.

1 **THE COURT:** In other words, and I'm not making an
2 argument, but I've been listening to this for a week and
3 the first time it came up about the missing bowel, I'm
4 thinking, what in the world has that got to do with
5 anything.

6 **MR. CORBIN:** Well --

7 **THE COURT:** He's not CEO of the hospital. He's not
8 the chief of staff; he's not the eye in the sky. Did y'all
9 depose the nurses from the OR?

10 **MR. CORBIN:** No.

11 **THE COURT:** Pathology people?

12 **MR. CORBIN:** No.

13 **THE COURT:** Try to get their protocol down as to
14 what happens when this comes out? I mean, if there was
15 some evidence that he leaned over and said, I wouldn't mind
16 if you lost that. Or he said, I want you to take this to
17 pathology or something like that. Obviously, you know what
18 you got.

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

20 **THE COURT:** You've got -- the defendant has a
21 problem. Frankly, we wouldn't be here if there was
22 evidence of that. But it's not his fault you don't know
23 how much you started with in April. That's -- that's just
24 the passage of time. Byerly's records, Carolina Pines'
25 records, through no fault of anybody's, they don't exist.

1 **MR. CORBIN:** That was an issue raised in the
2 defense. Nobody knows how much was taken out.

3 **THE COURT:** But the question is, he's not
4 responsible for what was taken out. He's responsible for
5 leaving her with so little. Regardless of how much she had
6 when he started.

7 **MR. CORBIN:** If, I kind of think the defense will
8 be, that, you know, at this stage, they can argue that she
9 had bowel resections before. We don't have records of
10 that. So -- and the testimony from Dr. Williams was, she
11 had an abnormal bowel. There was charts up there. Dr.
12 Kohler talked about previous resections, all that kind of
13 stuff. The difference right now would be the 10 or 12 feet
14 that's missing. According to the scientific records,
15 that's how much is missing.

16 **THE COURT:** Right.

17 **MR. CORBIN:** Okay. And Dr. Williams can't testify
18 how much he took out, so it must be Carolina Pines, maybe
19 they took out 10 or 12 feet?

20 **THE COURT:** Well, he can't argue that because
21 that's speculation. He doesn't -- he -- it's not
22 spoliation issue. A doctor who's taking somebody's bowel
23 out, to me, has a responsibility to know what he's working
24 with. If she had some taken out in '95, then he ought to
25 be thinking, okay, I might not have as much to work with.

1 MR. CORBIN: Yes, sir.

2 THE COURT: But the fact that it was lost by
3 someone who is not under his control --

4 MR. CORBIN: If --

5 THE COURT: -- is --

6 MR. CORBIN: Yes, sir.

7 THE COURT: -- what I -- I think it's two different
8 issues. I think --

9 MR. CORBIN: If I may just comment about that.

10 THE COURT: All right.

11 MR. CORBIN: Just because a witness said something
12 on the witness stand, the jury's not compelled to believe
13 them. I think there's enough there --

14 THE COURT: Okay.

15 MR. CORBIN: And I feel comfortable arguing that,
16 very, very comfortable that the jury doesn't need to
17 believe Dr. Williams. We've got a situation here --

18 THE COURT: All right. What could they believe?

19 MR. CORBIN: They could believe -- well, the reason
20 he didn't put it in his operative report and even his own
21 experts can't look at the operative report and can't see
22 what he did there because he realized he made a huge error,
23 number one. Number two, I think the jury, and I'm going to
24 argue that because when you look at the pathology reports,
25 the records of the other surgeries, Dr. Parker in his

1 second surgery, that made it's way to pathology. And
2 there's a pathology record there where pathology gets it,
3 they list the specimens that were sent to them -- that was
4 sent to them. And then they send back the report. They --
5 when you look at the pathology records of what was sent to
6 them for the first operation, it was listed two ovaries,
7 two fallopian tubes, the bowel is missing.

8 THE COURT: Did it say the bowel is missing?

9 MR. CORBIN: It says nothing.

10 THE COURT: Did it say the bowel is missing?

11 MR. CORBIN: No, sir, it said -- it said the
12 specimens that it got --

13 THE COURT: But does it say --

14 MR. CORBIN: -- which are the --

15 THE COURT: But does it say that the bowel is
16 missing?

17 MR. CORBIN: No, sir.

18 THE COURT: Okay.

19 MR. CORBIN: Okay. It says, this is what we got.

20 THE COURT: Right.

21 MR. CORBIN: I'm going to also -- I think a
22 reasonable argument to the jury would also be that when he
23 realized feet of bowel are taken out --

24 THE COURT: Where is it?

25 MR. CORBIN: Yes, sir. And you get the report

1 back --

2 THE COURT: That's different from spoliation, to
3 me. That's different. Spoliation connotes some degree of
4 either sponsorship of it being gone or it was under your
5 control when it was gone, even for --

6 MR. CORBIN: Yes, sir.

7 THE COURT: -- a good faith reason and it's to be
8 inferable that he has -- that the evidence would be against
9 him. But the argument that you're talking about is well,
10 he should have followed up.

11 MR. CORBIN: Yes, sir.

12 THE COURT: That might be an argument as to his
13 overall lack of attention.

14 MR. CORBIN: Well, we'll go with that argument Your
15 Honor.

16 THE COURT: But it is not -- it is not a spoliation
17 issue.

18 MR. CORBIN: Yes, sir.

19 THE COURT: I'm trying to be very specific.

20 MR. CORBIN: I understand. My argument about that
21 would be the reason -- there's no need to follow up.
22 There's no reason to follow up because he knew he didn't
23 send it.

24 THE COURT: Okay. Well I understand exactly --

25 MR. CORBIN: Yes, sir.

1 **THE COURT:** -- what you're saying and I think you
2 know what my train of thought is.

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

4 **THE COURT:** And I -- which I'm not going to make up
5 my mind until I hear all of the evidence.

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

7 **THE COURT:** Spoliation and overall lack of
8 diligence are two different things.

9 **MR. CORBIN:** I got you. Yes, sir.

10 **THE COURT:** Okay. Now, let's go to the charge if
11 we could.

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

13 **THE COURT:** And by the way, I am going to
14 respectfully deny both sides' motions for directed verdict.
15 Your argument about -- Mr. Corbin, your argument about
16 the --

17 **MR. CORBIN:** Informed consent issue.

18 **THE COURT:** I think there's gracious plenty for the
19 jury to conclude --

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

21 **THE COURT:** -- that informed consent was given. As
22 is -- it's going to depend on who they believe, which set
23 of witnesses.

24 **JURY CHARGE CONFERENCE**

25 **THE COURT:** All right. The jury charge. As I told

1 you in my e-mail, this is a lot -- I put a lot of stuff in
2 here and -- it's easier to take things out than it is to
3 go back and add. That's why I have perhaps too much in my
4 orders.

5 All right. Any objections first of all from the
6 Plaintiff? I got your e-mail where you indicated that
7 subsequent doctors not necessary.

8 MR. CORBIN: Yes, sir.

9 THE COURT: The favorable diagnosed section should
10 be injury or injured instead of death; that's obvious.
11 Doctor-patient relationship, I had already removed that
12 with my pencil.

13 MR. CORBIN: Yes, sir.

14 THE COURT: Breach of society. Where -- help me
15 out.

16 MR. CORBIN: The -- breach of standard of care
17 section.

18 THE COURT: Oh. Okay. I didn't know what those
19 initials were.

20 MR. CORBIN: There was a section, Your Honor, in
21 brackets and the basic gist of that was, if a doctor talks
22 to other doctors and say, this is your treatment or
23 whatever, that that's some kind of defense that you can
24 say, well somebody else told me to do it. The only thing
25 relevant about negligence in this particular case is a

1 standard of care.

2 THE COURT: All right. Do you have a page number?
3 I've got my breach of standard of care starting on page 15.

4 MR. CORBIN: Let me try to get it, Judge.

5 THE COURT: Talking about the short paragraph that
6 starts with difficulties and uncertainties?

7 MR. CORBIN: I think that's it. It should be -- it
8 was in brackets, Your Honor.

9 THE COURT: All right. Mr. McDow, any comment on
10 that?

11 MR. MCDOW: Yeah. That's on page 16 that you're
12 talking about?

13 THE COURT: I believe it is.

14 MR. MCDOW: Yeah, no, I think that's a correct
15 statement of the law.

16 MR. CORBIN: I think we start adding, it's okay to
17 listen to other doctors and --

18 THE COURT: Well, wouldn't you be contending that
19 he would be negligent for not listening to other doctors if
20 some of these doctors said -- here's the way I look at it
21 and here's how I think a jury would look at it after
22 hearing all of this. It's not negligent to follow their
23 advice, but it is negligent to follow their advice if their
24 advice would be a violation of the standard of care and
25 therefore his following advice that would be in violation

1 of standard of care is itself a violation of the standard
2 of care.

3 MR. CORBIN: I just --

4 THE COURT: I understand this is all about the
5 standard of care, which was breached, but --

6 MR. CORBIN: Yes, sir.

7 THE COURT: -- it's not an absolute defense that
8 you seek out and/or rely on it, so therefore, I can do
9 whatever I want as long as somebody else says it's okay.

10 MR. CORBIN: Yes, sir.

11 THE COURT: And that defies common sense. I don't
12 think that's what that charge says.

13 MR. CORBIN: What got my attention a lot was if the
14 Judge charges the jury that if another doctor tells you
15 what the best practices are, it's not an absolute defense,
16 but it's a, you know, partial defense and I just don't
17 think any --

18 THE COURT: Okay. In other words, you don't like
19 to exercise the best judgement.

20 MR. CORBIN: No, his best judgement is fine, but if
21 you -- if you put in there that he listened to other
22 doctors about their best course of treatment, I mean,
23 that's not the standard of care, what other doctors --
24 unless they're going to testify that under the standard of
25 care, this is what he was required to do.

1 **THE COURT:** Okay. I'll take a look at that more
2 closely. I think it may be, not the content of it, but
3 what you think that they may spin it.

4 **MR. CORBIN:** I don't mind him using his best
5 judgement, but when it's too wide open, then he could also
6 listen to other doctors, what their best course of
7 treatment would be. To me, that's irrelevant unless it's
8 the standard of care.

9 **THE COURT:** Well, is there any evidence in this
10 case, Mr. McDow, that Dr. Williams consulted with anybody
11 other than Dr. Parker?

12 **MR. MCDOW:** No, that's it.

13 **THE COURT:** Okay. But did he consult with Dr.
14 Parker before he did his second surgery?

15 **MR. MCDOW:** Yeah. Obviously he consulted with Dr.
16 Parker on May the 21st, partial small bowel obstruction,
17 suspect she may have to return to the OR and of course
18 we -- you know, she did.

19 **THE COURT:** I'll take a closer look at that. I
20 think all in all it's a correct statement of the law. The
21 only -- the part that I had question marked myself is a --
22 the doctor's bound only to exercise his best judgement in
23 determining which course on a whole is best for the
24 patient. I think the correct statement would be the doctor
25 is bound to comport with the standard of care in

1 determining which course on the whole is best for the
2 patient.

3 MR. CORBIN: Yes, sir.

4 THE COURT: Because if somebody uses their best
5 judgement, that might --

6 MR. CORBIN: Inadequate --

7 THE COURT: Might be his best judgement, but it
8 might not be --

9 MR. CORBIN: Yes, sir.

10 THE COURT: -- in compliance with the standard of
11 care.

12 MR. CORBIN: So the section where you said,
13 qualified doctors and experts may differ as to what
14 constitutes the best course of treatment.

15 THE COURT: I think the jury's been hit home with
16 that.

17 MR. CORBIN: I think it needs to be, qualified
18 doctors and experts may differ as to what constitutes the
19 standard of care.

20 THE COURT: And any breach of the standard of care.

21 MR. CORBIN: Yes, sir. Instead of the best course
22 of treatment. I just -- that scares me.

23 THE COURT: All right. I'll look at that and we'll
24 come back to that before the arguments.

25 All right. Any other objections?

1 **MR. CORBIN:** I can't look at two things at one time
2 Your Honor. In that letter I listed everything.

3 **THE COURT:** That was the end of your --

4 **MR. CORBIN:** Yes, sir. That would be it.

5 **THE COURT:** Okay. All right.

6 Mr. McDow, first of all, do you have any objections
7 to what I e-mailed? And I can help you guys out and tell
8 you I'm not going to define negligence twice.

9 **MR. MCDOW:** Yeah.

10 **THE COURT:** Page 9, 10, and 11 I've crossed out.
11 Page 12 I have crossed out the existence of doctor-patient
12 relationship and page 12, from that to the end of page 13.
13 On page 16, in brackets in the middle of the page, the fact
14 that a doctor acts on the advice of another doctor, who is
15 a specialist, is not an absolute defense. To claim that
16 the doctor failed to use the required skills. I think
17 that's a proper statement.

18 **MR. CORBIN:** I don't think it's any defense. I
19 really don't think it's --

20 **THE COURT:** Well, it's a defense if number one,
21 seeking the advice is appropriate.

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

23 **THE COURT:** And number two, following the advice --
24 he can't -- let's say he went to a doctor and the doctor
25 said, well just take the whole thing out. Can't do that.

1 It's got to be care that a reasonable doctor would still
2 provide.

3 MR. CORBIN: I think he's -- needs to satisfy the
4 standard of care and that's my whole point.

5 THE COURT: Well, it's not -- it is a defense if
6 what doctor number two says is reasonable and that doctor
7 takes it into account and then reasonably follows it.

8 MR. CORBIN: Oh gosh. I mean, we'd have to go
9 after all of the consultants and ask them standard of care
10 questions. That's just not been in this case.

11 THE COURT: All right. Go on to page 17. I've
12 added --

13 MR. CORBIN: I'm sorry, I don't mean to interrupt,
14 but one point -- the only consultant in this case is Dr.
15 Parker. If you recall, he's not been listed as an expert
16 witness. He also --

17 THE COURT: Didn't have to be.

18 MR. CORBIN: Exactly, but he also -- the Defense
19 notified the --- would not testify as to the standard of
20 care.

21 THE COURT: Right.

22 MR. CORBIN: So that'd be my position on Dr. Parker
23 giving --

24 THE COURT: Is it the law, Mr. Corbin -- I know
25 it's the law that in South Carolina that in order to

1 sustain a claim for a medical malpractice, the Plaintiff
2 has to establish a relevant standard of care and breaching
3 standard of care by expert testimony. Do you have to
4 establish approximate cause by expert testimony?

5 MR. CORBIN: Yes, but you don't need to use the
6 magical words and here the doctor's saying that the
7 violation between the standard of care and the -- that's
8 sufficient.

9 THE COURT: I -- I'm talking -- obviously the
10 damages established by the Plaintiff and the ---- but --
11 and of course, the permanency by the physicians who say
12 this is the condition and this is what happens when you
13 have it.

14 MR. CORBIN: Yes, sir.

15 THE COURT: But is expert testimony absolutely
16 required to establish causation? In other words, Dr. Irvin
17 says, this is the standard, he breached it, she's left with
18 short bowel syndrome. Do you need to go further and say,
19 and as a result of that, she incurred all of these expenses
20 and she's done this and done this and done this?

21 MR. CORBIN: No, sir. I think that -- I
22 think -- but we certainly looked further than that and I
23 recall the questions if Dr. Williams would not have
24 violated the standard of care, would these four surgeries
25 have been necessary? No, they would not have been. And it

1 was -- in my opinion, very confident about what caused her
2 injuries. I think you're absolutely right. Once the
3 doctor says the violation was the approximate cause of
4 damages, I think that damages that flow from that, you
5 don't have to have separate --

6 THE COURT: Pearson versus Bridges.

7 MR. CORBIN: Yes, sir.

8 THE COURT: Okay. All right. Mr. McDow, any
9 comment about whether or not you need expert testimony to
10 establish approximate cause.

11 MR. MCDOW: I think you do. I think that's the
12 whole point of my directed verdict motion.

13 THE COURT: But the charge -- the jury charges in
14 the cases say when it is used to establish proximate cause
15 because you need it for standard of care and breach. But
16 the cases say that when it's used to establish proximate
17 cause, the doctor's -- or the expert's opinion has to be to
18 a reasonable degree of certainty. Not that it has to be
19 used, but when it is used. So you claim that expert
20 opinion require for all three of the elements of the cause
21 of that?

22 MR. MCDOW: That's correct.

23 THE COURT: Okay. All right. On page 25 of my
24 charge, did we need that paragraph that begins with, in
25 determining whether? I doubt that Mr. McDow would ever

1 want to make that argument. In other words, you don't have
2 to disclose the risk to the patient if it's going to damage
3 their psychological condition.

4 MR. CORBIN: That is the law.

5 THE COURT: But it doesn't apply to this case.

6 MR. CORBIN: I don't think it applies to this case
7 because, I mean, even he said that he -- his testimony was
8 that he warned her of all these horrible things.

9 THE COURT: This only applies when the doctor --
10 when there's evidence that the doctor believes that
11 complete disclosure might have a detrimental effect on the
12 wellbeing of the patient.

13 I don't think we need that.

14 MR. CORBIN: There's been no testimony to that.

15 THE COURT: All right. Failure to diagnose and
16 treat, page 20. And I -- like I told you, I don't do these
17 things in the order that I've given you. The failure to
18 diagnose and treat. The way I've got it worded is, when a
19 plaintiff claims a physician negligently failed to diagnose
20 and treat, the plaintiff must prove that the defendant's
21 negligent failure to discover and treat the disease or
22 condition from which -- of which the Plaintiff suffers most
23 probably caused the plaintiff's damage.

24 MR. CORBIN: I think that's a correct statement of
25 the law.

1 **THE COURT:** However, a mistaken diagnosis in and of
2 itself will not support a verdict for malpractice.

3 **MR. CORBIN:** I agree.

4 **THE COURT:** All right. Mr. McDow, do you agree
5 that we don't need a substitution of doctors charge?

6 **MR. MCDOW:** I agree to that.

7 **THE COURT:** Okay. Actual damages, I'm going to --
8 on page 27, just let me read this to you generally. Y'all
9 with me?

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

11 **THE COURT:** I've added this: In the context of the
12 case in which the Plaintiff claims personal injury to have
13 been proximately caused by the Defendant, the actual damage
14 can fall into two general -- into two general categories.
15 Number one, noneconomic damages and then I'll just read
16 that little blurb from the statute. Number two, economic
17 damages, and then I'll read that blurb from the statute.

18 It's just going to be extremely cumbersome on that
19 verdict form when I explain it to them to go into those two
20 subparts without having them look at me like I'm from outer
21 space as to why that makes a difference. Of course,
22 they're not to know why it makes a difference. And y'all
23 can't argue about any caps; y'all realize that.

24 **MR. CORBIN:** Oh, absolutely not.

25 **MR. MCDOW:** Yes, sir.

1 **THE COURT:** All right. Of course, the elements of
2 noneconomic damages in this case are pain and suffering,
3 loss of enjoyment of life, mental anguish, disfigurement,
4 talking about in the context of emotional distress.

5 **MR. CORBIN:** Yes, sir. Embarrassment, humiliation.

6 **THE COURT:** Which is included in my mental
7 suffering charge.

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

9 **THE COURT:** The economic damages, reasonable
10 necessary medical expenses, present value of lost wages --
11 excuse me, lost wages and present value of lost earning
12 capacity, and I think that's it; isn't it?

13 **MR. CORBIN:** Oh, and -- I think that's it on that.

14 **THE COURT:** All right. Life expectancy table;
15 she's how old now, Mr. Corbin?

16 It's in the record; I'm sure her birth date's --
17 Anybody know?

18 **MR. CORBIN:** She was born in 1947, so I think she's
19 65.

20 **THE COURT:** Okay. And she has a life expectancy of
21 what? I'll just pull out Title 19 and put it in there.

22 **MR. CORBIN:** Dr. Wood testified to that.

23 **THE COURT:** All right. I will define at some point
24 in the charge, obviously what negligence is and I will
25 define gross negligence because the statute inexplicably

1 includes gross negligence, willfulness, wantonness, and
2 recklessness. Those terms -- willfulness, wantonness, and
3 recklessness to me are interchangeable. Gross negligence
4 is not. Gross negligence is the failure to exercise even
5 slight care. Willfulness, wantonness, and recklessness is
6 -- you are -- someone's not only negligent, but they knew
7 that they were being negligent and did it anyway. So it's
8 a conscious failure to exercise due care. So I'm going to
9 define all of those things.

10 **MR. CORBIN:** Okay.

11 **THE COURT:** Any objection to me defining
12 recklessness, willfulness, and wantonness as the same? Not
13 telling them it's the same thing, but I'll tell them that
14 those terms mean a conscious failure to exercise due care;
15 any problem with that?

16 **MR. CORBIN:** Your Honor, I would respectfully ask
17 the Court to strike out the word, willful. We have never
18 indicated -- we believe he didn't willfully. We think it
19 is reckless; we think it was wanton. We think it was
20 grossly negligent, but there's been no testimony at all, no
21 allegation from that witness stand from us. And we would
22 strike any reference to anything willfully.

23 **THE COURT:** Well, how about grossly negligent?

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

25 **THE COURT:** You want that?

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

2 **THE COURT:** Okay. Now, Mr. McDow, that sounds
3 logical because reckless, willful, and wanton mean the same
4 thing to me; might not mean the same thing to legislature,
5 but in our common law, they mean the same thing. The
6 statute says what it says. It says reckless -- grossly
7 negligent, willful, wanton -- they misspelled willfully by
8 the way -- and reckless.

9 **MR. CORBIN:** I would ask that they strike out
10 willfully.

11 **THE COURT:** Do you want willfully, wanton in there
12 or do you just want to go with reckless?

13 **MR. CORBIN:** I would like wanton, too, Your Honor,
14 I would just like to strike out willful.

15 **THE COURT:** All right. Okay. Any position on
16 that? I don't think that's going to be a deal killer, so
17 just -- we'll come back to that later.

18 All right. The lost of consortium. Go to -- that
19 page is not numbered. Do y'all have that one?

20 **MR. MCDOW:** My package ends on page 37, so --

21 **THE COURT:** Is that everybody?

22 **MR. CORBIN:** I don't -- I don't think I checked.

23 **THE COURT:** Okay.

24 **MR. MCDOW:** I don't see it in my -- like I said,
25 mine ends on page 37.

1 **THE COURT:** Well, I think everybody knows what it
2 is.

3 **MR. CORBIN:** We do.

4 **THE COURT:** Here's -- I'll give you a copy of it
5 before we begin. The Plaintiff William E. Atkinson,
6 Junior, claims loss of consortium due to the damages
7 sustained by his spouse; companionship and society of the
8 spouse are not articles of commerce, which can't be weighed
9 or measured or bought and sold. No expert is competent to
10 testify to their value.

11 Consideration of which they are given is not
12 monetary, but the Plaintiff William Atkinson is entitled
13 compensation and money for any loss sustained as a result
14 of any negligence of the Defendant. The amount of that
15 compensation is to be determined by you from your own
16 observation, experience, and knowledge conscientiously
17 applied to the facts and circumstances of this case.

18 That Plaintiff is entitled to recover the value of
19 those services of his spouse which have been proven by the
20 greater weight of the evidence to have been lost or were
21 otherwise damaged. Including the loss of her -- her
22 society and companionship in the home. That Plaintiff is
23 also entitled to recover for any expenses incurred.
24 There's no evidence of any expenses.

25 **MR. CORBIN:** No, Your Honor.

1 **THE COURT:** I'll take that out. Incurred with the
2 care and treatment of the spouse because of illness.
3 There's no evidence that he has sustained any medical
4 expense --

5 **MR. CORBIN:** No, sir.

6 **THE COURT:** -- responsibility because of her.

7 **MR. CORBIN:** No.

8 **THE COURT:** The charge goes on to say punitive
9 damages are not recoverable in a loss of consortium act.

10 **MR. CORBIN:** I agree.

11 **THE COURT:** Any objections to me saying that?

12 **MR. MCDOW:** I think that's fair.

13 **THE COURT:** All right. Okay. Now, I've been over
14 both of your submitted charges. First of all, plaintiffs.
15 I think all of yours, Mr. Corbin are included in what I've
16 indicated that I would want to give. You gave me two.

17 They here now?

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

19 **THE COURT:** Okay. You gave me two paperclip sets
20 and I think -- I think they're all included in my general
21 charge or what I gave to you gentlemen.

22 All right. Any disagreement with the -- Mr.
23 Corbin?

24 **MR. CORBIN:** I don't --

25 **MR. MCDOW:** Judge, what page was your bad result

1 charge on? Let me find that.

2 THE COURT: Well, one is on page 15 in the middle
3 of the page. That might be --

4 MR. MCDOW: Right. Okay. That's -- let's see.
5 That's where I would ask that my defense request charge
6 number seven and ----

7 THE COURT: We ain't got to yours yet.

8 MR. MCDOW: Oh, I'm sorry.

9 MR. CORBIN: Your Honor, the one charge that I
10 would ask Your Honor to consider and I don't think that it
11 is included. It's about the charge from Graham versus
12 Whitaker, you know, the standard malpractice case.

13 THE COURT: Well, I've got two. You cited Graham
14 twice. One for an attending physician.

15 MR. CORBIN: That's right.

16 THE COURT: Talking about Dr. Williams?

17 MR. CORBIN: Talking about --

18 THE COURT: Doctor who? Is there any other
19 physician in this case?

20 MR. CORBIN: What I'm talking about is Dr. Parker.

21 THE COURT: Okay. Your charges aren't numbered, so
22 which one is it? Give me the first few words of it?

23 MR. CORBIN: I think it's the negligence of the
24 attending physician is reasonably foreseeable and we're
25 talking about Dr. Parker there.

1 **THE COURT:** So you're saying that he was negligent?

2 **MR. CORBIN:** No. Well, I'm saying that if there's
3 an inference. And the issue is how much bowel he took out.
4 And it's -- you know, as long as the argument's not going
5 to be made, had to make this point that Dr. Parker was
6 negligent; which it doesn't make any difference.

7 **MR. MCDOW:** As a matter of a fact, I wrote a note
8 on that one last night.

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

10 **THE COURT:** If he argues it --

11 **MR. MCDOW:** You haven't inserted that as an
12 intervening note. There's no evidence of that and I'm not
13 arguing that. He supports my case by his findings on May
14 21st, and his recommendations.

15 **THE COURT:** All right. Anything else Mr. Corbin?

16 **MR. CORBIN:** That's it.

17 **THE COURT:** All right. Mr. McDow, going through
18 from the beginning. Number one is part of my general
19 charge. Number two is. Number three is. Number four is.
20 As five is, six is, and you said seven?

21 **MR. MCDOW:** Yes, sir. On page 15 of your charge,
22 you say that a bad result, injury, death, or failure to
23 cure, is not by itself enough to show that the Defendant
24 was negligent. And I would ask that you conform that to
25 say, or raise an inference or presumption of negligence on

1 the part of the physician.

2 THE COURT: In other words, meaning that is not
3 artistic enough, in other words. In other words -- I agree
4 with you.

5 MR. MCDOW: Well, it is a Ralph v. Anderson charge.

6 THE COURT: Which means it has more words.

7 MR. MCDOW: That's right.

8 THE COURT: I think I can clean that up to make it
9 more legally orderly and then follow that up with the
10 sentence in my charge, number seven, if you find the
11 Defendant, et cetera.

12 Okay. I think that's -- I think that's logical.
13 All right. Number eight --

14 (WHEREUPON there was a discussion out of the
15 hearing of the court reporter.)

16 THE COURT: If we do the -- If we do the -- If we
17 do the closing arguments and finish before lunch, we might
18 be able to send them to lunch and then we'll charge them
19 after lunch. If y'all finish by noon, we can bring them
20 back at 1:30. I'd rather not bring them back -- I'd rather
21 not -- so we may not need to order lunch.

22 I'm just talking to her.

23 MR. MCDOW: Yeah. You'll charge after lunch? I
24 mean, sit at lunch on their own and then charge them when
25 they come back?

1 **THE COURT:** Depends on how concise and brief and
2 clear y'all are with the jury. Concise and brief. In
3 other words, neither one of you need to talk for an hour.

4 **MR. MCDOW:** I'm not.

5 **THE COURT:** Okay. All right. How about number
6 eight?

7 You might want to get them to do it just in case;
8 how about that.

9 **THE CLERK:** Okay.

10 **THE COURT:** Just don't tell them any qualifiers.
11 Tell them that if lunch is ordered, that is the menu they
12 can go ahead and complete.

13 **THE CLERK:** Yes, sir.

14 **THE COURT:** All right. Mr. Corbin, any objections
15 to eight or any of the other ones? Most of which are a
16 part of general charge?

17 **MR. CORBIN:** No, sir.

18 **THE COURT:** All right. So eight. I'll include
19 eight. Nine is a general charge; ten is a general charge.
20 Eleven, we've already just talked about. Twelve is in my
21 general charge. Thirteen is part of the proximate cause
22 charge. Fourteen is a part of the general charge.
23 Fifteen, I just didn't understand how that fits into the
24 law of South Carolina with the logical extreme that if the
25 Defendant has -- if the Defendant has a reputable,

1 respectable, and reasonable expert, he can't be liable at
2 all reliable of what the other side's experts say. I guess
3 the key word might be reasonable, but I -- I think I'm not
4 going to give 15. Do you have a clean copy to give to the
5 court reporter for your -- we'll do that in a minute.

6 All right. Number 16 is -- I will give 16, maybe
7 not in the exact words. Seventeen is a part of my general
8 charge. I'll give 18 and that's pretty much a burden of
9 proof -- part of the burden of proof. Nineteen, twenty,
10 twenty-one are part of my general charge.

11 MR. MCDOW: Yes, sir.

12 THE COURT: That gets us to the aggravation.

13 MR. MCDOW: Yeah, that's number 22. I read it last
14 night. I'll take that one out.

15 THE COURT: Yeah, I agree. Yeah, I agree with
16 that. Defendant's No. 23, what I say in that context, the
17 verdict in this case cannot be based on sympathy for any
18 party or upon passion, prejudice, emotion, or some other
19 consideration not found in the evidence.

20 MR. CORBIN: I agree.

21 THE COURT: Informed consent is your number 24.
22 I'm already going to give that. And part of -- 25 is part
23 of that.

24 MR. MCDOW: Okay.

25 THE COURT: And I read y'all's comments back and

1 forth in the e-mail. The law in this state is that loss of
2 consortium is not a derivative action.

3 **MR. CORBIN:** It is not.

4 **THE COURT:** But -- and I agree with his
5 observations that the cap can be breached.

6 **MR. CORBIN:** Okay.

7 **THE COURT:** We'll talk about the verdict form after
8 y'all have had a chance to read it. I apologize I
9 mistakenly e-mailed the same thing twice.

10 Okay. We'll be taking another break to go over the
11 verdict form before you actually give this charge. On the
12 closing arguments, I want you to read from my charge.

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

14 **THE COURT:** What I'm about to read. Don't put it
15 on a projector. Don't put the verdict form on the
16 projector. And I would prefer you not hold that verdict
17 form and fill a mock verdict form out. You can refer to
18 it, but I would rather you not complete the forms.

19 **MR. MCDOW:** Judge, I'm going to hand up my request
20 for charge 15. I'll just take it out of this other packet.

21 **THE COURT:** Okay.

22 **MR. MCDOW:** For the court reporter. This is a
23 Court's Exhibit.

24 **THE COURT:** Okay. I'll step back and as soon as
25 she's finished with the menus, will you come get me?

1 THE BAILIFF: Yes, sir.

2 (WHEREUPON a recess was observed.)

3 THE COURT: Okay. Are we ready for the jury?

4 MR. CORBIN: We are ready.

5 THE COURT: Mr. McDow?

6 MR. MCDOW: Yes, Your Honor.

7 THE COURT: All right. You can bring them in.

8 And you did rest formally yesterday?

9 MR. MCDOW: I did.

10 THE BAILIFF: Do you want the foreman in his proper
11 seat now?

12 THE COURT: No, not yet. And I'll just tell Dr.
13 Irvin; is he still under oath?

14 MR. MCDOW: Yes, sir.

15 (WHEREUPON the jury entered the courtroom at 10:19
16 a.m.)

17 THE COURT: All right, ladies and gentlemen. We're
18 ready to move forward. The Defendant -- the Defendants
19 rested yesterday.

20 Mr. Corbin, will the Plaintiffs have any reply?

21 MR. CORBIN: Very short, Your Honor, yes, sir.

22 THE COURT: All right. Call your witness.

23 MR. CORBIN: Your Honor, at this time, I would like
24 to call Dr. William Irvin to the witness stand, please.

25 THE COURT: All right. Dr. Irvin, you can come up.

William Irvin - Direct Examination by Mr. Corbin

1 You are still under oath.

2 MR. CORBIN: Can he have a seat, Your Honor?

3 THE COURT: Yes, sir.

4 DIRECT EXAMINATION

5 BY MR. CORBIN

6 Q Good morning, Dr. Irvin.

7 A How are you?

8 Q I am doing well, thank you. As you know, Faye's
9 1995 records from the Byerly Hospital in Hartsville are not
10 available. Did I contact and ask you to do something for
11 the jury?

12 A You asked me to take a look at her CT scan from
13 March the 30th of 2007. I think the one that was obtained
14 when she initially presented to Hartsville Emergency Room
15 for her pain. And you asked me to evaluate that CT scan to
16 see if in my opinion the small bowel would be a normal
17 quantity at that point in time.

18 Q Did you, in fact, review that CT scan?

19 A I did.

20 Q Did you find several feet of bowel missing?

21 A I did not.

22 Q Tell the jury, so there's clarification here, this
23 is the CT scan that was taken within two weeks of seeing
24 Dr. Williams in 2007; correct?

25 A The CT scan was taken on March the 30th, and I

William Irvin - Direct Examination by Mr. Corbin

1 think she had her first surgery on April the 25th, so
2 roughly, almost a month later.

3 Q Do you have any proof at all that the date of that
4 CT scan and her seeing Dr. Williams for the first time, she
5 lost anymore bowel?

6 A No.

7 Q No proof of that?

8 A Not that I ever found.

9 Q Tell the jury what's your findings on this?

10 THE COURT: Wait just a second. Could you be more
11 specific?

12 MR. CORBIN: I can. I'm sorry, Judge.

13 BY MR. CORBIN:

14 Q I'm sorry, ladies and gentlemen.

15 Reviewing the CT scan, which is in evidence,
16 Plaintiff's Exhibit No. 36, did you have an opportunity to
17 review the condition of her bowel before she saw Dr.
18 Williams?

19 A I did.

20 Q Would you please describe to the jury what you
21 saw.

22 MR. MCDOW: Your Honor, I'm going to object at this
23 point as being nonresponsive or in reply. He had his
24 opportunity to --

25 THE COURT: All right. Ladies and gentlemen please

William Irvin - Direct Examination - In Camera by Mr. Corbin

1 step in the jury room. You may not discuss the case.

2 (WHEREUPON the jury left the courtroom at 10:24
3 a.m.)

4 THE COURT: All right. Question the witness
5 please, Mr. Corbin.

6 MR. CORBIN: Yes, sir.

7 THE COURT: And if you would be specific as to what
8 you're talking about his conclusions; he's not going to
9 repeat the ones he gave earlier in the week.

10 MR. CORBIN: Absolutely not.

11 THE COURT: All right. Go ahead.

12 **DIRECT EXAMINATION - IN CAMERA**

13 **BY MR. IRVIN:**

14 Q Tell us, Dr. Irvin, exactly in that CT scan within
15 two weeks of her seeing Dr. Williams, what did you see with
16 respect to her small bowel?

17 A She appeared to have a normal CT scan in terms of
18 the volume of the small bowel present on that scan.

19 Q Based upon your examination, do you have an
20 opinion based on a reasonable degree of medical certainty
21 of approximately how long her bowel was before she saw Dr.
22 Williams?

23 A I think that her bowel looked to be of normal
24 length. It would be difficult to know whether or not that
25 was 18.5 feet or 17.3 feet. But there clearly was not a

William Irvin - Direct Examination - In Camera by Mr. Corbin

1 significant portion of the bowel missing. So in my
2 opinion, looking at that CT, the volume of small bowel was
3 normal, what you would expect to see in any individual
4 having a CT scan.

5 **MR. CORBIN:** That'd be his testimony.

6 **THE COURT:** All right. Any cross at this time
7 during the proffer, Mr. McDow? Or would you just like to
8 be heard?

9 **CROSS-EXAMINATION IN CAMERA**

10 **BY MR. MCDOW:**

11 **Q** Doctor, you are not an expert radiologist?

12 **A** I am not a Board certified radiologist, no.

13 **Q** And when did you look at this particular CT scan?

14 **A** I looked at that CT scan two days ago.

15 **Q** Was that before or after your testimony?

16 **A** After my testimony.

17 **Q** So you were contacted after your testimony to take
18 a look at that CT scan?

19 **A** Correct.

20 **THE COURT:** All right. Mr. McDow, do you have any
21 argument that you would like to make about your objection?

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

23 **THE COURT:** Okay. And your questions would be
24 limited to that?

25 **MR. CORBIN:** Absolutely.

William Irvin - Direct Examination - In Camera by Mr. Corbin

1 THE COURT: All right. All right. You can bring
2 in the jury.

3 THE BAILIFF: Yes, sir.

4 THE COURT: Mr. McDow, if you believe that he
5 ventures away from the proffer and anything new comes to
6 light, just make your objection.

7 (WHEREUPON the jury entered the courtroom at 10:26
8 a.m.)

9 THE BAILIFF: The jury is seated, Your Honor.

10 THE COURT: All right. Thank you, sir. All right.
11 Mr. Corbin?

12 MR. CORBIN: Thank you, Judge.

13 DIRECT EXAMINATION

14 BY MR. CORBIN:

15 Q Dr. Irvin, please explain to the jury your
16 experience in examining CT scans of your patients' small
17 bowel, being a Board certified gynecologic oncologist.

18 A All right. Typically a CT scan is performed to
19 evaluate symptoms for which they may be presenting with.
20 So through the course of what we do in trying to figure out
21 and manage our patients, we learn how to read CT scans and
22 to evaluate CT scans. I'm not a Board certified
23 radiologist, as no gynecologic-oncologist typically is, but
24 of reading, evaluating, and making clinical decisions based
25 on my readings of CT scans for the last 19 years.

William Irvin - Direct Examination - In Camera by Mr. Corbin

1 Q Do you know short bowel syndrome when you see it
2 on the CT scan?

3 A You need to lose a significant portion of your
4 small bowel, roughly 60 percent or more of your small bowel
5 before you'll start to develop symptoms of what we
6 describe --

7 MR. MCDOW: Your Honor, I will object.

8 THE COURT: Sustained.

9 MR. CORBIN: I'll move on.

10 THE COURT: That's --

11 BY MR. CORBIN:

12 Q Dr. Irvin, if we may just focus. The CT scan that
13 you looked at.

14 A Right.

15 Q Two weeks before Dr. Williams' first visit with
16 Faye. Tell the jury please what you saw on that CT scan?

17 A On that CT scan, looking at specifically the volume
18 of small bowel that was present on the CT scan, it looked
19 to be perfectly normal. She did not look like she had any
20 significant loss of the amount of normal small bowel people
21 should have that they're born with. Roughly 16 to 18 feet
22 of small bowel. So she looked normal on that CT scan from
23 that perspective.

24 MR. CORBIN: That's all I have. Thank you, Judge.

25 THE COURT: Mr. McDow?

CROSS-EXAMINATION

BY MR. MCDOW:

Q Dr. Irvin, you looked at that CT scan, you say normally 16 to 18. Was there any missing at all that you could tell from prior surgeries in 1995?

A You can't really tell if a small portion is missing because, again, there is 16 to 18 to 20 feet of bowel there. So in looking at a CAT scan, if a foot, a foot and a half or two feet might be missing, it'd be very difficult to tell that on a CAT scan. If ten feet were missing, it would be very easy to tell that on a CAT scan.

Q She started out in the normal range from 16 to 18 to 20. If she was on the low end of normal at 16 and had some taken out, it could be anywhere from 14 to 18 then; is that correct?

A It would be hard to tell exactly the number of feet she had unless you opened her up and ran the bowel from one end of the other. You can only say on the CT scan of whether or not it appears to be normal, quote, unquote. Hers appeared to be normal.

Q All right. And when did -- when was it that you actually reviewed this CT scan?

A Yesterday.

Q Are you ready for the weekend to get back to Virginia?

1 A I've got a soccer game in Philadelphia, my daughter
2 does, so I got to get a plane.

3 Q I'll let you get to it; we're ready, too?

4 MR. CORBIN: Doctor, we appreciate you coming back,
5 sir. Thank you.

6 May Dr. Irvin catch an airplane, Your Honor.

7 THE COURT: Yes, sir.

8 MR. CORBIN: Thank you, Doctor.

9 THE COURT: All right. Anything else, Mr. Corbin?

10 MR. CORBIN: No, sir. That would be the
11 plaintiff's reply.

12 THE COURT: All right. Ladies and gentlemen, I
13 mentioned to you earlier about rules. The rules absolutely
14 require me to briefly recess at this point even though
15 you've been in here for about five minutes. So please
16 forgive me for that; don't scratch your head about it.
17 That's a rule that we have. So we're going to do that now.
18 This break will not be long.

19 The next phase of the trial will be the closing
20 arguments given to you by the lawyers and you might notice
21 that we did start a little late this morning. One of
22 those -- one of those reasons for you to complete a menu
23 just in case lunch becomes an issue.

24 Also, I was completing my discussion with them on
25 what the charge is going to be and what the verdict form is

1 going to look like. I'm going to cover some -- with them,
2 some very minor clean up details and we'll have you back
3 out very shortly.

4 You may not begin discussing this case yet.
5 That'll be coming very, very soon. But please go to your
6 jury room and we'll have you come back in shortly.

7 (WHEREUPON the jury left the courtroom at 10:31
8 a.m.)

9 THE COURT: Okay, Mr. McDow, do you want to just
10 incorporate your directed verdict motions?

11 MR. MCDOW: I would renew and incorporate all of my
12 prior directed verdict motions.

13 THE COURT: All right. As do you, Mr. Corbin?

14 MR. CORBIN: Same for me, Judge.

15 THE COURT: All right. On the spoliation issue --

16 MR. CORBIN: Yes, sir.

17 THE COURT: I'm not going to give the spoliation
18 charge.

19 MR. CORBIN: Yes, sir.

20 THE COURT: I will permit you to argue the lost
21 bowl, not in the context of him either having something to
22 do with it, because there's no evidence of it, and not in
23 the context of it must have shown something bad or it
24 should have would probably be here. You can -- you can
25 argue that it is a further indication of his -- your

1 theory --

2 MR. CORBIN: Yes, sir.

3 THE COURT: -- that's he just generally been lax in
4 following up with the standards of care. In other words,
5 he didn't even exercise diligence to follow up on that
6 missing bowel.

7 MR. CORBIN: Yes, sir.

8 THE COURT: Now, so that's my ruling on that. Does
9 that cover all of motions to strike that you -- the
10 alternative motions to strike? Any of those Mr. McDow, or
11 was there one more?

12 Well, no, the overly aggressive part, I'm going to
13 deny that. I think the jury can sort through that. It's
14 going to be made clear that overly aggressive in the sense
15 of a violation of the standard of care.

16 All right. How about the verdict form? Did y'all
17 have a chance to look at it?

18 MR. CORBIN: I'm fine with the verdict form.

19 MR. MCDOW: I actually have a comment about it. I
20 agree with the verdict form for William E. Atkinson, Jr.

21 THE COURT: All right.

22 MR. MCDOW: On the other verdict form, I think
23 we're on the same page and based on what I kind of came up
24 with as well, but under number three, I would go ahead and
25 put in the actual damages there and then divide it up as

1 you have.

2 THE COURT: Number four? Excuse me, number --

3 MR. MCDOW: That's right. I would put the gross
4 negligence questions at the end.

5 THE COURT: Okay.

6 MR. MCDOW: So that they can go, okay here's the
7 actual damage. Now, let's look at see whether or not he
8 was grossly negligent.

9 THE COURT: For cap purposes and punitive?

10 MR. MCDOW: For cap purposes and punitive purposes.

11 THE COURT: That's probably logical. Do you agree
12 with that Mr. Corbin?

13 MR. CORBIN: I agree.

14 MR. MCDOW: And then I would ask that you put on
15 there, by clear and convincing evidence. So as to entitle
16 the Plaintiff to punitive damages.

17 MR. CORBIN: Your Honor, I just don't think the
18 verdict form is a place to do a charge. I disagree with
19 that.

20 THE COURT: All right. Well, let -- I'll note your
21 request and while the -- while you're making your
22 arguments, I'll think about that. Of course, that would be
23 the unspoken context of that at least as far as unspoken
24 context of the verdict form.

25 MR. CORBIN: I can say --

1 **THE COURT:** But I understand what you're saying.

2 I'll --

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

4 **THE COURT:** I'll make --

5 **MR. CORBIN:** I just don't want -- you know, was the
6 Defendant, Dr. Williams, negligent about failing to
7 properly diagnose and treat the plaintiff's condition. I
8 just -- that's in the charge and I don't want it in the
9 verdict form. The only thing that I'd suggest about the
10 verdict form, Your Honor, strike out the word willful,
11 please, and willingness.

12 **THE COURT:** Willingness? Where is willingness?

13 **MR. CORBIN:** I'm sorry, willfulness. My eyes
14 aren't functioning too well today.

15 **THE COURT:** All right. Mr. McDow, you have any
16 heartburn about that?

17 **MR. MCDOW:** No, I understand that, Judge.

18 **MR. CORBIN:** And if, Your Honor would consider
19 adding, or disregard the plaintiff's rights.

20 **THE COURT:** Where did I put that?

21 **MR. CORBIN:** It's not there.

22 **THE COURT:** You're asking me to put that?

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

24 **THE COURT:** Well then -- that's not in the --

25 **MR. CORBIN:** Okay.

1 THE COURT: That's the same thing you don't want me
2 to do for him.

3 MR. CORBIN: Yes, sir. I'm good.

4 THE COURT: Okay.

5 MR. CORBIN: I'm good.

6 THE COURT: All right.

7 MR. CORBIN: And that's where I want -- you know,
8 punitive damages answers -- the gross negligence question
9 answers those, so I don't know --

10 THE COURT: No, it really doesn't.

11 MR. CORBIN: Okay.

12 THE COURT: Because -- under the law, at least the
13 way I look at it, if it's willful -- excuse me, grossly
14 negligent, wanton, or reckless, period cap is irrelevant.
15 But if it's for punitive damages, it's grossly negligent,
16 wanton or reckless, they still going to have to award it.

17 MR. CORBIN: That's true.

18 THE COURT: So you want to make punitive damages
19 mandatory, I will. If they find grossly negligent --

20 MR. CORBIN: That's where I -- okay.

21 THE COURT: All right.

22 MR. CORBIN: So I --

23 THE COURT: I will do that if you want, but I don't
24 think it's the law and I think it would be damaging to lump
25 it all together. I think it would be, number one,

1 misleading in light of the law; and number two, I think
2 it's clear enough here.

3 MR. CORBIN: Your Honor, one last -- one last
4 point. Bill and I did work together. I agreed not to have
5 Dr. Wood examine the defendant's financial situation. We
6 agreed to stipulation.

7 THE COURT: Are y'all going to read that to the
8 jury?

9 MR. CORBIN: Yes, sir. Because it -- the burden's
10 on me to show his ability to pay.

11 THE COURT: Well, that's just a component.

12 MR. CORBIN: What -- what --

13 THE COURT: If y'all want to publish that, fine,
14 you can do it right during your closing arguments.

15 MR. CORBIN: Yes, sir.

16 THE COURT: So I -- it doesn't matter to me as long
17 as y'all have agreed on it, it can be made known to the
18 jury in any way you want. And by the way, I am going to
19 tell the jury, we mentioned yesterday, that James A.
20 Williams, Jr.'s conduct -- conduct that's in issue and that
21 South Carolina Oncology Associates is the Defendant and
22 that -- the reason for that is that he's an agent of that
23 group and any negligence that --

24 MR. CORBIN: As a matter of law is --

25 THE COURT: But as a matter of law -- under law,

1 this state is imputed to his principal.

2 MR. MCDOW: I agree that as far as stipulation of
3 fact, that is correct, that is what we agreed to. I don't
4 know that that comes in as a -- I would object to it being
5 brought in as a Court's Exhibit.

6 THE COURT: Huh-uh. No. Court's Exhibit doesn't
7 go to the jury.

8 MR. MCDOW: Don't go to the jury --

9 THE COURT: If y'all going to make it known to the
10 jury, somebody's got to read it.

11 MR. CORBIN: That's correct.

12 MR. MCDOW: He could read that, but I also want on
13 the record the conversation that we had in your chambers
14 yesterday. Of course, the four million dollars comes from
15 the insurance coverage. One million for SCOA and three
16 million for Dr. Williams and the Plaintiff agrees that
17 they -- in the event of a verdict greater than four million
18 dollars, they're not going after any additional money.
19 It's capped at four million.

20 THE COURT: I -- certainly, I heard y'all talking
21 about that yesterday, but then there was some --

22 MR. MCDOW: Well, that was the intent of my --
23 whatever. If that raises a different issue, we'll take
24 that up at a higher time, but that was the intent of
25 avoiding Dr. Wood and capping at four million dollars

1 because that's where we were going to be.

2 THE COURT: All right.

3 MR. MCDOW: And I --

4 THE COURT: So I heard y'all talking yesterday and
5 when there's not an agreement, I can't sit there and
6 referee that. So Mr. Corbin, do you agree to cap any
7 recovery at four million dollars. That would be key, not
8 the verdict, by any recovery? Of course, necessarily, that
9 would render any excess a moot point. Because I haven't
10 seen any of the letters that Mr. McDow is talking about.

11 MR. CORBIN: And I don't doubt that was his intent,
12 but it was never expressed to me that way.

13 THE COURT: And the reason for --

14 MR. CORBIN: The reason for the stipulation was
15 that I have served a production request, requesting
16 financial data -- and I'm not saying we can't talk about
17 this, Your Honor, but requesting financial data --

18 THE COURT: Well, it doesn't have anything to do
19 with what we're doing now.

20 MR. CORBIN: No.

21 THE COURT: But if it has something to do with
22 whether or not Mr. McDow's going to allow that stipulation
23 to be read, then we got to address it. So --

24 MR. CORBIN: I agree there is a letter in writing
25 that says I'll stipulate he has the ability to pay, okay.

1 THE COURT: Okay.

2 MR. CORBIN: My intent was to satisfy a judgement
3 of up to that and that was it and if -- I'll live and learn
4 it by next time.

5 THE COURT: Well, I don't mean ----

6 MR. MCDOW: Okay. I'm ready to proceed, Your
7 Honor.

8 THE COURT: All right. Y'all need to take anymore
9 break? Y'all ready to go?

10 MR. CORBIN: I don't think so.

11 THE COURT: All right. You can bring in the jury.

12 MR. CORBIN: Your Honor, my paralegal will not be
13 here; she's taking Dr. Irvin to the airport --

14 THE COURT: All right.

15 MR. CORBIN: She's not going to be back anytime
16 soon. Had to take him to Florence to catch a flight.

17 THE COURT: Less expensive anyway.

18 MR. CORBIN: Yes, sir.

19 THE BAILIFF: The jury is seated Your Honor.

20 THE COURT: All right. Thank you, sir.

21 (WHEREUPON the jury entered the courtroom at 10:41
22 a.m.)

23 All right. Ladies and gentlemen, as I mentioned,
24 we're going to move forward now to the part of the trial
25 that will consist of the attorneys giving their closing

1 arguments. And just a few points on that before Mr. Corbin
2 begins, what lawyers say to you during the course of their
3 arguments is not evidence. They are permitted under the
4 rules to make the arguments to you that they believe that
5 the evidence or lack of evidence compels you -- to argue to
6 the conclusions they believe the evidence or the lack of
7 evidence compels you to reach in this case.

8 They will not purposefully misquote or
9 mischaracterize any evidence, but if they make an argument
10 to you and recite facts or their version of the facts that
11 does not correspond with your memory or your view of the
12 facts, you go with the evidence as you've seen it and heard
13 it. Likewise, with regard to their arguments, they're
14 permitted to incorporate into that the points of law that I
15 will be charging you. That's one of the reasons we spent
16 time on that in your absence because they do have that
17 right.

18 If they recite or quote or refer to a principle of
19 law that does not correspond with the law as I give it to
20 you, you go with what I say it is, not with what they say
21 it is. The rules state that the Plaintiff will -- the
22 Plaintiff will present the first argument; the Defendants
23 will present the second argument and under the rules, the
24 plaintiffs do have the right to present the last argument.

25 All right. Mr. Corbin, are you prepared to go?

1 MR. CORBIN: I am, Your Honor.

2 THE COURT: McDow?

3 MR. MCDOW: Yes, sir.

4 THE COURT: All right.

5 CLOSING ARGUMENTS

6 MR. CORBIN: The work that you've done for the last
7 four and a half days and will soon complete in your
8 deliberation room will affect many people, not just the
9 people in this courtroom, but it will affect many people
10 beyond the walls of the courtroom. We're talking about
11 setting the standard of care in this particular community,
12 not just for Faye, but for grandparents, parents, moms and
13 dads, children in this community.

14 Remember the standard of care is, simply put, rules
15 that establish what a doctor is supposed to do to protect
16 patients. It requires all doctors to be careful in
17 treating their patients. If you decide, and my job is
18 nearing the end, if you decide that a surgeon in this
19 community, at a major hospital, treated lots of patients,
20 can ignore not one, but hundreds of signs, red flags,
21 orange cones, and still satisfy the standard of care, there
22 will be more Fayes. I'm telling you, there will be more
23 Fayes.

24 I kind of believe that a function of the jury
25 system is for the jury to speak as the conscience of this

1 community. I live in Florence; I love Columbia, but
2 Florence is my community. Columbia is yours. I believe
3 that jurors owe the community an obligation and duty to
4 exercise your power to prevent others from being hurt like
5 Faye. I can't do that; Faye can't do that. Faye has paid
6 the price. You've got to do something to stop it from
7 happening again.

8 What are just a few of the standard of care rules?
9 And we hear standards of care. Standards is just a fancy
10 word for rule. What are the rules of care that Dr.
11 Williams was supposed to abide by? Rule number one, and
12 everybody on that witness stand agreed. You have to rule
13 out the worst first. Worst first. Between the first and
14 second surgeries, Dr. Williams testified that Faye had a 30
15 percent to 50 percent chance that she'd have a bowel leak.
16 That's what she had. That is exactly what she had. She
17 had a 30 percent to a 50 percent chance of a bowel leak.

18 A bowel leak over time, left untreated could kill a
19 patient. A bowel leak is at the top of the list of the
20 worst conditions that were consistent with her complaints.
21 And I'm not going to go through all of these again, but
22 there were hundreds of episodes of nausea and vomiting, of
23 distention, her belly being full, of wound drainage,
24 purulent drainage; hundreds of instances. If it were one
25 or two or ten, we wouldn't be here.

1 Faye testified, she's never been in a courtroom in
2 her life. She's never had a case before in her life.
3 Bucky testified in his deposition, he's never sued anybody
4 in his life. Faye wants you to use what's happened to her
5 to protect your community.

6 So there's no confusion, an obstruction merely
7 means a dysfunction in your intestinal system. An
8 obstruction can be caused by lots of things. Could be
9 caused by adhesions, which won't kill you, but in this
10 case, Dr. Williams ignored a perforation causes
11 obstructions, too. Abscesses cause obstructions, too.
12 Peritonitis, the inflammation that he found when he opened
13 her up the second time, that causes obstructions, too.

14 This big stack of warning signs. And I hope you
15 gathered from Faye's testimony, she's a very private
16 person, but these signs and symptoms of what happened to
17 her in the hospital between operations one and two are huge
18 warning signs. The vomiting sometimes five times a day.
19 Sometimes what the doctors like to call feculent. Nothing
20 pretty about that; that's when you throw up bowel content.
21 That's where you throw up your feces. That's where it
22 comes out of your mouth.

23 And you recall I asked Dr. Williams, 63 episodes of
24 nausea and vomiting, sometimes feculent, did that change
25 your course of treatment? Even a little bit? A tiny bit?

1 Didn't make any difference. That warning sign didn't make
2 any difference. The wound drainage. We're talking about
3 large amounts. And these are the nurses. These are the
4 nurses who are there 24 hours a day. A doctor comes in 15
5 or 20 minutes and he's gone. He's gone on the weekends
6 too.

7 The nurses put in the records that she had large
8 amounts of purulent drainage. Even Dr. Williams agrees,
9 purulent drainage is a sign of a surgical mishap. She was
10 pouring out large amounts of brown, yellow, thick, purulent
11 drainage for several days. Would you expect a doctor --
12 I'm not a doctor, nobody on the jury's a doctor; would you
13 want to have that large amount of thick drainage cultured,
14 sent into a laboratory so the doctor would know what it
15 was? He didn't do a single culture in 32 days.

16 CT scan. If he would have taken that CT scan on
17 day number two, post-operative day number two, when there
18 was evidence in the record that the nurse saw green, brown,
19 foul-smelling drainage coming from her surgical incision.
20 All the surgeons who testified in this case indicated
21 that's a big, big warning. Red flag. That's a sign of a
22 surgical mishap. You need to take a CT scan. He didn't do
23 that.

24 NG tube. Let's talk a little bit about the NG tube
25 and we kind of got a hail Mary on the witness stand because

1 the testimony has been -- and I apologize for having to
2 read to you what the literature is. I wish I didn't have
3 to read it, but when a doctor gets up there and says, NG
4 tube, gosh, do you really want to stick that in because you
5 got to keep it in her nose the rest of her life, we had to
6 pin her down to a bed and she might get aspirate pneumonia.
7 That's really not the standard of care. Remember Dr.
8 Kohler, MUSC? When we read to him his own literature that
9 he produced. NG tube is mandatory in a situation like
10 Faye's. Mandatory.

11 What did Dr. Williams do? Because there's nothing
12 in two thousand pages of records that he did the basic
13 mandatory thing to get rid of distention throw-up and pain.
14 He didn't do it. Nothing in the records. So what did he
15 testify? I just -- I did it numerous times, Mr. Corbin. I
16 just offered it numerous times. All through her
17 operation -- all through her hospitalization, I did it
18 numerous times, but I didn't put it in the record. I
19 didn't put it in the record. I did what's called a
20 standing order. Standing orders don't make any sense at
21 all unless it's something in writing in the patient's
22 record.

23 How in the world does somebody else come along
24 later, when he's on vacation for example, and know what in
25 the world is in his head? That doesn't make any sense at

1 all. Don't believe that. There was no standing order for
2 an NG tube, decompression any time Faye wanted it. It
3 wasn't there.

4 One more point about the NG tube. The day before
5 her second operation, and that's the focus of this case is
6 what happened between operations one and two. That second
7 operation should have never happened. That is dangerous.
8 That's an extremely dangerous and complicated surgery.
9 That should have never happened. The day before Dr.
10 Williams got her into the operating room for the second
11 time, his resident, Dr. Toll who represented Faye, he
12 inserted the NG tube, and what happened? Brown, dark, gunk
13 came out; two plastic jars full of stuff and the records
14 indicated she was not distended anymore. She was feeling
15 good, doing well. Well, the standard of care required him
16 from the beginning to do that. Nothing had changed. Her
17 condition hadn't changed.

18 If he would have done like he's required to do
19 under the simple rules, in the beginning, post-operative
20 day two, three, or four, in the beginning, we wouldn't be
21 here. The literature is clear. If you do that. And that
22 was part of Dr. Kohler's testimony; that's typical and some
23 other stuff. If you do what you're supposed to do as a
24 surgeon in Faye's situation, 70 percent of the time in the
25 first week, the patients get better; 70 percent. Wouldn't

1 you want to know that?

2 If you let that patient go two weeks, another 25
3 percent for a total of 95 percent of patients like Faye
4 with a simple NG tube get better. By day 17, the other 5
5 percent get better. If you let her go two weeks, 95
6 percent chance that you're not going to heal without
7 surgery. If you allow Faye after that first surgery that
8 he indicates was very difficult, complex the first time he
9 did it, he took out the bowel; there's no reference in the
10 records how much bowel he took out. There's no reference
11 in the records that he sent it so pathology; and there's no
12 record that he got a result back from the feet of bowel he
13 removed.

14 That's why Dr. Irvin had to come back from
15 Virginia, to tell you that before she went to see Dr.
16 Williams the first time, her bowel was relatively normal,
17 within the range of 16 to 18 feet. She didn't lose ten
18 feet of bowel at Carolina Pines or Byerly in 1995. She was
19 fine for 12 years. If they would have taken out 10 or 12
20 feet of bowel, she would be just like she is now. She was
21 fine for 12 years. Do not let them confuse the issue
22 because the records are missing in 1995.

23 Dr. Irvin looked at the CT scan two weeks before
24 she went to see Dr. Williams. Two weeks. And he testified
25 to you that he reviewed it; her bowel appeared to be

1 normal. It appeared to be within the range of 16 to 18
2 feet.

3 Just because you have a resection doesn't mean that
4 you need to lose 10 feet of bowel. A normal resection like
5 Dr. Parker, who got in there with a mess, got in there into
6 a mess; he took out 2 or 3 inches, 3 or 4 inches the second
7 time. He didn't take out feet. Competent doctors do not
8 take out feet of bowel.

9 Do not let the Defense argue that nobody knows
10 whether or not she had short bowel syndrome before she went
11 to see Dr. Williams or she was on the verge of it or maybe
12 somebody back in 1995 did something inappropriate.

13 Another rule that applies to all doctors, and when
14 I talk about Dr. Williams being a surgeon, please don't let
15 that be confusing. He is a gynecological-oncologist that
16 does surgery. He has to abide by the surgical rules.
17 Another rule that applies to surgeons is that if you want
18 to do surgery, you need to obtain your client's, your
19 patient's, informed consent. Informed consent.
20 Patients -- everybody in this courtroom that is competent
21 and conscious, you have a right to decide what's going to
22 happen to your body, not the doctors. You have that right.
23 It's a basic right. It's our bodies.

24 What is the doctor's obligation under the rules?
25 The doctor's obligation under the rules are -- is, he must

1 carefully diagnose the patient, look at all the signs and
2 symptoms. If he needs to do a more sensitive test, like a
3 CT scan, he needs to go ahead and do it. When he gets
4 these symptoms together, he needs to tell the patient, you
5 have these symptoms and these are the options of treatment.

6 Let me focus on the second surgery. That doesn't
7 mean we don't think informed consent wasn't obtained
8 otherwise, but the important one I want you to focus on,
9 please, is the second surgery. Let's go on the second
10 surgery -- between the first and second. The first
11 surgery, Faye had feet of bowel taken out. The bowel is
12 missing and Dr. Williams does not know how much bowel he
13 took out and he didn't tell Faye. And he didn't tell her
14 that she had holes in her bowel. He sewed her back
15 together.

16 Remember Dr. Kohler's testimony. This is their
17 expert witness. This is their expert witness. Dr. Kohler,
18 and I appreciate it, he produced his written notes. And
19 you recall the notes. But he produced his written notes.
20 He was hired to analyze the medical records. He found
21 numerous problems. You will have his notes in the
22 deliberation room.

23 One of the major issues that he had, and I think it
24 might have been five stars. He said that the bowel is
25 missing. Where is the bowel? We need to pin him down on

1 that one. Then he put, nightmare scenario. He didn't
2 properly attach it, something bad happened during it, he
3 didn't tell us what he did, and the bowel is missing.
4 Between the first and second operations, Faye starts having
5 all of these terrible complications and the Defense and
6 their experts can downplay it. Oh, she was doing well, she
7 didn't look sick, you know better. You know better.

8 We're approaching the second operation. The record
9 is clear and nobody disputes, Faye told Dr. Williams, I do
10 not want more surgery. The first one didn't go too well,
11 I'm not doing well, my stomach is ballooned, I don't want
12 anymore surgery. No more surgery. The records indicate
13 that she was anxious about surgery; what was Dr. Williams
14 required to do? This surgery, if you listen to the Defense
15 and their experts was what you call elective.

16 Now, this is important. In Dr. Williams's mind,
17 the second surgery was elective. In other words, Dr.
18 Kohler said she was not falling off the cliff, she was not
19 septic, she was well, she didn't have infections, didn't
20 have a perforation, didn't have a fistula, she was doing
21 well. The second surgery was elective. If the second
22 surgery is elective, that means the patient has the right
23 to pick or choose not to do it. Under the informed consent
24 rules, he had a duty before the second surgery. He should
25 have warned her about her situation after the first

1 operation and he should have given her the options.

2 The conversation really should have happened like
3 this, and he did not even tell you that he explained to her
4 the options, like his partner said. And I'm sorry I didn't
5 read the deposition transcript to you, but his partner
6 wasn't here. His partner told you that she had three
7 options before that second surgery. His own partner. One
8 option was the surgery. He said that's the most dangerous,
9 that puts her at the most risk.

10 The other option is putting in an NG tube, continue
11 with the TPN. And the third option would be to give her
12 some kind of PIC line, calm her down and send her home.
13 The point is, we need to delay the surgery three or so
14 months if we can because she has what is called a hostile
15 abdomen. There were options. There were options. Dr.
16 Kohler mentioned options.

17 The second surgery, Dr. Williams was absolutely
18 required as a basic right owed to Faye. He should have
19 said something about -- like this and it probably would
20 have been shorter: Faye, the first surgery that you had, I
21 had to remove feet of your bowel. It was complicated; I
22 put two holes in your bowel. I took out feet; I sewed it
23 back together. You have a 30 to 50 percent chance that
24 when I sewed that bowel back together, there's going to be
25 a leak. If there's a leak, that's a very dangerous

1 situation. I decided to remove all your scar tissue from
2 the top all the way to the bottom.

3 The testimony from the plaintiff's experts has
4 been, in Faye's situation, because of the two prior
5 resections, she had some adhesions. They hadn't caused her
6 troubles. If adhesions don't cause you troubles, leave
7 them alone. Because when you take them out and cut them
8 out with scissors, they're coming back and they're coming
9 back worse than before. And if you try to mess with them
10 when you don't need to, you can access the ovaries down
11 here and you start up here because you really don't know
12 where you are. Do you believe that?

13 I had to go to the top of her abdomen because I
14 just couldn't tell where I was. He started at the top and
15 he did what they call running the bowel. He sought out
16 adhesions. Every one he could find, he took the scissors
17 and he cut. He cut knowing it's coming back. Knowing it
18 will cause perforations and low and behold he perforated
19 her twice. He should have told Faye. We're going into the
20 second surgery now, Faye, and you've had all this nausea
21 and vomiting. I believe -- I know -- I know for a fact,
22 Faye that this second operation is going to be even more
23 difficult and complex and dangerous than the first. You're
24 at a risk if I do the second operation I'm going to have to
25 take out more bowel, you'll probably have more

1 perforations, and it's going to be a complex surgery.

2 Well, Doctor, I'm scared of surgery. Can we do
3 anything else? Faye, what we can do is, you've got the TPN
4 through the IV. You've got -- you took the NG tube
5 yesterday and it worked. Let's avoid this surgery. If the
6 distention comes back in the next few days, we'll do the NG
7 tube again and you can avoid it. That's what he was
8 required to tell her.

9 The third thing he's required to tell her was, and
10 he didn't do any of this, If I don't do surgery, what could
11 happen to me? You can't just say you need surgery. You
12 have to say, You need surgery and if you don't do this
13 Faye, this is what I think will happen to you. He totally
14 disregarded her rights as a patient. He exposed her to a
15 dangerous surgery when he went in there the second time.
16 She was scared to death, it's in the records. She didn't
17 want it; he ignored it. He went in there, as soon as he
18 opened her belly, sure enough, right in his face, he found
19 massive inflammatory changes.

20 Massive inflammatory changes. And it's in the
21 second operative report and you will see this. Read as
22 much as you'd like of the findings for the second
23 operation. When he opened her belly, the first sentence is
24 massive inflammatory change of the abdomen. That's
25 peritonitis. By definition that's peritonitis. He missed

1 it. He didn't check her for it. He missed it. It's a
2 potential condition that could kill her.

3 His second statement was, quote, pocket of probable
4 extravasated dye. Now, that means one thing. One thing in
5 the world if you believe it's true. If you believe it's
6 true, doctors have a duty to put accurate stuff in the
7 record. The only way that barium got outside of Faye's
8 system and was extravated (sic) or leaked, there had to be
9 a hole in her bowel. They all agreed to that. If the
10 second sentence is true, she had a bowel leak and he missed
11 it. He missed it.

12 The signs of the bowel leak, if he would have been
13 paying attention to the warning signs and changed his
14 course of treatment early on, bowel leak -- remember
15 post-operative day two, green and brown wound drainage, all
16 this other drainage. He took plain -- what they call plain
17 films, KUB's. They're not sensitive. CT scans are what
18 she required. She was a complex patient, she was having
19 troubles. She required CT scans. He did five or six KUB's
20 over the thirty days. Even the KUB on May 12th, we're
21 talking 17 days after the surgery. She's not getting
22 better, she's getting worse. He does another KUB.

23 The radiologist who was instructed, Check her for
24 nausea and vomiting. The radiologist wasn't instructed,
25 check her for a potentially deadly bowel perforation. That

1 requires a different test. He should have ruled it out.
2 He wanted to check about nausea and vomiting. The simplest
3 film in the world, KUB, is not 3-D like a CT scan. Even
4 the radiologist picked it up. You've got barium stuck all
5 through her bowel. It's been there two or three weeks. It
6 stayed there for 20-some days in her bowel, but on this
7 day, May 12th, it would be 17. Radiologists warned Dr.
8 Williams. I'm checking for nausea and vomiting, but this
9 plain film shows there is a possibility it looks like maybe
10 barium is leaking outside her intestine. Extraluminal,
11 outside the intestine. That is a huge warning sign.

12 Did he follow up? The standard of care would
13 require him in that situation given her condition, simple
14 CT scan. A CT scan 90 to 100 percent of the time show
15 perforation. If he would have done that, the way you treat
16 a perforation is, you put in a drain, you drain it out. He
17 didn't do a CT scan. It wasn't enough. What's his excuse?
18 What's his reason for not doing it? Well the radiologist
19 said it was just possible that she had a deadly perforation
20 so I just didn't check.

21 The second surgery, he encountered peritonitis
22 which was caused by the bowel leak. He encountered the
23 pocket of barium, which was caused by the bowel leak. The
24 testimony from the Defense as well as the plaintiff's
25 experts have been: Barium is dangerous. Barium is not

1 like a water-soluble, something that dissolves in water for
2 the contrast. He can now say that I didn't really specify
3 not to use barium, but he's sending off these requests for
4 these KUB's for nausea and vomiting and he's telling the
5 radiologists, check for nausea and vomiting. He doesn't
6 tell the radiologist, which he has a right to do, that's
7 his patient, let's use the water-soluble stuff instead of
8 this deadly barium. She might have a leak. He went with
9 the barium, it leaked out, it was shown May 12th, and it
10 stayed there until the second operation. That's when he
11 found it.

12 You don't use barium because it causes peritonitis.
13 That's what caused the peritonitis, the leaking out barium.
14 Leaking out barium causes abscesses. She had an abscess,
15 she had a peritonitis, she had a bowel leak, and then
16 because the abscess went on for a long time, Dr. Irvin and
17 Dr. Parker, she developed what's called a fistula. That's
18 what was bringing all that stuff up to the skin's surface.
19 It was a fistula, which is a well-established perforation;
20 it'd been there a long time. It's draining all that pus
21 out. The nurses saw the pus. There was no reference in
22 Dr. Williams' records about pus or any concern at all when
23 he read the records of the nurses.

24 Faye and Bucky have been married for 47 years. We
25 have brought this action on behalf of Faye. She's the

1 patient. We believe that you'll be convinced that under
2 those 200 warning signs was enough to do a simple CT scan
3 to properly check out your patient who's not getting
4 better. That's medical malpractice. If you're married,
5 under the law, and your spouse is hurt, and it affects your
6 relationships -- your relationship with your spouse, you're
7 injured as well. That's called loss of consortium.

8 Bucky has his claim. And do not hold it against
9 him because he's not here. Bucky has his claim for being a
10 dutiful, loving, caring husband. Faye testified that she
11 relied upon Bucky for the first five and five and half
12 years before he developed his condition which will not be
13 covered. We do not want you to consider any damages for
14 Bucky because he has none. We're not going to ask the
15 Judge to tell you what the normal life expectancy is
16 because he has none. What I'm asking you to do, though, is
17 to consider what he's done to this point.

18 Faye said that when she was in the hospital all the
19 time and he had the RV take her home. Got his wife home
20 and he would clean her up when she would mess herself or
21 soil herself and lay in the floor. A loving husband. For
22 five years. That's his companion. He lost her love in
23 society. They couldn't do the stuff they used to do. You
24 know, retirement ought to be fun. When you consider
25 Bucky's damages, I ask you, use your common knowledge and

1 experience, and the Judge will tell you, it's up to you.

2 You know, my parents were married 50 years. It's
3 up to you. What would that relationship be worth if a
4 person's spouse at 47 years or 42 years at that time were
5 put in Faye's condition? Wearing diapers, 67 bowel
6 movements a day at its worse. Thank the Lord it's calmed
7 down to 20-something today. Her anus is raw. They can't
8 go amongst friends anymore.

9 What are Faye's damages? In general in a medical
10 malpractice case, if you believe that Dr. Williams violated
11 the standard of care or broke his rules and she was hurt.
12 Patients are entitled to asking for damages and we are not
13 here -- do you think Faye came here for sympathy? Do you
14 think that she would just come up here and make people feel
15 sorry for her? It pained her to testify.

16 A patient -- if you find negligence of Dr. Williams
17 and also Dr. Williams' medical practice is included, the
18 Judge will tell you as a matter of law because the doctor
19 works for the company that if you conclude that Dr.
20 Williams did something inappropriate and broke the rules
21 and hurt Faye, his company, as a matter of law, is also
22 included. This -- this is the easy part of an argument
23 about damages. The easy part is the economic loss.

24 Faye would want you to consider -- and if you find
25 that Dr. Williams was careless and hurt her, her medical

1 expenses of her as of this time was \$571,058.62. You will
2 have this in the -- in the deliberation room. And attached
3 to that page is the proof of that damage. The other type
4 of damage that you can consider are the economic damages of
5 Faye. And I'm sorry we've got to talk like lawyers. I
6 don't like it.

7 The law has what are economic and noneconomic
8 damages. These are economic damages, what a jury can put a
9 dollar a day on. If you had to buy it, you'd buy it. If
10 you had to pay for it, you could pay for it in cash.
11 Medical bills are economic damages. Dr. Wood, he had
12 nothing to do with the \$600,000 in medical bills, but as an
13 economist, he is an expert in determining, what were Faye's
14 financial losses because she can't do what she used to do.
15 She can't teach handicapped children like she used to.

16 What were here economic damages? And the bottom
17 line of Dr. Wood was, if you consider and give her \$7 or \$8
18 an hour, Dr. Wood is conservative, we've learned he's
19 conservative. If you believe Faye was worth \$7 or \$8 an
20 hour, you also calculate what the worth of her services
21 around the house would be before she was injured. She no
22 longer could do these things; his calculation was \$240,751.
23 That is -- that is more economic damage.

24 Economic damages for Faye are about \$800,000. The
25 difficult part, and no one can make this decision but you.

1 No one can hand you a bill and say this is what it is.
2 You've got to determine what is her pain and suffering
3 worth. What is her humiliation and embarrassment worth?
4 What is her isolation worth? What are her scars and
5 disfigurement worth? Time out.

6 You know, one of the best ways I know it, I'm
7 trying to think how to explain it so it makes sense to help
8 you do your job. Imagine want-ads, the State newspaper,
9 looking at the want-ads. You see an add in there.
10 Position to be filled, lifetime position to be filled. \$3
11 million. Meet me at the Carolina Coliseum tomorrow. How
12 many people you reckon would show up? A lot of people
13 showed up wanting to know, tell us about this \$3 million.
14 That sounds great. I want a position worth \$3 million.
15 Tell us about it.

16 Well, first of all, if you assume this position,
17 you will not get a dime for five years. Then you'll get
18 paid, but you've got to work for the rest of your life.
19 Some people get up and leave. Others stay. Tell us more.
20 Well, from day one, we've got to do a few things if you
21 want this position. We're going to surgically take out
22 feet of your bowel. We're going to perforate your bowel.
23 You're going to stay in the hospital and have six
24 operations, 62 days, lots of nausea and vomiting and I need
25 to tell you sometimes it's going to be feculent. And

1 you'll be able -- when you get finished with you for that
2 hospitalization will be \$600,000. A lot of people will get
3 up and leave. A few remain.

4 Oh, by the way, some more duties of this position
5 is, when you get out of the hospital, you go home and
6 you're going to have diarrhea 67 times a day, night and
7 day. It'll calm down after a few years. Down to 20 times
8 or so a day. Your anus will be raw. Your friends, no,
9 they're going away. It'll affect your relationship with
10 your husband. Forget about playing with your
11 grandchildren -- grandchildren. Almost everybody leaves.
12 One person stays.

13 Oh, by the way, this is a lifetime position, but we
14 need to take ten years off of your life too. That's Faye's
15 position. You will be asked when you go back to your
16 deliberation room, you'll be given what's called a verdict
17 form. And on the verdict form it'll say, you know, words
18 to the affect, we find that Dr. Williams essentially did
19 nothing wrong. Didn't commit negligence. If you find
20 that, you're finished.

21 Another part of that form will say that, We the
22 jury, we find that Dr. Williams was negligent. In other
23 words, he broke the rules and Faye was hurt.

24 If you believe that, then the next question is how
25 much in economic damages do you think is reasonable? And

1 we would ask you, don't discount Faye's damages. Justice
2 is no justice unless you obtain full justice. You'll be
3 asked about economic damages. You'll be asked about
4 fill-in-the-blank for noneconomic damages. What is her
5 pain and suffering worth? What is it worth?

6 You will also be asked for Bucky. Do you believe
7 that because Faye was hurt, Bucky incurred some damages?
8 Did it affect him? Loss of consortium. Did he do -- how
9 much in actual damages do you think that will be worth?
10 Another question you'll be asked, and this is where the
11 community comes in. You'll be asked, are you convinced?
12 Is it clear that Dr. Williams broke the rule and hurt Faye?

13 Nobody intended to do it on purpose. If somebody
14 hurt somebody on purpose like Faye was hurt, you wouldn't
15 be in this courtroom. So like the guy going down the road.

16 If you believe that his negligence was gross, more
17 than just simple, more than one or two little things. No
18 harm, no foul, something you can correct. Faye's condition
19 can never be corrected. She is ruined. If you believe and
20 if you're convinced that in this particular case with
21 hundreds of warning signs, with serious damage and risk.
22 With his truly violating her right to know about that
23 second surgery. If you're convinced that he was grossly
24 negligent, his conduct was reckless, or he disregarded her
25 rights, then you're allowed as a jury, only you can do it,

1 to what are called exemplary damages. Sometimes they're
2 called punitive damages.

3 These damages are designed to protect the
4 community. You're not required to do it; I'm asking you to
5 do it. If you find that he was grossly negligent, not just
6 a little bit, but grossly negligent, you are allowed
7 beyond, you know \$800,000 in actual damages is a lot. What
8 we're asking for her pain and suffering is a lot. What
9 we're asking you to do for Bucky is a lot. But punitive
10 damages are designed so he won't commit the same errors in
11 the future. He contends even now, when there's absolute
12 scientific proof that he perforated her bowel, that he
13 didn't do anything wrong. He has -- there's going to be
14 another Faye.

15 We're asking you to determine that what he did was
16 gross negligence and reckless. If you decide that, and it
17 is up to you to decide, what is the appropriate amount to
18 get the attention -- not only Dr. Williams, and like I
19 said, this goes beyond this courtroom. Don't believe that
20 what you do is going to be in this room, is going to be --
21 the door's going to be closed and nobody in doctors and
22 hospitals don't give tahoots.

23 A lot of people are here watching this and you're
24 speaking for the community. You're going to set your
25 standards here. If you decide to reward exemplary damages

1 so Dr. Williams won't do it again, but even more
2 importantly, you're telling the hospitals and the doctors,
3 you cannot do this again. You need not violate your
4 patient's rights. You need to not let them suffer for 32
5 days without doing simple, simple tests. You can't do this
6 anymore.

7 If you decide to do this, there is a burden on me,
8 it's not Faye's burden, it's mine. There is a burden. We
9 are not here to economically bankrupt anybody. That's not
10 what this is about. Faye's damages have ruined her. She
11 will never, never, never recover. Punitive damages are
12 based upon the person's ability to pay. I want to read to
13 you a stipulation of fact. This is fact. This is
14 stipulated by both sides. This is a fact.

15 Stipulation of fact, James A. Williams, Jr., M.D.,
16 the parties hereby stipulate that James A. Williams, Jr.
17 M.D., has the ability to satisfy a judgement of \$4 million
18 in this case without a material effect on his net-worth.
19 Not a material effect on his net-worth. He's telling you.
20 If you decide on punitive damages, four million dollars
21 will not have any kind of material effect on this man.

22 The Defense, Mr. McDow, they've done a great job.
23 You've had a long trial; I appreciate your patience, both
24 of us; I appreciate Mr. McDow. We've taken thousands of
25 pages of medical records; we distilled them down, you've

1 hardly heard any objections in this case, which is unusual.
2 We want you to consider all the facts in the case; make a
3 fair determination in this case and render a fair verdict.
4 Mr. McDow has a chance to come up here and argue again.

5 During that argument, ask yourself, when he starts
6 talking about his complex, difficult patient, Faye
7 Atkinson. Well, if she's so complex and difficult, why not
8 a simple CT scan? They do them by the wheel barrel full.
9 Why not a simple CT scan? When he starts talking about, oh
10 she's just so complex and difficult from the day she came
11 into the operating room, why not ask yourself the question,
12 if she's so complex and you're really not sure what's going
13 on with her, wouldn't a doctor as a basic rule send off
14 this wound drainage for a culture to see what it is? Can't
15 explain it.

16 If the Defense says that he really didn't remove a
17 whole lot of bowel the first time, not a whole lot, ask
18 yourself if that were the case, if that really is true, why
19 wouldn't he put that in his operative note? Dr. Kohler
20 said, we need to pin him down on that. How much bowel did
21 he take out? We need to pin him down; it could be a
22 nightmare. No one's ever pinned him down. He still says,
23 I don't know; I don't know how many feet I took out. Ask
24 yourself that. What happened to the missing bowel?

25 Remember the chart the other day. Scientifically,

1 we were showing at Palmetto Richland Hospital, about two
2 feet or so of bowel was removed, not including Dr.
3 Williams' first surgery. That's a big question. She now
4 has 2 feet left, so we can account for 4 feet. Dr. Irvin
5 came back from Virginia because he doesn't want anybody to
6 be confused about this. They can count the 4 feet plus
7 whatever he's removed. Dr. Irvin came back from Virginia,
8 testified that he looked at Faye's CT scan two weeks before
9 she went to see Dr. Williams. It appeared to be normal;
10 the normal range is 16 to 18 feet. She wasn't missing 10
11 feet of bowel. I ask you to accept that. It's not been
12 disputed.

13 If she had a normal sized bowel, it would be 16 to
14 20 feet. It was at least 16 feet, we can account for four.
15 Four. You tell me where the rest went. It never got to
16 pathology. Keep asking yourself where did the rest of that
17 bowel go. I appreciate your attention in this case. I
18 know it's been difficult. Thank you.

19 **THE COURT:** Thank you, Mr. Corbin.

20 Mr. McDow?

21 **MR. MCDOW:** Thank you, Your Honor. May it please
22 the Court?

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

24 **MR. MCDOW:** Ladies and gentlemen of the jury, we've
25 been here all week together. I want to not insult you by

1 thanking you for your service. There was not a sign on the
2 courthouse last week that said that everybody who wants to
3 spend a week away from their jobs and their families, sign
4 up and volunteer to be here; I'll recognize that. I do,
5 however, want to thank you for your attentiveness during
6 the week. You've paid attention, you've been on the edge
7 of your seat, you've taken notes, you've taken in
8 everything that's been said, all the evidence. And on
9 behalf of Dr. Williams, we appreciate that.

10 There are twelve of you. There's only one of me.
11 I cannot sit here in thirty minutes and adequately
12 summarize all the testimony, all the medical records. If I
13 mistake something, there's twelve of you, there's one of
14 me. I'm sure you'll be able to remember what was testified
15 to from the witness stand. I have some things I did,
16 however, pull out of the records, pulled out of the
17 testimony and want to bring to your attention and ask you
18 some questions.

19 My first question is, after listening to all the
20 evidence, what's the plaintiff's theory in this case? What
21 is the plaintiff's theory in this case? Did she have a
22 leak or not? Did she need the second surgery or not?
23 Because I submit to you, you can't have it both ways.
24 Let's look at the plaintiff's experts. The first thing I
25 would point out to you about the plaintiff's experts is

1 that they were never asked to interpret Dr. Williams's
2 progress notes. Their testimony was based on the
3 presentation, the nursing notes.

4 Dr. Williams was the one who was there almost every
5 day or he was on call. Those progress notes are written in
6 the medical records, you can follow along, we went through
7 each one of those on direct examination. I would submit to
8 you this: There was testimony from the Plaintiffs about
9 how long both of the surgeries took and how much time was
10 spent on adhesiolysis. If we had been here in the
11 courtroom, if he had been in the operating room for less
12 than that amount of time and the same injuries occurred,
13 we'd still be here because then they would have said that
14 he didn't take enough time to tease out and go through the
15 adhesions.

16 Dr. Bailey, three things I want to point out to you
17 about his testimony that was interesting to me. His
18 testimony as I recalled it was that Dr. Williams missed a
19 life-threatening perforation. Number two, that the barium
20 stayed there on all the subsequent films. And three, he
21 couldn't have avoided all of the other surgeries except for
22 one and that was one to go back in to fix the leak. If
23 there's a leak there for 33 days, as they have said, where
24 does it all go? Where is all the barium? Where is all the
25 Lactulose that she took? Where's the succus entericus?

1 Just like Dr. Parker found in his surgery? Where is that
2 at the time of the second surgery? Think about that.

3 Now, Dr. Irvin says three things that I picked out
4 of his testimony. Again, there's twelve of y'all, there's
5 one of me. Number one, he was not there so he can't
6 comment on where the adhesions were. Number two, the
7 option, if possible -- if possible, is to always leave the
8 adhesions. And number three, only Dr. Williams knows what
9 he found. Now, Dr. Williams was there and that's the
10 truth. And we understand that none of the experts are
11 going to be there. That's why you have to look at the
12 medical records and the testimonies on both sides to come
13 up with those expert opinions. But Dr. Williams testified
14 that in his judgement, he was not overly aggressive. He
15 did not remove any of the adhesions -- more than were
16 necessary.

17 You wouldn't want him to go in there and not be
18 able to look and see and identify and know what he was
19 taking out. So that's why he had to start with adhesions
20 at the Ligament of Treitz, an anatomical landmark and go
21 down to where the pelvis is and where the ovaries are and
22 take those out. He was being prudent and cautious and
23 careful and that's what he did and that's why he did what
24 he did.

25 There's been a lot of descriptions about adhesions

1 and whether they're a leftover bowl of spaghetti or not or
2 whatever. I tend to think of them as Christmas tree
3 lights. Every year, I take those Christmas tree lights
4 down and I put them up in the attic and every year when I
5 get them out the next year, that gremlin has gone into that
6 bag and gone into that box and those Christmas tree lights
7 are all tangled up again. And so what do you do? You take
8 one end of the plug, you take the other end of the plug and
9 you sit on the floor and you start unraveling.

10 And that's exactly what Dr. Williams did, carefully
11 dissecting each of the adhesions. Do you really think he
12 wanted to go in there on the first surgery and just take
13 down adhesions that weren't necessary? If the ovaries were
14 sitting there to start with, then that's what he would have
15 done. He couldn't do that because he was there and that's
16 what Dr. Bailey said. If possible. And if possible, Dr.
17 Williams would have done that, but based on her prior
18 history, he wasn't able to do it. Based on her prior
19 history of hysterectomy and the two surgeries in 1995.

20 Now, Dr. Irvin also testified and Mr. Corbin
21 pointed out that you need to get a CT scan to diagnose the
22 leak. And again, what is their theory? Is there a leak
23 after the first surgery or not? I submit to you, of
24 course, that there wasn't. They submit to you that there
25 was. But again, where is the barium on the radiology

1 films? Where is it at the second surgery? Other than, as
2 Dr. Williams explained, when he lifted up that piece of
3 bowel that was on the back anterior wall, pulled it up, and
4 there it was. So it came out of the bowel because it was
5 stuck and it made a hole at that point and it was one
6 little pocket at the base of the mesentery. Even their
7 experts agreed that the base of the mesentery is in the
8 upper part of the abdomen, in the upper part of the
9 abdomen. Yet the KUB's that they want you to believe
10 showed a leak that would require to get a CT scan is down
11 in the left lower quadrant. The left lower quadrant. A
12 different area. A different area. So there was no abscess
13 in the second surgery. There was no barium-stained
14 peritonitis there. Dr. Williams appropriately took her
15 back for the second surgery.

16 Now, let's talk about the KUB's. You have those in
17 evidence here and I want to explain one thing first when
18 you go through and read them. You will see on page one of
19 the radiology reports that there was an Upper GI small
20 bowel series done on April the 23rd, 2008; that was ordered
21 by Dr. Daniel Isenan, I-S-E-N-A-N. Those records were over
22 here and there wasn't a lot of testimony about that. He
23 was a gastroenterologist that she started out seeing after
24 the -- after she got out of the hospital here in Columbia.
25 He ordered this test in April of 2008 and then she started

1 going to Dr. Williamson because it was closer to home. I
2 just don't want you to be confused about why is this one in
3 2008 radiology report in this exhibit when the rest of the
4 file is from the 2007 hospitalization.

5 Now, there was concern, of course, by Dr. Williams
6 for a small bowel obstruction and that's where the small
7 bowel series was born and whether or not it was a post-op
8 ileus on May the 2nd because of the manipulation of the
9 bowels or whether she had this partial obstruction. So the
10 patient sipped single contrast barium from a straw and it
11 was explained as he goes through and takes a film and
12 another film and another film and another film to see where
13 it goes so that they can see it going all the way through
14 because you know it starts in the mouth and goes to the
15 stomach and we know more about the colon system than
16 probably any of us wanted to know this week.

17 So it goes part of the way through. Abnormally
18 dilated small bowel that slowed transit time in the KUB.
19 Either severe small ileus or small bowel obstruction.
20 Recommend a.m. follow up on film. And that was read by Dr.
21 Sheila Jones. Now, the reason I pointed Dr. Jones out to
22 you is because when you go through each one of those
23 KUB's -- and I've got one on the set right here -- and
24 there were some other radiology exams done during this time
25 frame that were pretty self-explanatory.

1 They did one the next day on May the 3rd. Loops of
2 bowel which are abnormally dilated, although no significant
3 colon to see. The appearance would suggest partial small
4 bowel obstruction. If there's a leak, where is it going,
5 okay? They prepared through the next day. That was by Dr.
6 Ravenel. There was one on May the 4th by Dr. Jansen.
7 Client appears to be battling partial or incomplete
8 mechanical small bowel obstruction, comparison with the
9 exam dated 05/03. So they're following it. They're
10 following it on film. Each day. And I challenge you to go
11 through each one of the KUB's and the x-rays that are in
12 here and count up the number of radiologists that compared
13 to the last film and the angular appearance in the lower
14 left quadrant on May the 12th is no longer there. There
15 was no leak. It wasn't found at the second surgery because
16 there was never one there.

17 And if there were -- and again, taking us back to
18 the plaintiff's theory. They want you to believe she had a
19 leak immediately after the first surgery. So that leads
20 into the time frame that begins, like I told you, between
21 the first surgery and the second surgery. And I want to
22 talk to you about informed consent as a part of that
23 process. Of course, there was informed consent for the
24 original surgery. I think you'll see from the testimony,
25 the calcifications. The calcifications that were around

1 the mass and the size of the mass and the septations and
2 her history and the concern for ovarian cancer were all
3 indicative of recommending surgery in this case.

4 She even testified she wanted the surgery, she
5 needed the surgery. Not just based on what she was told,
6 recognize that. There was no reason to follow this mass
7 with serial ultrasounds when she's got hydronephrosis and
8 the pain that she's in. He was concerned with the
9 calcifications because even Dr. Irvin believed that that's
10 what you look at on mammograms. That that calcium, that
11 small little piece is what you look for. A radiologist
12 would look for on a mammogram.

13 Can I look at it? Can a radiologist look at it and
14 say, that's cancer when you have a mammogram done? No. It
15 would say, suspicious for carcinoma. Or, just like in this
16 case, the radiologist report that said, this should be
17 worrisome for carcinoma. So this surgery was indicated;
18 Dr. Williams appropriately advised her for potential injury
19 to the bowel, bladder, organs, and even death.

20 Now, that leads you up to the informed consent for
21 the second surgery and how that occurred and I'm going to
22 get to that in a few minutes as it relates to Dr. Parker's
23 consults. But I would submit to you that on page 1085
24 through about page 1088 in the hospital records, there is
25 an informed consent documented from each of the procedures

1 that Ms. Atkinson had while in the hospital. That includes
2 putting a PIC line in, the line that goes into the arms and
3 they give her the TPN. Remember, that was explained to
4 you.

5 But there's also the consents in there for the
6 surgery on April the 25th and again for the one for May
7 28th. Take a look at it because it says in there about the
8 risks that were explained. And it's in there, it talks
9 about lysis of the adhesions and bilateral
10 salpingo-oophorectomy for the first surgery and it talks
11 about lysis of adhesions and bowel resection for the second
12 surgery. So as a result of that, we looked at the hospital
13 records.

14 Again, if there's a leak and their contention is
15 that she's so septic she needs to be taken back, then why
16 are they saying no, we need to give her more options to
17 send her home. I don't understand that. You can't have it
18 both ways. If there's a leak, their expert says it needed
19 to be fixed. If there's not a leak, well, okay, let's send
20 her home. Well, she did have her bowel fixed because we
21 knew from her prior history -- from her prior history that
22 she had it before. That her bowels didn't wake up from her
23 other surgery that she ended up with a second surgery over
24 in Hartsville.

25 Now hospital records, as far as the drainage is

1 concerned. You get back there, there's twelve of y'all,
2 there's one of me. You want to divide them up, 2,000 by
3 12, have at it. Now, that being said, the wound was well
4 handled. It's in the wound's reports. It says, drain
5 scant amount, page 373. Page 493, her last vital signs
6 before surgery, normal. She's not in a cesspool. She's
7 not septic at that point in time. She's not on the edge
8 about ready to die because of a bowel leak. 850 -- pages
9 853 to 860 -- look at those days. I'll take those out.

10 Again, if you want to flip through them page by
11 page, you can. Look at those where she's up, walking, with
12 family around the hall, sitting up in the chair. Sipping
13 on liquids. She was sick, there's no doubt about that.
14 She was sick. She had nausea and vomiting but not to the
15 degree that it meant go back to surgery immediately and not
16 to the degree that she needed the NG tube. Take a look at
17 inputs and outputs, I's and O's. Look at the decrease in
18 the amount of drainage after the first surgery to the
19 extent that the drains are removed. Indicative of the fact
20 that she didn't have a leak.

21 What happened after the second surgery? She
22 declared herself. She declared herself because she had a
23 bowel that was diseased. We know that. A bowel that
24 unfortunately became weak and like a pin hole in the
25 balloon, sometimes there's a little leak and then over time

1 it stretches out and stretches out; and that's what Dr.
2 Parker found when he did his surgery. And that was the
3 difference between the first surgery and the second
4 surgery. She declared herself. Her heart rate went up,
5 her white blood cell count went up. That's in the last --
6 that's in the system's review. Follow that along because
7 there were plenty of days where she didn't have greater
8 than 100 degree temperature.

9 I submit to you as a matter of fact on one of the
10 exhibits related to temperature, there's a date that
11 there's a whole blank between May the 2nd or May the 23,
12 she didn't have a temperature above 100 at that time. So
13 again, you can look at the records when you get back there.

14 Now, that leads me to Dr. Parker. Oh, one other
15 thing too -- well, Dr. Parker. Why was he asked to give a
16 second opinion? Well, I submit to you that it was due to
17 the May 18th progress note. The progress note where Dr.
18 Williams documented that he had a conversation with the
19 patient and the daughter about her course and what was to
20 be expected. And it was that conversation that lead the
21 family to think, we want a second opinion. She don't want
22 that surgery.

23 They -- I agree with that. Would you? Why would
24 you after what she's been through? So I submit to you that
25 the family gets together and says, We'd like a second

1 opinion. And sure enough, we get a second opinion. As it
2 turns out on Monday, what would not be Monday May the 21st,
3 so you back that up, Sunday the 20th, Saturday the 19th,
4 Friday the 18th. That makes perfect sense. She's got all
5 weekend to talk to her family. Dr. Williams comes in on
6 Monday morning and at that point, he says, you know, here's
7 what we're thinking, Let's talk a little bit about it and
8 that leads three days later to Dr. Parker's consult.

9 Now, don't you find it interesting that if their
10 theory is that she had a bowel leak that was undiagnosed
11 that Dr. Parker missed it. And don't you find it
12 interesting that if their alternative theory is, don't
13 operate on her. Send her home that yet Dr. Parker, in his
14 note stated, I suspect she'll have to return to surgery.
15 And in his note he said, I had a lengthy conversation with
16 the family and she has opted for maximum medical
17 management. And they gave that a little while longer.
18 They gave her the Lactulose. They gave her the enema to
19 try to stimulate everything and it didn't work. There's no
20 testimony, no testimony, and we submit to you that Dr.
21 Parker -- there's no testimony that he violated any
22 standards of care.

23 We don't think he violated any standards of care.
24 He confirmed the care that we had done. He did everything
25 that was asked of him. She was not toxic. She had a

1 normal heart rate. He looked at her and said she's got a
2 partial small bowel obstruction. That's exactly what it
3 is. So it's Dr. Parker, who the defense had to call in
4 their case who shoots down either of the alternative
5 theories that the plaintiff has in the case.

6 It was also Dr. Parker who testified about, you
7 know, a couple of days later when he came back in, the NG
8 tube was septic for now. He had a lengthy conversation
9 with her about likely needing surgery and again when the
10 Lactulose was given, if there's a leak -- if there's a
11 leak, why doesn't it show up on the followup radiology
12 films.

13 Now, there's talk about where the bowel is. What
14 happened in 1995. I am not trying to confuse the issue.
15 There is no issue to be confused. I told you on Monday
16 that this case was déjà vu all over again. That's what I
17 submitted on Monday. I submit it to you again today
18 relative to she had a blockage in 1995 and she had
19 adhesions and they had to go back in the second time and
20 resect part of her bowel. She did not have short bowel
21 syndrome when she came to see Dr. Williams. She's got it
22 now. We don't contest that. We've never contested that.
23 How much he took out at the first surgery, we don't know.
24 The pathologist doesn't have it. Dr. Irvin testified that
25 both of the notes were dictated appropriately. She's got

1 short bowel syndrome now and we recognize that. We don't
2 contest it.

3 The map on the bowel about it is doesn't matter.
4 The pathology report from the second surgery indicates that
5 it was adhesed together. The testimony was that you don't
6 tease it out and measure it like a string, so who knows?
7 But it doesn't matter because we removed the portion of the
8 bowel that needed to be removed on both occasions. We also
9 don't contest -- I apologize for my fall allergies, I'm
10 losing my voice. We don't contest that Ms. Atkinson is not
11 a whiner, not a complainer. She's a nice lady. I enjoyed
12 taking her deposition. I enjoyed taking her husband's
13 deposition. We don't contest that. And I don't contest in
14 any way whatsoever that she's had a tough go of it. She
15 has. There's no doubt about it. I had very little
16 cross-examination.

17 Any of the treating witnesses regarding what her
18 current condition, whether she came back every six months,
19 whether she gets the supplemental shots, so forth and so
20 on, you've got the records of Dr. Reynolds over there if
21 you want to look at what her -- what she was like before
22 and after. She's had a tough go of it, we recognize that.
23 She's got a bad result. She got a bad result. I told you
24 that on Monday. But a bad result, as I told you, also
25 doesn't mean that she got bad care or bad medicine.

1 Now, that leads me into my final comments regarding
2 what I believe to be the law in this case. As I told you
3 on Monday and the judge told you again today, if I say
4 something wrong about the law, don't take it from me.
5 Don't take it from me. I'm just a lawyer down here. The
6 judge is the judge of the law. That's why he sits up
7 higher than everybody else in this courtroom. That's why
8 it's elevated because he's the one to charge you the law of
9 the case.

10 The law of the case, of course, is, that the
11 plaintiff has to prove their case by a preponderance of the
12 evidence. They have to prove gross negligence by clear and
13 convincing evidence. I gave you the example on Monday when
14 we came in here, the scales are even and that the plaintiff
15 has to prove by a preponderance of the evidence: They have
16 to tilt the scales ever so slightly in order for you to
17 find a verdict for the plaintiff. However, if the scales
18 are still even, or the defendant has tilted the scales in
19 their favor, then you would be required to render a verdict
20 for the defendant.

21 So what's clear and convincing evidence? Well,
22 beyond a reasonable doubt, you might have heard that phrase
23 relative to a criminal case. Beyond a reasonable doubt.
24 Clear and convincing is somewhere between preponderance,
25 somewhere less than beyond a reasonable doubt. The judge

1 will give you a full charge on that. As he's giving you
2 the charge, I challenge you to listen for the word safer or
3 better. I submit to you, you won't hear it. Because
4 whether or not a CT scan was safer or a CT scan was better,
5 is not the law. The law requires a doctor to act as a
6 reasonable and prudent person; what a reasonable and
7 prudent physician would or would not do under like or
8 similar circumstances.

9 I told you on Monday that Dr. Williams -- that a
10 doctor is not a guarantor of a good result. Dr. Williams
11 used his best judgment in this case. And he was there.
12 Dr. Parker confirmed that. There was no leak. There was
13 no leak. She needed to go back to surgery the second time
14 to fix that diseased bowel and Dr. Williams acted as a
15 reasonable and prudent physician would at all times.

16 Now, I want to close with this: I have to sit down
17 now at this point and Mr. Corbin gets to sit back up -- get
18 back up; because again, the plaintiff has the burden of
19 proof. Whatever he says, you think about what would Bill
20 say in response to that. And again, there's twelve of you,
21 there's one of me. I've tried to adequately summarize our
22 position.

23 You saw the testimony from the experts. You weigh
24 the credibility of the witnesses. You weigh the
25 credibility of Dr. Williams. We're sorry for the result in

1 this case, but it wasn't because of bad medicine and it
2 wasn't because there was a violation of the standard of
3 care. And you will be able to return a true verdict, verus
4 dicto, verus, truth, voracity. That's where we get that
5 word from. Dicto, to speak, dictate, Dictaphone. Your
6 verdict, I submit to you, will speak the truth. It will
7 speak the truth because the scales have tilted in favor of
8 the defendant this week. Thank you.

9 **THE COURT:** Thank you, Mr. McDow.

10 All right. Mr. Corbin.

11 **MR. CORBIN:** I too ask you to ask yourself, what
12 will Bill say about this. March 30th, 2007, Faye has
13 abdominal pains. She doesn't go to a huge hospital. She
14 goes to a small rural hospital without doctors as qualified
15 as Dr. Williams. No fancy doctors there in Hartsville, at
16 that little hospital. The first thing they did with
17 abdominal pains was a CT scan. Thank goodness we have it.
18 The first thing they did for abdominal pains was a CT scan.

19 Dr. Parker -- and I -- we all know they're friends
20 and all this. The important thing to remember about Dr.
21 Parker, how much bowel, small intestine did Faye have left
22 when this man finished his surgery. How much did she have
23 left. No dispute in the world. Two and a half feet left
24 after Dr. Williams finished. Not 16 feet. When Dr. Parker
25 got involved, Faye had two and a half feet left.

1 Dr. Smith -- did not testify from the witness
2 stand, but you recall the reading parts of the sworn
3 testimony and assume in fact that if he would have come to
4 the courtroom, this is what he said in his deposition under
5 oath. The question is if someone were to tell you that
6 using an NG tube in early small bowel obstruction cases is
7 no longer the standard, what would you say? Dr. Smith,
8 senior partner, I would generally regard it as still being
9 the standard of care. Dr. Smith, page 90 lines 18 through
10 23, If you had suspicions of an abscess or a small bowel
11 leak in Ms. Atkinson, would it be a violation of the
12 standard of care not to get a CT scan. Dr. Smith said, if
13 indeed you had those suspicions up front, then it would be
14 a violation of the standard of care not to look.

15 Let's talk about informed consent. Recall the
16 testimony of Dr. Parker and Dr. Irvin. Even if a patient
17 signs an informed consent, well they all list lots of
18 things. The doctor still needs to explain it to them,
19 number one; but number two, nobody's going to tell you
20 under the law that if you sign an informed consent form
21 you're giving a doctor permission to give you negligent
22 care. That's not the way it works. That's not the way it
23 works. Choices, informed consent. It was horrible. That
24 second operation was horrible. She was not given her
25 rights. It was horrible. That's why we're here. He chose

1 surgery. He chose not to tell her the options.

2 His testimony is well, she didn't really have an
3 option. I was going to do surgery. Senior partner, Dr.
4 Smith, three options: Page 122, this was read before --
5 starting on line 7 -- and I'm sorry about having to read
6 this to you, but this is his sworn testimony.

7 Question, Well, you certainly agree out of those
8 three potential options, Ms. Atkinson should have been
9 given all three. Answer: I think the patient needs to be
10 given as much information as is possible with the intended
11 complications and the long term things. So the answer is
12 yes.

13 Question: Under the standard of care, all three,
14 correct? Answer: Yes.

15 Question: Would you agree that of those three, the
16 surgery would be the riskier option. Answer of Dr. Smith:
17 The short answer is yes. The one with the greatest chance
18 of making her better is also the one of which is riskier.
19 It is like most things in the world that has the greatest
20 cost, usually has the greatest benefits.

21 Dr. Smith, page 121, lines 4 through 13: Dr.
22 Smith, if you would have been there instead of Dr.
23 Williams, what would you do? Answer: Had I been there
24 then, we would have had discussion regarding several
25 options. One option would be to put an NG tube in,

1 continue the TPN and see how we did. Another option would
2 be to put the NG tube in, then to consider a hist ostomy
3 tube if it could be placed and TPN. The third option would
4 be to go to the operating room with all the intended
5 complications. She was just given one. There could not be
6 any more gross violations of the rights of a human being as
7 well as a patient facing complicated surgery that could
8 kill her, to know there was a nonsurgical option. We kind
9 of wish Dr. Smith had been there that day.

10 This one point -- we talked about spaghetti and
11 Christmas tree lights. This is an extension cord. And you
12 don't have the missing ten feet of bowel, you know a normal
13 resection, talking about Dr. Parker who got the mess -- it
14 was all wadded up together. It goes a long ways, across
15 this courtroom. That's what we've got here, we have to get
16 here. If you hold that as negligence, we don't need
17 standards. We don't need rules.

18 What Dr. Williams did, Faye is paying the price for
19 what he did every single day. She will continue to pay a
20 horrible price, horrible price until she draws her last
21 breath. That's her fate. You know her fate. If you
22 decide that everything is relative that everything is
23 relative in this world. If you decide Dr. Williams ought
24 to pay reasonable compensation, everything's relevant,
25 isn't it.

1 And if you decide, we don't want him to do it again
2 and we don't want anybody to do this again in our
3 community, \$4 million wouldn't affect -- materially affect
4 his net worth. He won't skip a beat. Thank you.

5 **THE COURT:** All right. Thank you, Mr. Corbin.

6 All right. Ladies and gentlemen, we'll take a
7 brief recess. The next -- and this will be brief -- I've
8 got to make one change on the verdict form, so I've got to
9 go back there to my computer and do that. Please go to
10 your jury room. You may not discuss the case yet, that
11 time will be coming after I give you the charge. Thank you
12 very much.

13 (WHEREUPON the jury left the courtroom at 12:05
14 p.m.)

15 **THE COURT:** All right. During this brief recess,
16 if you gentlemen would make sure that all the marked
17 exhibits, plaintiffs and defendants, are up there and, of
18 course, the court reporter will make sure that the Courts
19 exhibits are out of there.

20 **MR. CORBIN:** Your Honor, I guess for -- at least
21 for identification purposes we need to mark this --

22 **THE COURT:** Court's exhibit.

23 **MR. CORBIN:** -- stipulation, yes, sir.

24 **THE COURT:** I'll agree to the stipulation, I won't
25 agree to the letter though.

1 MR. CORBIN: What letter.

2 THE COURT: My letter behind it.

3 MR. CORBIN: Oh, no. All right.

4 (WHEREUPON a recess was observed.)

5 THE COURT: All right. That's the verdict form,
6 gentlemen.

7 MR. CORBIN: Yes, sir.

8 THE COURT: There may be changes for the -- order
9 changes questioned by Mr. McDow and agreed to by Mr.
10 Corbin. I did add on the Williams, Atkinson verdict form
11 question number 3. I thought that would be accurate
12 because conceivably the answer could be different on the
13 point raised there.

14 All right. Anything before we begin?

15 MR. CORBIN: No, sir.

16 THE COURT: Mr. McDow?

17 MR. MCDOW: One moment, Judge, if I might.

18 (WHEREUPON there was a pause in the proceedings.)

19 MR. MCDOW: The only thing I would actually like to
20 add to the verdict form is I would request that there be
21 the explanation regarding clear and convincing evidence for
22 the gross --

23 THE COURT: All right.

24 MR. MCDOW: -- I'm just asking --

25 THE COURT: When I go over the verdict form with

1 them, as part of my charge, I will make that clear, but I'm
2 not going to add it in there in writing. Okay?

3 MR. MCDOW: Yes, sir.

4 THE COURT: All right. Anything else, Mr. McDow?

5 MR. MCDOW: I don't think so, Judge.

6 THE COURT: Mr. Corbin?

7 MR. CORBIN: I'm fine.

8 THE COURT: All right. You can bring in the jury.

9 THE BAILIFF: Yes, sir.

10 (WHEREUPON the jury entered the courtroom at 12:24
11 p.m.)

12 THE BAILIFF: The jury is seated, Your Honor.

13 THE COURT: All right. Thank you, sir.

14 JURY CHARGE

15 THE COURT: All right. Ladies and gentlemen, let
16 me have your attention so I can give you what is called the
17 charge on the law.

18 A few things before I begin the specifics: I would
19 much rather, quite frankly be standing there in front of
20 you. I'm much more comfortable if I'm standing up, but I
21 have to sit up here because I have certain things that I
22 will have to actually read to you; and I know that may
23 sound bad to you in the beginning, but the reason that I
24 have to do that, I have to make sure I read these things as
25 the law requires me to give you a complete charge on the

1 law. I can't just give it to you off the top of my head.
2 Even though I may be able to do that. I don't want to take
3 a chance on leaving anything out because as I mentioned,
4 the law requires the Court to have conference with the
5 attorneys to make sure all these points are discussed and
6 so that they will know what the charge on the law is going
7 to be.

8 Now, I will tell you a few other things before I
9 begin. I'm going to be talking about a lot of things --

10 And Mr. Corbin and Mr. McDow, would you perhaps
11 slide that television over. I can only see the foreman's
12 head.

13 (WHEREUPON the attorneys moved the television.)

14 **THE COURT:** All right. That's good.

15 -- I'm going to be talking to you about a lot of
16 things, a lot of legal principals that you may have heard
17 of from time to time during the course of your life, but
18 you may not have known what they meant or you know a little
19 bit about what they mean. These are things such as
20 credibility of witnesses, burden of proof. I'll talk to
21 you about direct and circumstantial evidence. I will talk
22 to you about what the greater weight of the evidence means,
23 what clear and convincing evidence means, negligence,
24 proximate cause. I'll talk to you about damages and things
25 of that nature.

1 I can guarantee you one thing and that is that I
2 will repeat myself. That is not because I will have lost
3 my place or heaven forbid, I do not know what I'm talking
4 about. It's simply when a discussion of legal principals
5 occurs in any given case, whatever the case is, those legal
6 principals will intertwine and relate to one another down
7 the road. For example, if I talk about negligence, burden
8 of proof, I'm going to mention those things when I talk
9 about damages. And I will talk about various legal
10 principals more than once.

11 Now, I'm not going to do that to bring attention to
12 something or to emphasize it because I think it's
13 important. I'm going to do that so that I can make sure
14 that as a whole you have a complete understanding of what
15 these principals are and how they relate to one another.

16 Now, I remind you, ladies and gentlemen, that
17 during the course of this trial, as I told you at the very
18 beginning, you and I have certain duties to perform. You
19 are the judges of the facts and I'm the judge of the law.
20 You will notice that during the course of the trial,
21 certain exhibits were introduced. You may have noticed
22 that I have not seen those exhibits. The reason for that
23 is it does not matter from a factual standpoint what I
24 think about those exhibits. It doesn't matter. It matters
25 what you think about them. I am not permitted to have a

1 view of the facts. That would be such as to invade your
2 responsibilities. That's your job and your job alone.

3 So getting a little bit more specific, as far as
4 evidence is concerned, you are to base your decisions in
5 this trial on the evidence that has been introduced; and
6 that evidence comes in various forms as I mentioned:
7 Testimony, exhibits, and any stipulations. That's the
8 evidence. You will see and you will hear no more evidence
9 other than what has been introduced because all the
10 evidence is in.

11 Now, I have the additional duty of then presiding
12 over this trial, the charging of the law. Now, in the
13 course of anything that I've said or done or in the course
14 that I say during the course of this charge, don't take
15 from any of that that I have a particular view of the facts
16 or that I think your verdicts ought to be such and such or
17 such and such. I have no right to indicate to you what I
18 think about the facts or what I think about what your
19 verdicts should be. And so don't take from anything that
20 I've said, for example, how I've ruled on any certain issue
21 or any objection, that I favor one side over the other.
22 Because I don't.

23 I respect your responsibilities in that regard. A
24 trial judge is not permitted to comment on the facts and I
25 hope -- I don't think I've done this in this trial and

1 since you're the sole judges of the facts, again, don't
2 take from anything that I say or do, body language or
3 otherwise, that I think one particular result ought to be
4 reached.

5 All right. Now, ladies and gentlemen, the law that
6 I'm going to charge you, you have to accept it exactly as I
7 give it to you even if you disagree with it. You have to
8 accept it exactly as I give it to you.

9 Now, the burden of proof in this case. The
10 plaintiffs have advanced certain claims against the
11 defendants. They have the burden of proving those claims.
12 Now, the burden of proof in this case with regard to the
13 standard of care, whether or not it was breached and the
14 question of actual damages, the plaintiffs have the burden
15 of proving those things by what we call the greater weight
16 of the evidence. Another way it is described is the
17 preponderance of the evidence.

18 Now, a preponderance of the evidence simply means
19 evidence which, as a whole, shows that the facts sought to
20 be proven is more likely proved than not true. As I did at
21 the beginning, you can imagine in your mind's eye, a set of
22 scales. If you've ever looked at the picture or statue of
23 the lady justice and she's holding up scales. Those
24 scales, if the rendering of the artist is correct, they're
25 even, because when the plaintiffs and the defendants come

1 into this courtroom, those scales are even. And under the
2 law, the plaintiffs have to present evidence that at least
3 tips those scales ever so slightly as to the issue that
4 you're considering at that time, whether it be what the
5 standard of care is, whether or not there was a violation,
6 whether or not there was damage, and whether or not there's
7 a causal between the two.

8 So those things have to be proven by the greater
9 weight of evidence; and in your mind's eye, if those scales
10 remain even after your analysis, the plaintiffs would not
11 have met their burden by the greater weight of the
12 evidence. If on the other hand those scales are tipped
13 slightly in favor of the defendants, then obviously these
14 plaintiffs would not have met their burden. But the
15 plaintiffs do have to tip those scales ever so slightly.

16 Now, ladies and gentlemen, there are two -- I've
17 told you about the way evidence comes in: Testimony,
18 exhibits, stipulations. There are two types of evidence
19 that are generally presented during a trial. These are
20 called direct evidence and circumstantial evidence.

21 Direct evidence is evidence that immediately
22 establishes the main facts sought to be proved. For
23 example, I saw the dog cross the road. If you choose to
24 believe that witness, what he says, then that's direct
25 evidence because it's based on a perception such as that.

1 Circumstantial evidence is proof of a chain of
2 facts and circumstances that indicate the existence of a
3 fact. So it's evidence that immediately establishes
4 collateral facts from which the main fact may be inferred.
5 It's based on an inference, it is not based on a personal
6 knowledge or an observation.

7 Now, ladies and gentlemen, the facts and
8 circumstances, in so far as circumstantial evidence is
9 concerned should be considered in light of ordinary
10 experience and common sense. The existence of any fact
11 sought to be proved cannot be based on speculation or
12 surmise or conjecture.

13 Now, ladies and gentlemen, the law makes absolutely
14 no distinction whatsoever between the weight or value that
15 you are to give to either direct or circumstantial
16 evidence. Nor is a greater degree of certainty required of
17 circumstantial evidence than of direct evidence.

18 You have considered -- or excuse me, you have heard
19 and watched the testimony of several witnesses in this
20 case. It's up to you and you alone to determine the
21 believability or credibility of the witnesses who have
22 testified. Those two words obviously mean the same thing,
23 credibility and believability. It's your duty as jurors to
24 evaluate the evidence and determine which evidence
25 convinces you of its truth. And in so far as your

1 determination of the credibility of the witnesses, you can
2 believe one witness over several; you can believe several
3 over one; you can believe part of what one witness has to
4 say and totally disbelieve the rest; you can believe
5 everything the witness has to say or you can disbelieve a
6 witness' testimony in its entirety. It's up to you in your
7 common sense analysis in making that determination.

8 Now, ladies and gentlemen, in determining whether
9 or not you believe a witness, you use your common sense.
10 Some of the things that you can consider -- and this is not
11 an exhaustive list -- are things such as: How did that
12 witness appear on the stand? Hesitant or straightforward
13 in answering questions. We call that demeanor. How did
14 they look? How did they appear?

15 Now, also you can take into account whether or not
16 the witness may have an interest in the result of the
17 trial. In other words, does he have a reason to give
18 testimony that helps or hurts one side over the other.
19 That's called bias or prejudice. You can also take into
20 account what was that witness' opportunity to know about
21 the things that he or she claims to know. You can also
22 take into account whether or not that witness' testimony
23 was strengthened or weakened by other evidence that's in
24 this record. You can also take into account whether or not
25 that witness may have said something different or the same

1 on a prior occasion.

2 Now, ladies and gentlemen, as I mentioned to you
3 several times during the trial, the rules of evidence
4 typically do not permit witnesses to testify to opinions or
5 conclusions. An exception to that rule is for witnesses
6 that we call expert witnesses. A witness who by education,
7 training or experience has become an expert in some
8 particular art or science or profession can give opinions
9 as to the subject of the witness -- of the subject that the
10 witness claims to be an expert in. And that witness can
11 give reasons for those opinions.

12 You consider an expert opinion given by a witness
13 just like any other evidence and you give it the weight
14 that you believe it deserves. If you believe that an
15 opinion from an expert is not based on sufficient education
16 or training or experience, or if you decide that the
17 reasons given in support of that opinion are not sufficient
18 in your mind or if you believe the opinion is outweighed by
19 other evidence, you can disregard that opinion entirely.

20 An expert's opinion is to be given no greater
21 weight than that of other witnesses simply because that
22 witness is an expert. And you do not have to accept an
23 expert's opinion even though it might be uncontradicted.

24 All right. As I go, ladies and gentlemen, I'm
25 going to get more and more specific. In this particular

1 case, the plaintiffs, Mr. And Ms. Atkinson, obviously, are
2 individuals. The defendant, Doctor Williams, is an
3 individual. There's another defendant in the case named
4 South Carolina Oncology Associates. That is what is called
5 in the law a legal entity. Those are things such as
6 corporations, limited liability companies, partnerships,
7 things of that nature.

8 In our court system, no distinction whatsoever is
9 to be made as to how a jury treats individuals and legal
10 entities. These legal entities are persons in the eyes of
11 the law and individuals and those legal entities are
12 entitled to the same fair and impartial consideration and
13 to justice from the jury by the same legal standards. In
14 other words, they're to be treated the same in so far as
15 your analysis of the facts and your application of my
16 charge to you on the law to those facts.

17 Now, whatever your verdicts in this case may end up
18 being, a verdict cannot be based upon sympathy for any
19 party; cannot be based upon passion, prejudice, or emotion;
20 and may not be based on any other consideration that is not
21 found in the evidence that has been introduced.

22 All right. To get more specific, in this case, if
23 I mistakenly use the word plaintiff, I mean plaintiffs
24 because there are two plaintiffs. And going back to the
25 issue about the South Carolina Oncology Associates, Dr.

1 Williams in the eyes of the law -- we have things called
2 master/servant. It's also called respondeat superior.
3 It's also called principal/agent or the servant of South
4 Carolina Oncology Associates. All the questions that you
5 will answer about whether or not he was or was not
6 negligent and whether or not he should or should not
7 respond in damages to the plaintiffs, those findings that
8 you make will be imputed to the South Carolina Oncology
9 Associates because his actions, if wrongful are imputed to
10 South Carolina Oncology Associates.

11 Now, the plaintiffs claim that the defendant, Dr.
12 Williams, committed medical malpractice. That's a form,
13 ladies and gentlemen, of carelessness or negligence. The
14 words carelessness and negligence mean the same thing. In
15 order to recover in a medical malpractice action, a
16 plaintiff must prove by the greater weight of the evidence,
17 you remember those words, three things -- four things --
18 the standard of care, a breach of the standard of care,
19 damages and that the damages were proximately caused by
20 that breach of the standard of care.

21 The plaintiffs must prove the standard of care the
22 defendant owed to the plaintiff in treating the plaintiff.
23 When a doctor treats a patient, the law does not require
24 perfection or absolute accuracy in either his practice or
25 his judgment; nor does the law impose a standard of

1 infallibility. The law does require that the doctor use
2 that degree of knowledge and care and skill ordinarily
3 possessed and used by doctors in good standing in the
4 doctor's field of medicine under the same or similar
5 circumstances and that the doctor follows the generally
6 accepted practices and procedures in the profession.

7 The word treatment that I just used in the context
8 of medical treatment includes the diagnosis of a patient's
9 condition and the course of care of the patient by the
10 doctor.

11 Now, I told you that the plaintiff has to prove
12 what the standard of care is. Next, the plaintiff must
13 prove by the greater weight of the evidence that the
14 defendant negligently departed from this standard of care
15 in treating the plaintiff. Negligence or carelessness is
16 the failure to do what an ordinarily careful doctor in the
17 defendant's field of medicine would have done under the
18 same or similar circumstances. Or the doing of something
19 that an ordinarily careful doctor would not have done under
20 the same or similar circumstances. A doctor is not an
21 insurer of a cure. He is not an insurer even of a positive
22 result; therefore, the mere fact that a treatment does not
23 benefit a patient or that it even harms a patient does not
24 in and of itself mean that that defendant was negligent. A
25 bad result or injury or failure to cure is not by itself

1 enough to prove that the defendant was negligent.

2 Now, negligence on the part of a physician is not
3 presumed but must be proven by the greater weight of the
4 evidence; and in the absence of evidence to the contrary,
5 it is presumed that a physician has fully discharged his
6 duty to the patient, including the exercise of reasonable
7 care and skill in his treatment.

8 Now, ladies and gentlemen, the mere fact that an
9 injury or damage alone after medical treatment has been
10 rendered is not in and of itself evidence of negligence.
11 The plaintiff does have to prove by the greater weight of
12 the evidence that the defendant negligently departed from
13 the applicable standard of care in treating the plaintiff.

14 Now, ladies and gentlemen, a doctor's mistake or
15 error in making a decision alone does not constitute
16 negligence. However, if a doctor fails to gather
17 information reasonably available which a reasonable doctor
18 would have gathered before making a decision, the doctor
19 has failed to comply with the recognized standard of
20 medical care, which would be exercised by a similar doctor
21 under similar circumstances.

22 And ladies and gentlemen, difficulties and
23 uncertainties in the practice of medicine is unpredictable
24 variations and response to treatment are such that no
25 doctor can guarantee results. And where there is more than

1 one recognized diagnosis or treatment and no one of them is
2 used exclusively and uniformly by all doctors in good
3 standing, it is not negligence for a doctor in making a
4 decision to choose one of the approved methods, even when
5 the choice later turns out to be the wrong selection, as
6 long as the doctor uses or chooses methods that are in
7 accordance with the standard of care.

8 Qualified doctors and experts may differ as to what
9 constitutes the proper course of treatment and these
10 differences do not necessarily amount to malpractice or
11 negligence. And when doctors in good standing disagree or
12 when medical authorities are divided with regard to a
13 reasonable course of treatment or care, then the doctor is
14 bound to have possessed the degree of learning and skill
15 required and is required to use the degree of care and
16 skill and learning required.

17 Now, ladies and gentlemen, if the doctor did not
18 have a requisite learning or skill, or if he did not use
19 the care required, it is no defense that -- to a charge of
20 negligence -- that the doctor did the best he could.

21 In considering whether or not the defendant
22 violated a standard of care, you must consider the decision
23 and the treatment in relation to the facts as they existed
24 at the time and not in light of what hindsight may reveal.
25 And you are not permitted to arbitrarily set up a standard

1 of care on your own in determining whether or not the
2 defendant doctors learning, skill, and conduct fulfill the
3 duties imposed upon him by the law. The standard is what I
4 already explained to you. Did he possess the requisite
5 learning and skill and did he exercise that degree of
6 knowledge, care, and skill possessed by members of his
7 profession in good standing under the same or similar
8 circumstances.

9 It follows, therefore, ladies and gentlemen, that
10 the only way that you may properly determine whether or not
11 the defendant doctor's conduct does or does not measure up
12 to that standard is through evidence presented during the
13 trial by physicians called as expert witnesses. If
14 opinions of medical experts are relied upon to establish a
15 causal connection of evidence, the expert must, with
16 reasonable certainty, state that in his or her professional
17 opinion, the injuries and damages complained of, most
18 probably resulted from the alleged negligence of the
19 defendant.

20 Now, ladies and gentlemen, I'm going to discuss
21 with you now, or charge you on the law on the principal of
22 informed consent. A doctor has the duty to inform a
23 patient of the known risks or dangers of the treatment or
24 procedure that the doctor proposes so that the doctor will
25 be able to make an intelligent decision as to whether to

1 follow the doctor's proposed treatment. The basis of the
2 doctrine of informed consent is the patient's right to
3 exercise control over her own body by deciding for herself
4 whether to submit to any particular procedure.

5 In the absence of an emergency that requires
6 immediate treatment, the doctor must tell the patient six
7 things: The diagnosis, the general nature of the proposed
8 procedure, the material risks involved in the procedure,
9 the probability of success associated with the procedure,
10 the prognosis if the procedure is not done, and lastly the
11 existence of any alternatives to the procedure.

12 The risks that a doctor has to disclose are those
13 risks that are material to the proposed procedure. And a
14 risk is material if a reasonable person in the plaintiff's
15 position would find it significant in deciding whether or
16 not to have the proposed treatment or procedure. If the
17 possible injury greatly outweighs the possible benefit to
18 be gained from the procedure, this might be a material and
19 significant factor the patient would be entitled to know
20 before giving consent to the procedure.

21 Further, ladies and gentlemen, as to probability or
22 severity of the risk to the patient increases, the duty of
23 the doctor to tell the patient of the risks increases. The
24 doctor must tell the patient those risks that an average,
25 competent doctor with similar training in the same field of

1 medicine would tell a patient under the same or similar
2 circumstances. In addition, the doctor must evaluate how
3 great the risk is, how often it happens and the feasibility
4 of alternative treatment. A doctor is not ordinarily
5 required to disclose a risk to a patient where the risk is
6 small and remote. In order to prove that the defendant's
7 failure to inform was the proximate cause of the
8 plaintiff's injury, the plaintiff must prove that a
9 reasonable person in the plaintiff's position would have
10 refused the treatment or the procedure had the doctor
11 informed the person of the risks that resulted in the
12 patient's injury, not simply that the patient would have
13 refused the treatment.

14 Also, ladies and gentlemen, with regard to any
15 claim arising from the failure to diagnose and treat --
16 when a plaintiff claims that a physician negligently failed
17 to diagnose and treat a particular condition, the plaintiff
18 must prove -- and all of this is by the greater weight of
19 the evidence -- that the defendant's negligent failure to
20 discover and treat the disease or the condition from which
21 the plaintiff suffers most probably caused the plaintiff's
22 damages. However, a mistaken diagnosis without there being
23 proof of the violation of the standard of care will not
24 support a verdict for the plaintiff.

25 Ladies and gentlemen, further a patient who is

1 treated by a doctor is entitled to a careful evaluation.

2 The evaluation should be made with the diligence and
3 methods of diagnosis that are generally accepted in
4 practice of doctors of ordinary learning, judgment, and
5 skill acting under the same or similar circumstances.

6 Now, in order to prove that the defendant was
7 negligent, the plaintiff must prove that the patient's
8 physical condition required a careful doctor to investigate
9 further before continuing a course of treatment or care;
10 and that the defendant did not make this investigation and
11 that as a direct and proximate result of that failure to
12 investigate, the patient received improper treatment or
13 care from which the patient suffered injury.

14 Now, I've talked to you about the things so far
15 that the plaintiffs have proven, the standard of care, the
16 breach of the standard of care. The plaintiff must also
17 prove by the greater weight of the evidence that the
18 defendant's negligence proximately caused the plaintiff's
19 damages.

20 Now, proximate cause, that's a legal term.
21 Proximate cause is something that produces a natural chain
22 of events, which in the end they bring about the injury or
23 damages. Proximate cause is the direct cause of the injury
24 or damage. And to prove that the defendant's negligence
25 proximately caused damage, the plaintiff must first prove

1 that the injury or damage would not have occurred, but for
2 the defendant's negligence.

3 The defendant -- the plaintiff must also prove that
4 the injury occurred as a natural and probable consequence
5 of the defendant's negligence. And the plaintiff must
6 prove that some injury from that negligence was
7 foreseeable, but does not have to prove that the particular
8 injury that occurred was foreseeable. However, ladies and
9 gentlemen, the defendant cannot be held responsible for
10 something that could not be expected to happen.

11 Now, proximate cause does not mean the only cause.
12 There may be more than one proximate cause of a plaintiff's
13 injury or damage. And the defendant's actions can be a
14 proximate cause of the plaintiff's injury if it was at
15 least one of the direct incurring causes of the injury.

16 Now, ladies and gentlemen, where the cause of a
17 plaintiff's damages or injury -- I use those terms
18 interchangeably -- where the cause of the plaintiff's
19 injury or damage may be as reasonably attributed to an act
20 for which a defendant is not responsible as to one for
21 which the defendant is responsible, the plaintiff has
22 failed to carry the burden of establishing that the damages
23 sustained were proximately caused by that defendant's
24 negligence. And whether the plaintiff has proven that his
25 or her damages were the proximate result of some conduct of

1 the defendant, that can't be left to speculation, surmise,
2 or conjecture as I previously have charged you.

3 Now, I've told you, ladies and gentlemen, that the
4 plaintiff has to prove standard of care, a breach of the
5 standard of care and proximate cause between that breach
6 and damages.

7 Now, I'm going to talk to you about damages. If
8 you decide that a plaintiff is entitled to a verdict, your
9 next step would be to decide how much money you should
10 award the plaintiff. Actual damages, that is also,
11 obviously a legal term. Actual damages are also called
12 compensatory damages. That's because actual damages are
13 intended to compensate a plaintiff for the plaintiff's
14 injury or loss or damages and to put the plaintiff as near
15 as possible in the same position that the plaintiff was in
16 before the events occurred. In other words actual damages
17 are the actual losses and expenses which the plaintiff has
18 suffered because of the defendant's negligence.

19 Now, in the context, ladies and gentlemen, of a
20 case in which a plaintiff claims personal injury, or claims
21 a personal injury that has been proximately caused by a
22 defendant's negligence, actual damages fall into two
23 general categories, and these are called economic damages
24 and noneconomic damages.

25 Now, ladies and gentlemen, economic damages means

1 pecuniary damages arising from medical expenses and medical
2 care, rehabilitation services, loss of earnings and earning
3 capacity, loss of income and claims for loss of spousal
4 services.

5 Now, ladies and gentlemen, noneconomic damages
6 means nonpecuniary damages arising from pain and suffering,
7 inconvenience, physical impairment, disfigurement, mental
8 anguish, emotional distress, loss of society and
9 companionship, loss of consortium and humiliation or other
10 nonpecuniary damages and any other theory of damages,
11 including, but not limited to fear of loss, illness or
12 injury.

13 So those are the two general categories of actual
14 damages. Whatever your award of actual damages, if any, in
15 these cases, that award may not be based upon speculation
16 or conjecture or guesswork.

17 Now, with regard to actual damages, the plaintiff
18 must prove that any medical expenses caused by the injury
19 were necessary and reasonable in amount.

20 Now, I'll get more specific in just a moment, but
21 actual damages for a plaintiff who has been physically
22 injured include pain and suffering, mental anguish,
23 impairment of health or physical condition, disfigurement,
24 lost wages, and reduced earning capacity for the future.

25 In determining the amount of compensation for

1 personal injuries, it's proper for you to consider past and
2 present aspects of the injury and that would include
3 physical and mental pain and suffering, the expenses
4 incurred for necessary medical treatment, loss of time and
5 income from work and also impairment and the ability to
6 learn -- excuse me the ability to work and earn a
7 livelihood, loss of enjoyment of life and any other losses
8 which are reflected by the nature and character of the
9 injuries.

10 The injured party may also recover from those
11 future damages that are reasonably sure to result from the
12 injuries and that's because the principal underlying
13 compensation for damages is that only one action can be
14 brought and only one recovery had. It's proper to include
15 in any estimate of future damages, compensation for those
16 things which will with reasonable certainty result.

17 All right. Now, ladies and gentlemen, we're going
18 to talk more specifically about some things. Pain and
19 suffering. Pain and suffering compensates a plaintiff for
20 physical discomfort and emotional response to the sensation
21 of pain caused by the injury itself.

22 Now, there's no definite standard by which to
23 compensate a plaintiff for pain and suffering. In other
24 words, with regard to pain and suffering, and some other
25 things that I will talk about, you can't go to Food Lion

1 and buy a pound of pain and suffering. It doesn't have a
2 market price. You have the authority to determine the
3 amount, if any, to be allowed within your actual damage
4 award for pain and suffering. Using your calm and
5 reasonable judgment to ensure that the damages are just and
6 reasonable in light of the evidence presented in this case.

7 Also, I mentioned, ladies and gentlemen, loss of
8 enjoyment of life. Loss an enjoyment of life or damages
9 for loss of enjoyment of life compensates a plaintiff for
10 limitations on the plaintiff's ability to participate in
11 and derive pleasure from the normal activities of daily
12 life: Mental suffering, apprehension, shock, fright,
13 emotional upset, humiliation, and anxiety, either expected
14 for the future or present now, can be properly considered
15 as an element of damages. As is the case with pain and
16 suffering and loss of enjoyment of life, ladies and
17 gentlemen, the amount of damages for mental suffering
18 cannot be actually measured, but the existence of and any
19 dollar amount for mental suffering, loss of enjoyment of
20 life or pain and suffering cannot be based on speculation
21 or guesswork on your part.

22 Now, ladies and gentlemen, the loss of, or the
23 impairment of earning capacity resulting from injuries to
24 the plaintiff as a proximate result of a defendant's
25 negligence is a proper element of damages. In determining

1 the amount of damages due to a plaintiff for loss or
2 impairment of earning capacity, you should consider the
3 following: The loss of earning power, and that requires
4 you to consider all matters that relate to the issue of any
5 impairment. Also consider the effect of which the
6 impairment will have on the plaintiff's capacity to work;
7 the extent to which the impairment will impair the
8 plaintiff's earning capacity; and also the present value of
9 all losses due to the plaintiff's impaired earning power;
10 and the physical pain and suffering as reasonably certain
11 will result in the future from the injuries to the
12 plaintiff; and also taking into account the evidence of
13 what the plaintiff had previously earned when employed in
14 the past.

15 Now, ladies and gentlemen, in awarding damages for
16 loss or impairment of earning capacity, a plaintiff may
17 also recover for the loss or decrease of earning capacity
18 during her entire expectancy of life. And in determining
19 the loss of earning capacity, which may result in the
20 future, the fact that the plaintiff is making the same or
21 more since the injury is only one factor to consider.

22 Now, I'll get into this in just a few minutes, but
23 if you determine that the plaintiff is entitled to damages
24 for impairment of earning capacity, you must decide the
25 amount of damages using the life expectancy tables as a

1 guide.

2 Now, ladies and gentlemen, if you find that a
3 plaintiff has suffered permanent injury or permanent damage
4 as a result of the defendant's negligence, you must then
5 decide how, if at all, that injury will affect the rest of
6 that plaintiff's life. A person's life expectancy is
7 determined by life expectancy tables, which are a part of
8 the laws of this state. And that life expectancy table is
9 only an estimate of the average, probable, remaining length
10 of all persons in our state, given sex and given age.

11 The plaintiff, Doris Faye Atkinson, is a
12 65-year-old female, with a life expectancy, according to
13 those tables of 20.12 years. And that fact is to be
14 considered by you along with any other factors and the
15 circumstances in evidence that bear on her life expectancy,
16 including her occupation, habits, and health at the time of
17 the events complained of. And you determine the amount of
18 damages, if any to be awarded to her.

19 Now, ladies and gentlemen, as I mentioned to you
20 earlier, a plaintiff is never entitled to recover
21 speculative or conjectural damages. If you find a
22 plaintiff is entitled to a verdict for actual damages, your
23 verdict should include an amount to cover any past,
24 present, and future damages proven to you by the greater
25 weight of the evidence to have been proximately caused by

1 the defendant's negligence. Any future damages must be
2 reasonably certain to occur in the future as a result of
3 the defendant's negligence.

4 Actual damages need not be proven to a mathematical
5 certainty or be based on evidence of the precise amount of
6 damage the plaintiff has suffered. Instead, the evidence
7 must allow you to determine what amount the damages is
8 fair, just, and reasonable. Any part of your actual damage
9 award that's based on what you think is future damages,
10 those must be reduced to their present value.

11 Now, ladies and gentlemen, the plaintiff, William
12 E. Atkinson Jr., claims loss of consortium arising from the
13 negligence of the defendant, Dr. Williams. The
14 companionship and society of a spouse are not articles of
15 commerce that can be weighed or measured or bought or sold.
16 No expert is competent to testify to their value. The
17 consideration in which they are given is not monetary. So
18 the plaintiff is entitled to compensation in money for
19 their loss, as long as that loss has arisen as a proximate
20 result of a defendant's negligence. The amount of
21 compensation is to be determined by you, not from evidence
22 of value, but from your own observations, experience, and
23 knowledge, conscientiously applied to the facts and
24 circumstances of this case.

25 The plaintiff -- a plaintiff making a loss of

1 consortium claim is entitled to recover the value of those
2 services of his spouse which have been proven by a greater
3 weight of the evidence to have been lost, including the
4 loss of her society and companionship in the home. Now,
5 ladies and gentlemen, punitive damages, which I'll cover in
6 a moment are not recoverable in a loss of consortium
7 action.

8 Now, ladies and gentlemen, with regard to the claim
9 of Doris Faye Atkinson, if you award her actual damages,
10 you may also consider an award of punitive damages. As I
11 mentioned to you earlier, actual damages are intended to
12 compensate a plaintiff for actual loss that has been
13 sustained as a result -- a proximate result of a
14 defendant's negligence. Punitive damages are intended to
15 punish a defendant and to prevent the defendant and others
16 from committing similar acts in the future. Punitive
17 damages can only be awarded when the conduct of the
18 defendant has been something more than mere negligence or
19 carelessness.

20 The evidence must establish that the defendant's
21 actions were reckless, willful, and wanton, meaning that
22 there was a conscious failure to exercise due care or a
23 conscious indifference to the rights and safety of others,
24 or a reckless disregard thereof. If you find that the
25 defendant's conduct was reckless, willful, or wanton, you

1 may award the plaintiff punitive damages.

2 Now, I mentioned to you earlier that the standard
3 of care, the violation, the damages -- actual damages, and
4 the proximate cause have to be proven by the greater weight
5 of the evidence. To support an award of punitive damages,
6 the plaintiff must prove by clear and convincing evidence
7 that the conduct complained of was reckless, willful and
8 wanton. That is the conduct included as consciousness of
9 wrongdoing at the time of the conduct. In other words,
10 that the person was not only careless or negligent, but was
11 aware that he was being careless or negligent at the time.

12 Now, within the context of this burden of proof, by
13 clear and convincing evidence, clear and convincing
14 evidence is more than just a preponderance or the greater
15 weight of the evidence, which only requires proof that
16 persuades you that a claim is more likely true than not.
17 On the other hand, clear and convincing proof is not a high
18 standard in a criminal case, which is beyond a reasonable
19 doubt. Clear and convincing proof leaves no substantial
20 doubt in your mind. It means that the evidence is not
21 ambiguous, doubtful, equivocal, or contradictory. The word
22 convincing in the context of clear and convincing means
23 persuading by proof or argument or causing one to believe
24 in the truth of what is asserted. Clear and convincing
25 proof establishes in your mind not only that the fact is

1 probable, but that it is highly probable.

2 Now, ladies and gentlemen before awarding any
3 punitive damages, first of all, you must have awarded
4 actual damages. In other words, you cannot award punitive
5 damages unless you have also awarded actual damages.
6 Before awarding punitive damages, you must consider and
7 weigh four elements which may be pertinent to the facts of
8 this case.

9 You must first consider the relationship between
10 any punitive damage award and the harm caused. Any
11 punitive damages imposed should take into account the
12 reprehensibility of the defendant's conduct, the harm
13 caused, the defendant's awareness of the conduct,
14 wantonness, duration of the conduct, and any concealment of
15 the conduct. Any punitive damages imposed should bear a
16 relationship to the nature and extent of the conduct and
17 the harm caused and should also bear a relationship to
18 the -- any actual damage award made by you.

19 Second, any punitive damages awarded should take
20 into account as a mitigating factor any other penalty that
21 may have been imposed or which may be imposed for the
22 conduct involved. Next, you should take into account
23 whether the award of and the amount of any punitive damages
24 may deprive the defendant of any profits derived from any
25 improper conduct and whether any ill-gotten profits should

1 be awarded to the plaintiff.

2 Finally, in the award, punitive damages must be
3 limited to punishment and may not effect economic
4 bankruptcy. In that regard, the defendant's ability to pay
5 any punitive damage award should be considered.

6 Now, ladies and gentlemen, returning back to the
7 discussion about the differences between negligence and --
8 the difference between negligence and recklessness,
9 willfulness, and wantonness, I want to talk to you about
10 those things again. In the eyes of the law, negligence is
11 carelessness. It's the failure to do something that a
12 reasonable person would have done under the circumstances
13 or it's doing something that a reasonable person would not
14 have done under the circumstances. In context of the law,
15 recklessness, as I mentioned to you, is a conscious failure
16 to exercise due care. The words willfulness and wantonness
17 basically mean the same thing, conscious failure to
18 exercise due care. The words gross negligence means the
19 failure to exercise even slight care.

20 All right. Now, ladies and gentlemen, I'm going to
21 talk to you now about the verdict form and we'll be about
22 concluded.

23 There will be two verdict forms in the case,
24 Mr. Foreman, and ladies and gentlemen. There's only one
25 case, but there's two verdict forms because there are two

1 people making claims.

2 I would like for you -- I'm instructing you to
3 complete the verdict form that has Verdict Form, Doris Faye
4 Atkinson, complete that one first. Now, you've heard what
5 I've said to you and your head may be spinning a little
6 bit, but once you go over this verdict form, you probably
7 will be able to remember what I said and apply it to these
8 questions.

9 Question number one on this verdict form says: Was
10 the defendant, Dr. Williams negligent. And of course, you
11 recall the plaintiffs have to prove that by the greater
12 weight of the evidence. There are two answers. You can
13 probably guess what they are. Yes or no.

14 Now, the verdict form says this: Was the
15 defendant, Dr. Williams negligent. When you're answering
16 that question, remember all that goes into that. Has the
17 standard of care been proven, has it been proven to have
18 been breached and those are the things by the greater
19 weight of the evidence.

20 If your answer is yes, you go to question number
21 two. If your answer is no, and this is on the verdict
22 form, you stop and you deliberate no further.

23 Mr. Foreman, if you would go down to the bottom,
24 sign the verdict form, date it and move to the next one.
25 And, by the way, your verdicts have to be unanimous. That

1 means everybody's got to agree. This is not ten to two,
2 nine to three, seven to five, your verdict has to be twelve
3 agree, all twelve.

4 All right. If you answer the question yes that
5 Dr. -- was the Dr. negligent, you go to question two. Did
6 his negligence proximately cause actual damages to Doris
7 Faye Atkinson. Of course, she will have to have proven
8 that to you by the greater weight of the evidence. There
9 are two answers there. Yes or no.

10 If the answer is no, you deliberate no further.
11 You sign and date the verdict form and move onto the next
12 one.

13 If your answer is yes, you go to question three:
14 We find the total amount of actual damages proximately
15 caused by the defendant's negligence is. And you put in
16 numbers, the amount of actual damages that she sustained in
17 your view as a proximate result of the defendant's
18 negligence.

19 Now, a subpart of that question on the same page,
20 of this amount -- in other words in the amount you entered
21 in that blank right above: Of this amount, blank dollars,
22 consist of economic damages and blank dollars consist of
23 the noneconomic damages. And as you recall, hopefully --
24 you'll recall, hopefully what my explanation as to those
25 things.

1 The fourth question: Was the defendant, Dr.
2 Williams grossly negligent, willful, wanton or reckless.
3 Those are the things that have to be proven to you by clear
4 and convincing evidence, as you recall from my charge.
5 There are two answers to that question. Yes or no. If the
6 answer is no, you would go to question -- I've got a
7 misprint here and I'll correct it. If the answer is no,
8 you will go to question -- well, you'll be concluded.

9 If the answer is yes, you go to the next question,
10 which is: Did this gross negligence, willfulness,
11 wantonness, or recklessness proximately cause the
12 plaintiff's noneconomic damages. And those are the things,
13 including but not limited to, pain and suffering, mental
14 anguish, loss of enjoyment of life, and things of that
15 nature.

16 Now, ladies and gentlemen, the last question on the
17 verdict form is: We award the sum of blank dollars,
18 punitive damages against the defendants. And as you
19 remember, you may not award punitive damages unless you
20 award actual damages and you may not award punitive damages
21 unless the plaintiff has proven by clear and convincing
22 evidence that the defendant was not only negligent, but was
23 also reckless, willful and wanton.

24 Now, that takes care of that verdict form.

25 The verdict form of William E. Atkinson Jr. has

1 three questions on it. Up at the top, it says: Please do
2 not complete this form until you have completed the verdict
3 form for Doris Faye Atkinson.

4 It then says, if your answer to question one on
5 Doris Faye Atkinson's verdict form was no, in other words
6 that's the question about whether or not Dr. Williams was
7 negligent, if the answer on her form is no, then you will
8 not address any questions on this form, you'll simply date
9 it, sign it and then that will conclude your deliberations.

10 If your answer to question one on Doris Faye
11 Atkinson's verdict form was yes, you will answer question
12 one: Did the defendant, Dr. Williams' negligence
13 proximately cause actual damages to William E. Atkinson,
14 Jr., yes or no. That has to be established by the greater
15 weight of the evidence.

16 And then number two: We find that the total amount
17 of actual damages proximately caused by the negligence of
18 Dr. Williams is blank dollars.

19 And number three: If you answer yes to the
20 question four on Ms. Atkinson's verdict form about gross
21 negligence, recklessness, willfulness, or wantonness, then
22 you would answer this last question, did the gross
23 negligence, recklessness, willfulness, or wantonness of the
24 defendant, Dr. Williams, proximate the actual damages of
25 William E. Atkinson Jr.

1 Now, that may sound like a whole lot of hullabaloo
2 that I just read, but when you get these verdict forms and
3 you go over them, I think it will be very clear.

4 Now, I also referenced these verdict forms as Doris
5 Faye Atkinson's verdict and William E. Atkinson's verdict
6 form. I did that to explain which plaintiff I was talking
7 about. They're also Dr. Williams verdict forms -- there
8 also South Carolina Oncology Associates verdict forms. I
9 did not mean -- I don't want you to think that anything I
10 meant that they are not guilty. They're their verdict
11 forms too.

12 Now, you have been selected to be fair and
13 impartial jurors in this case. The plaintiffs expect and
14 are entitled to a fair and impartial verdict at your hand.
15 The defendants expect and they are entitled to a fair and
16 impartial verdict at your hand. Your job is just getting
17 ready to start. You've paid attention. You have taken in
18 all of the evidence in this case and now it's the time in
19 just a few minutes for you to begin reaching your decisions
20 in this case that will result in verdicts that will speak
21 the truth. That's what your verdict has to do.

22 Now, Mr. Foreman, you don't have any greater
23 authority in that jury room over anybody else. This is not
24 a situation where Robert's Rules of Order applies and the
25 head of the table gets to decide when a certain topic has

1 been debated enough. That's not your right. If someone
2 wants to discuss these issues, as long as that person wants
3 to discuss them, you don't have any authority to cut off
4 the debate. If someone simply wants to make his or her
5 decision known as to a particular issue or question, no one
6 has the right to insist upon complete expansion from that
7 juror, but your job is, Mr. Foreman, to make sure that the
8 verdicts are unanimous. Again, that means everybody must
9 agree. I think that you will give the issues in the case
10 and all of the questions on this verdict form the complete
11 and honest discussion that they deserve. That's what these
12 parties do deserve.

13 Now, the next order of business, ladies and
14 gentlemen -- one final thing before I let you go back to
15 your jury room, if you have any questions during the course
16 of your deliberations, there will be a notepad in your jury
17 room. Write the question down and sign the question,
18 Mr. Foreman, date it, tap on the door and let the bailiff
19 know you have a question.

20 Now, the law dictates if and how I can respond to
21 your question, and we'll approach those as they come in
22 case you do have any questions. There will be no other
23 evidence introduced. The evidence that's been produced is
24 all of the evidence that you have. Again, if you do have
25 any questions, you simply let us know.

1 Now, once you have completed these verdict forms,
2 you make sure they are completed, sign and date it, and you
3 tap on the door and you let the bailiffs know that you have
4 reached verdicts. I've had juries before, actually as an
5 attorney, where the jury just sat back there for hours and
6 we couldn't figure out why; and finally the bailiff, at the
7 instruction of the judge, tapped on the door and said,
8 Y'all need anything and they said, no, we finished a long
9 time ago, we just didn't know what to do. So when you have
10 finished, sounds simple, but complete the verdict forms,
11 knock on the door, and let the bailiffs know you are
12 concluded.

13 If somebody needs to use the phone, you've got to
14 get permission to come out of the jury room first. And if
15 somebody does come out, you have to stop until that person
16 comes back. Also, I know that the restrooms are
17 immediately adjacent to the deliberation area, if someone
18 does excuse himself or herself to go to the restroom, wait
19 for that person to come back before you resume your
20 conversations.

21 Now, ladies and gentlemen, under the rules that we
22 have, the law requires me to discuss with the attorneys
23 whether or not I said something wrong in my charge or
24 whether or not I left something out. That is -- in a
25 moment they're going to have that opportunity. So having

1 said that; you can go to your jury room, but you can't
2 start talking yet. Your signal to deliberate is when the
3 bailiff comes to the door with all the exhibits and tells
4 you that you can begin.

5 All right. Thank you for your time.

6 (WHEREUPON the jury left the courtroom at 1:24
7 p.m.)

8 THE COURT: All right. First of all, Mr. Corbin,
9 do you have any objections or additions to the charge? Not
10 the verdict form, but the charge.

11 MR. CORBIN: None, Your Honor.

12 THE COURT: All right. Mr. McDow?

13 MR. MCDOW: Did you charge my number eight? I got
14 lost in there flipping through pages. About arbitrarily
15 setting up a standard. You may have.

16 THE COURT: Yes, I did.

17 MR. MCDOW: Okay.

18 THE COURT: I did charge that.

19 MR. MCDOW: Okay.

20 THE COURT: I remember using the word arbitrarily.
21 And let me --

22 MR. MCDOW: As I said I was flipping pages, that's
23 all.

24 THE COURT: I will tell you where it was. It was
25 right after I charged the jury about breach of the standard

1 of care. It was at the end of that. Right before informed
2 consent.

3 Okay. Anything else, Mr. McDow?

4 MR. MCDOW: No, sir.

5 THE COURT: I do see that I will have to -- on the
6 verdict form for Doris Atkinson, if you go to question --
7 and this is the one that I gave you right before the
8 charge, so don't get confused with the one I gave you
9 before.

10 Question number four: Was the defendant, Dr.
11 Williams, grossly negligent, willful, wanton or reckless;
12 yes or no. If no they would be finished.

13 MR. CORBIN: Yes, sir.

14 THE COURT: When I made the changes that Mr. McDow
15 asked, I didn't go in those parentheses and change those
16 numbers. So if no --

17 MR. CORBIN: Deliberate no further.

18 THE COURT: Deliberate no further.

19 MR. CORBIN: Yeah.

20 THE COURT: If yes, go to question five.

21 MR. CORBIN: Yes, sir.

22 THE COURT: Okay.

23 MR. MCDOW: (Whereupon Mr. McDow shook his head.)

24 THE COURT: I -- we all have acquaintances in the
25 legislature that -- well, I'm just not going to say it.

1 (Laughter.)

2 THE COURT: Okay. I'll -- I'll make those changes
3 and if you would use this time, if you haven't already,
4 make sure all of these exhibits are in order. The lunch
5 should be about here.

6 Is it here?

7 THE BAILIFF: Yes, sir.

8 THE COURT: All right. What you can do is go ahead
9 and start doling the lunch out, but you tell them not to
10 deliberate yet, I'll have the verdict form completed in
11 just a minute.

12 I'll say one final thing, Mr. Corbin, I know your
13 clients are not here.

14 MR. CORBIN: Yes, sir.

15 THE COURT: Mr. McDow, your client is. I don't
16 ever say this lightly. I do not say it unless I absolutely
17 mean it, the representation provided to the clients has
18 been exemplary. You know the rules, you have followed the
19 rules, you have tried your case well and your clients
20 should be very pleased. It's certainly easy -- lawyers
21 will say it's always easier to try a case against a bad
22 one. And judges will say the same thing. Y'all have done
23 an excellent job. It makes my job a lot easier and I
24 certainly do appreciate that.

25 One final thing, if your clients or anybody is

1 concerned or wants to hear any questions or a verdict, I
2 will wait a greater amount of time for the actual party to
3 be back, but anyone else, if you leave, you run the risk of
4 not hearing the question or the verdict if you aren't close
5 at hand.

6 MR. CORBIN: Yes, sir.

7 THE COURT: If the lawyers leave, please leave a
8 cell phone number with the court reporter so I can find
9 you. Okay.

10 MR. CORBIN: Yes, sir.

11 THE COURT: I'll be right back with this verdict
12 form.

13 MR. CORBIN: Thank you, Judge.

14 (WHEREUPON a recess was observed.)

15 THE COURT: Okay. Y'all want to come on up and
16 give this one more trial. It will be just the verdict form
17 for Ms. Atkinson.

18 (WHEREUPON the attorneys were looking at the
19 verdict form.)

20 THE COURT: Okay. Anything else before the jury
21 begins, Mr. Corbin?

22 MR. CORBIN: No, sir.

23 THE COURT: Mr. McDow?

24 MR. MCDOW: No, Your Honor.

25 THE COURT: All right. We'll haul in the exhibits.

1 THE BAILIFF: I will.

2 THE COURT: All right. Here are the verdict forms.

3 THE BAILIFF: Yes, sir.

4 THE COURT: And if you need somebody else to help
5 you with that evidence or not --

6 THE BAILIFF: I'll get it.

7 THE COURT: And tell them they can begin, okay?

8 THE BAILIFF: Yes, sir.

9 THE COURT: All right. And you guys want to come
10 on back.

11 (WHEREUPON the deliberations began at 1:35 p.m.)

12 (WHEREUPON it was reported to the Court that the
13 jury had a verdict at 2:50 p.m.)

14 THE COURT: All right. Mr. Corbin, Mr. McDow, I
15 understand that the jury has a verdict, is the plaintiff
16 ready?

17 MR. CORBIN: The plaintiff is ready, Your Honor.

18 THE COURT: Defendant ready?

19 MR. MCDOW: Yes, sir.

20 THE COURT: Okay. I'll take a look at the forms,
21 if there's any irregularity, I'll just have to send the
22 jury out and we'll figure out the best way to go. I trust
23 they've completed them as I instructed.

24 Okay. Bring in the jury.

25 (WHEREUPON the jury entered the courtroom at 3:05

1 p.m.)

2 **VERDICT**

3 **THE BAILIFF:** Jury is seated, Your Honor.

4 **THE COURT:** All right. Thank you, sir.

5 All right. Mr. Foreman, has the jury reached a
6 verdict?

7 **THE FOREMAN:** Yes, we have.

8 **THE COURT:** All right. And are the verdicts
9 unanimous?

10 **THE FOREMAN:** Yes, sir, they are.

11 **THE COURT:** All right. You can hand the forms to
12 the bailiff. Thank you, sir.

13 (WHEREUPON the Court is looking at the verdict
14 forms).

15 **THE COURT:** All right. If you would, please,
16 publish the verdict form, Doris Faye Atkinson first. Okay.

17 **THE CLERK:** Yes, sir.

18 State of South Carolina, County of Richland, Civil
19 Action Number 2010-CP-40-5705, Doris F. Atkinson and
20 William E. Atkinson versus James A. Williams, Jr., M.D. and
21 South Carolina Oncology Associates, in regards to Doris
22 Faye Atkinson, was the defendant, Dr. Williams negligent?
23 No.

24 This is signed by the Foreman, Richard Levick, No.
25 151, on October 12th, 2012.

1 In regard to William E. Atkinson, Jr. --

2 THE COURT: The verdict form is just signed,
3 correct?

4 THE CLERK: Yes, sir. It's just signed by the
5 Foreperson, Richard Levick, No. 151, October 12, 2012.

6 THE COURT: All right.

7 All right. Ladies and gentlemen of the jury, the
8 verdicts as recited by the clerk, as recorded on the
9 verdict form, if those are your verdicts, or were your
10 verdicts and are still your verdicts, please raise your
11 right hand.

12 (WHEREUPON all jurors hands were raised.)

13 THE COURT: All right. The record will show that
14 all twelve jurors did raise their right hands. Thank you.

15 All right. Mr. Corbin, anything before the jury is
16 released?

17 MR. CORBIN: No, sir.

18 THE COURT: All right. Anything, Mr. McDow, before
19 the jury is released?

20 MR. MCDOW: No, sir.

21 THE COURT: All right. Ladies and gentlemen, that
22 does conclude your service. I want to talk to you for just
23 a moment about a couple of things.

24 First of all, no one can quarrel with your verdict.
25 And no one should. You paid very close attention. I know

1 this was a tough job for you and you've been called upon to
2 satisfy your civic duty and you've done that. Having said
3 that, I've told you all week that you can't talk about this
4 case, you can't talk about this case. Now, you can talk
5 about it all you want. However, this might be the last
6 thing that you want to talk about. If you want to talk
7 about it, you can. Someone that you see out on the street
8 or at the mall or whatever may say, Hey, tell me about that
9 case. What you think, what you think. If you want to talk
10 about it, that's fine. If you don't, tell the person that.
11 If that person persists, you've -- please, if you would,
12 contact the clerk of court's office and they will notify me
13 and I'll deal with it because nobody should take you to
14 task for anything about your jury service.

15 But you are released. As you know it's Friday. I
16 think they tried one case --

17 Where on the second floor?

18 **THE CLERK:** Yes, sir.

19 **THE COURT:** Upstairs. They tried another case this
20 week that used a jury and perhaps another one, so the jury
21 pool has been discharged and you are too. If you need a
22 work excuse --

23 Madame Clerk, what do they do?

24 **THE CLERK:** I have those.

25 **THE COURT:** She has a work excuse for you. If you

1 have anything in the jury room, you can go retrieve that.
2 The notes that you took, they'll be shredded or burned.
3 They won't be left here after for any of the litigants to
4 look at. And I don't look at them because one time a juror
5 drew a picture of me. (Laughter)

6 But in any event, you are released. Does anyone
7 have any questions about your jury service or anything
8 else, I will be here for the rest of the afternoon and you
9 can let a bailiff know and I'll answer any questions that
10 you have about the court system, things of that nature.

11 Thank you for the attention that you've paid and
12 again you are discharged. Thank you very much.

13 (WHEREUPON the jury left the courtroom at 3:10
14 p.m.)

15 **THE COURT:** All right. Mr. Corbin, if you would
16 like 10 days, I'll certainly be glad to accommodate you in
17 that regard.

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

19 **THE COURT:** The only thing I do not do is count the
20 10 days. I leave that up to you.

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

22 **THE COURT:** I'll give you 10 days to file any
23 post-trial motions. If you would do one thing to
24 accommodate me, of course, file it timely, serve it upon
25 Mr. McDow, and please send me a copy because if you just

1 file it here, I'll never see it.

2 MR. CORBIN: Yes, sir.

3 THE COURT: You can send it to me at my regular
4 address in Sumter.

5 MR. CORBIN: Will do.

6 THE COURT: Again, I think both sides were very
7 ably represented. I appreciate that and I would have hoped
8 it would be a good idea if other attorneys were here to
9 watch, those young guys, but I think you did an excellent
10 job.

11 Good luck to you, Doctor.

12 And please give my regards to Mr. And Ms. Atkinson,
13 Mr. Corbin.

14 MR. CORBIN: Yes.

15 THE COURT: Just give my regards to your clients.
16 I certainly do wish them luck and I wish you luck also.

17 MR. MCDOW: Thank you.

18 THE COURT: Thank you.

19

20 * * * * * END OF TRANSCRIPT * * * * *

21

22

23

24

25

1 STATE OF SOUTH CAROLINA)
2 COUNTY OF AIKEN) CERTIFICATE OF TRANSCRIPTION
3
4
5

6 I, THE UNDERSIGNED, Brenda J. Sigwald, do hereby
7 certify that I transcribed the proceedings in the captioned
8 case that were reported by Crystal Holmes, Circuit Court
9 Reporter for the State of South Carolina, in the Court of
10 Common Pleas in and for the State of South Carolina on the
11 8th through the 12th days of October, 2012.

12 I FURTHER CERTIFY that the foregoing pages,
13 numbered 1 through 1064, constitute a true, accurate and
14 complete transcript of said hearing.

15 I FURTHER CERTIFY that I am neither kin, counsel,
16 nor of interest to any party hereto.

17 IN WITNESS WHEREOF, I have hereunto set my hand and
18 seal at Aiken County, this 30th day of July, 2012.
19
20

21 _____
22 Brenda J. Sigwald,
23 Court Reporter and
24 Notary Public for the
25 State of South Carolina
My commission expires
January 4, 2020

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admitting Physician: Williams MD, James A

Age: 59 years

Admit Time: 2:12:00 AM

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Date: 6/25/2007

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Williams MD, James A

Performed Date/Time:

4/25/2007 11:30:00 AM

Authenticated By:

Williams MD, James A

Authenticated Date/Time:

5/2/2007 5:43:44 AM

Electronic Signature(s) Below:

Williams MD, James A

Signed Date/Time:

5/2/2007 5:43:44 AM

Operative Report

DATE OF OPERATION: 04/25/2007

DATE OF SURGERY: 4/25/07.

PREOPERATIVE DIAGNOSES:

1. Pelvic mass.
2. Previous laparotomy times several.

POSTOPERATIVE DIAGNOSES:

1. Pelvic mass.
2. Previous laparotomy times several.
3. Multiple abdominal adhesions.

OPERATIVE PROCEDURE:

1. Bilateral salpingo-oophorectomy.
2. Extensive adhesiolysis, occupying greater than 2/3 of the operative time.
3. Small bowel resection.
4. On-Q pain catheter insertion.

SURGEON: James A Williams, Jr. MD.

ANESTHESIA: General.

FINDINGS: The patient had 2 previous laparotomies for bowel disease. This resulted in extensive adhesions, not only interlooped but to the anterior abdominal wall, requiring extensive dissection, occupying about 2-1/2 hours of this 3-1/2 hour procedure. Benign serous cystadenoma of the pelvis noted. Left ovary with adhesions but otherwise unremarkable.

ESTIMATED BLOOD LOSS: 200 cc.

COMPLICATIONS: None.

DISPOSITION: To recovery room in stable condition.

DESCRIPTION OF OPERATION: The patient was taken to the operating suite and after adequate anesthesia, AV foot pumps, and a Foley catheter were placed, she was prepped and draped in usual sterile fashion. We did a

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Page 14 of 978

0991

Print Date/Time 7/12/2010 4:00 PM

PHR 0022

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

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Admitting Physician: Williams MD, James A

Age: 59 years

Discharge Date: 6/25/2007

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Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

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Authenticated By:

Authenticated Date/Time:

Williams MD, James A

4/25/2007 11:30:00 AM

Williams MD, James A

5/2/2007 5:43:44 AM

Electronic Signature(s) Below:

Signed Date/Time:

Williams MD, James A

5/2/2007 5:43:44 AM

time out, and the patient had been given antibiotics.

The previous incision was excised, making a large vertical midline skin incision. The incision was taken down to the fascia which was divided with the knife. Upon entering the abdominal cavity, massive adhesions were noted. Beginning at the upper abdomen, adhesions to the anterior abdominal wall were taken down sharply. An enterotomy was encountered and a large mass of adhesions adhered to the anterior abdominal wall. All adhesions of the anterior abdominal wall were lysed. The ascending, transverse, and descending colon were obviously noted. All interloop adhesions were lysed, beginning at the ligament of Treitz to the terminal ileum, except for an area where the enterotomy had been encountered, and this was resected first by defining the proximal distal margin, transecting with a GIA green anastomosing, taking down the mesentery, removing the bowel. Excellent tension-free anastomosis was accomplished.

Dissection of the pelvis unroofed a large cyst coming from the right adnexa. The ureter was clearly identified. The IP ligament was separated and skeletonized, clamped, cut and tied with 2-0 Ethibond tie. Using careful circumferential dissection, keeping the ureter under direct visualization, the right ovary was removed intact, sent for frozen section, returning as a benign serous cystadenoma. The left IP ligament was identified, separated from the ureter, clamped, cut and tied with 2-0 Ethibond tie and traced down the pelvis where a cystic solidarity of ovary on the left side was noted. This was completely resected with its surrounding peritoneum, keeping the ureter separate and distantly intact.

Additional colon adhesions were lysed, showing a very redundant colon. The pelvis was otherwise normal. The bowel was run from the ligament of Treitz to the terminal ileum and was excellent and normal. The small bowel resection and anastomosis site was clean. The upper abdomen was clean. The liver edge was clean. The diaphragms were clean. The pelvis, in order to reduce the adhesions, some Seprafilm was placed. A #10 flat Jackson-Pratt was placed in the deep pelvis.

The skin and subcutaneous tissues were mobilized off the fascia to allow tension-free skin closure. After closing the fascia with a running #1 nylon and placing Seprafilm to reduce adhesions, 19 Blake drains were placed over the fascia bilaterally. Some bleeding was noted from the left drain insertion site. This was controlled with a hemostatic () suture of 3-0 Vicryl. The skin was closed with skin clips. All needle, lap, and instrument counts were correct x3. The

Client Name: Palmetto Health Richland

Client Address: 5 Richland Medical Park

Columbia, SC 29203

Admitting Physician: Williams MD, James A

Attending Physician: Williams MD, James A

Patient Name: ATKINSON, DORIS P

Patient Address: 2251 FOREST BREEZE DR

HARTSVILLE, SOUTH CAROLINA 29550

Age: 59 years

Date of Birth: 11/3/1947

MRN: R013367701

FIN: R0710700924

Financial Class: Blue Cross PPC

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Discharge Date: 6/25/2007

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Williams MD, James A

Electronic Signature(s) Below:

Williams MD, James A

Performed Date/Time:

4/25/2007 11:30:00 AM

Signed Date/Time:

5/2/2007 5:43:44 AM

Authenticated By:

Williams MD, James A

Authenticated Date/Time:

5/2/2007 5:43:44 AM

patient was awakened, taken to the recovery room in stable condition.

JJW:hs

D: 04/25/2007 11:09 A T: 04/25/2007 11:30 A

Job #: 000633203 T Job #: 134930 Doc #: 1014317

cc:: James A Williams, Jr., MD

Electronically Signed & Verified on 05/02/2007 05:43

by James A Williams MD

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Admitting Physician: Williams MD, James A

Age: 59 years

Discharge Date: 6/25/2007

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

SURGERY DOCUMENTS

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

Last Modified By:

Wise RN, Regina
04/25/07 11:29:17

etc. Removed

SN - R - IO - Patient Positioning

Pre-Care Text:

Patient will be free from signs and symptoms of injury related to positioning.

Table
Right Arm Position
Arm

Entry 1
OR Table Electric
Extended on Padded Arm

Body Position
Left Arm Position

Supine
Extended on Padded

Right Leg Position
Positioning Aids

Board
Extended
Arm Board, Arm Strap

Left Leg Position
Safety and Comfort
Statements

Board
Extended
Anesthesia Personnel
Assisted with Posit,
Blanket, Foot Pumps
Applied and

Activated,

Secured With Safety
Strap, Warming

Blanket,

Surgeon Checked
Patient's Position

Last Modified By:

Wise RN, Regina
04/25/07 07:53:38

Post-Care Text:

Patient's skin is intact. Neuromuscular and cardiovascular status are maintained. Patient's skin condition, other than the incision, is unchanged between admission and discharge from OR.

SN - R - IO - Site Prep

Pre-Care Text:

Patient will be free from signs and symptoms of chemical injury.

Skin dry and intact
at surgical site
pre-op?

Entry 1
Yes

Hair Removal
Methods

No Hair Removal
Indicated

Skin Prep
Prep Site
Prep By

ABDOMEN TO UPPER THIGHS

Prep Agents

CHG, Zephiran

Last Modified By:

Wise RN, Regina
04/25/07 07:53:54

Post-Care Text:

Patient's skin is intact and free from redness, rash, abrasion, and/or blistering.

SN - R - IO - Specimens and Cultures

Pre-Care Text:

Patient will be free from injury related to obtaining surgical specimens.

Specimen Sent?
Specimen
Tests Ordered
Time Sent

Entry 1
Yes
RIGHT TUBE & OVARY
Frozen

Entry 2
Yes
LEFT TUBE & OVARY
Routine/Formalin

Last Modified By:

Wise RN, Regina
04/25/07 11:29:48

Wise RN, Regina
04/25/07 11:29:48

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

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Age: 59 years

Admit Time: 2:12:00 AM

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Date: 6/25/2007

Discharge Time: 7:11:00 PM

Pathology Reports

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

S

Date of Collection: 4/25/2007 09:56

Date of Receipt: 4/25/2007 09:56

Date Completed: 4/26/2007 11:21

Patient Name: ATKINSON, DORIS F.

MR#: 013367701

Specimen #S07-4066

Ordering Physician:

JAMES A WILLIAMS

Specimen(s) Received:

1: right tube and ovary

2: 1 tube and ovary

Clinical Information:

MASS

Final Diagnosis:

I. RIGHT ADNEXA, SALPINGO-OOPHORECTOMY:
SEROUS CYSTADENOMA OF OVARY.
UNREMARKABLE FALLOPIAN TUBE.

II. LEFT ADNEXA, SALPINGO-OOPHORECTOMY:
SEROUS CYSTADENOMA OF OVARY.
UNREMARKABLE FALLOPIAN TUBE.

JAB:jh04/26/07

***Electronically Signed Out By JACQUELINE EMERY MD ***

Frozen Diagnosis:

I. Received for frozen section labeled "right tube and ovary" is a 525 gram, 13 x 9 x 7 cm smooth, pink-white resilient mass having a cystic cut surface containing clear fluid and no excrescences. RS submitted for frozen section in one block. There is a 4.8 cm in length fallopian tube attached to the external surface. Further sectioning reveals a 2.5 cm in diameter serous cyst having a smooth internal lining. Additional sections to include tube submitted in four cassettes.

Frozen Section Diagnosis:

Right ovary: Benign serous cystoma. (JTV)

Patient Name: ATKINSON, DORIS F

Page 22 of 978

Print Date/Time 7/12/2010 4:00 PM

MRN: R013367701

0995

PHR 0030

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Admitting Physician: Williams MD, James A

Age: 59 years

Discharge Date: 6/25/2007

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

P A T H O L O G Y R E P O R T S

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

LM:krh 4-25-07

Gross Description:

II. Received in formalin labeled "left tube and ovary" is a 6.2 x 6 x 2.8 cm aggregate of tan gray membranous appearing tissue and a 2.5 cm in diameter cyst having a smooth to shaggy external surface, containing clear watery fluid and a 0.4 cm area of white excrescences. The remaining tissue has solid, yellow tan cut surface to include a 3.5 cm in length fallopian tube. Sections submitted as A-cyst, excrescences toto; B-C - solid area, fallopian tube.

LM: dr 4/25/07

Microscopic Description:

I. Permanent sections confirm the frozen section impression and demonstrate portions of fibrous cyst with attenuated serous lining. No nuclear atypia is identified. The lining contains tubal type mullerian epithelium. Portions of unremarkable ovarian parenchyma are admixed. An unremarkable fallopian tube is also seen.

II. Sections of the left adnexa demonstrate portions of benign serous cysts. Fibrous papillary excrescences are noted; however, no nuclear atypia or piling is seen. An unremarkable fallopian tube is present.

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

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Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

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Admitting Physician: Williams MD, James A

Age: 59 years

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Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Parker III MD, Harris H

Performed Date/Time:

6/3/2007 12:24:00 PM

Authenticated By:

Parker III MD, Harris H

Authenticated Date/Time:

6/23/2007 12:42:18 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:42:18 PM

Operative Report

DATE OF OPERATION: 06/03/2007

DATE OF SURGERY: 6/3/2007

OPERATIVE PROCEDURE: Exploratory celiotomy, small-bowel resection, thecal resection, vacuum-assisted closure device placement.

SURGEON: Harris Parker, MD

ASSISTANT: Dalton S. Prickett, MD

REQUESTING PHYSICIAN: S. Terry Smith, MD

IV FLUIDS: IV fluids as per anesthesia.

ESTIMATED BLOOD LOSS: Less than 100.

INDICATIONS: This is a 59-year-old female status post abdominal exploration with resection of cystadenoma and subsequent exploration, approximately 1 week prior for small-bowel obstruction with small bowel resection and closure of enterotomies. She presents now with succus from her drains, leukocytosis, and tachycardia.

FINDINGS:

1. Succus within the intraperitoneal cavity.
2. Significant intraperitoneal inflammatory process with thickened small bowel.
3. Approximately 0.5 cm to a 1 cm area of small bowel perforation in the very proximal jejunum, just distal to the ligament of Treitz.
4. Intact distal small-bowel anastomosis.
5. Small bowel perforation distal small bowel, just proximal to the anastomosis.

DESCRIPTION OF OPERATION: After informed consent was obtained, the patient was taken to the operating suite and placed supine on the operating table. After adequate induction of general anesthesia, the abdomen was prepped and draped in the usual sterile fashion. The vacuum had previously been removed. There was succus coming from the upper midline. The midline fascia was opened and approximately 2 liters of succus was evacuated from the intraperitoneal cavity. At this point, the abdomen was copiously irrigated to clear the abdomen and the abdomen explored, first starting proximally. There was fairly firm adhesions at

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FDN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Admitting Physician: Williams MD, James A

Age: 59 years

Discharge Date: 6/25/2007

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

Parker III MD, Harris H

6/3/2007 12:24:00 PM

Parker III MD, Harris H

6/23/2007 12:42:18 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:42:18 PM

this point, the inflammatory reaction. A 0.5 to 1 cm area of perforation was visualized at the root of the mesentery in the proximal jejunum with mucosa exposed. There was gross leakage from this point. The remainder of the small bowel was visualized with approximately 7 to 8 cm of small bowel remaining. The distal anastomosis was identified without evidence of leak, however, just proximal to this there was an area of leak in the antimesenteric portion of distal small bowel. This was just adjacent to the anastomosis and the cecum also appeared to be fairly indurated and somewhat darkened in appearance, although no leak was appreciated. At this point, the proximal enterotomy was addressed and oversewn using three 3-0 Lambert type sutures, full-thickness. It was similarly buttressed using adjacent mesentery. At this point the small bowel was divided using a single fire of the 75-GIA stapler just proximal to the anastomosis and similarly resected just distal to the anastomosis, however, this staple line along the cecum did not appear to be healthy given the tissue, and thus the right colon was mobilized with division of the white line of Toldt mobilized medially up to the hepatic flexure. Mobilization of the hepatic flexure and the ascending colon was divided in its midportion using a single fire of the TA stapler and passed off the field. This was a quite healthy staple line. At this point the abdomen was copiously irrigated with normal saline. Hemostasis was assured. The remainder of the bowel appeared to be viable, edematous, but without evidence of further leak identified. The liver was smooth. There was a gelatinous process noted in the left upper quadrant, this was similarly irrigated copiously with normal saline, hemostasis was assured. Once this had been appreciated, it was decided to plan a second look exploration. A bowel-bag was placed as well a vacuum-assisted closure device sponge. Sterile dressings were applied. Sponge, needle, and instrument counts were reported to be correct. The patient taken to the Post-anesthesia Care Unit in satisfactory condition.

HHP:hs

D: 06/03/2007 11:55 A T: 06/03/2007 12:24 P

Job #: 000676640 T Job #: 872047 Doc #: 1033355

cc:: Harris Parker, MD

James A Williams, Jr., MD

Electronically Signed & Verified on 06/23/2007 12:42

by Harris H Parker MD

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admitting Physician: Williams MD, James A

Age: 59 years

Admit Time: 2:12:00 AM

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Date: 6/25/2007

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

Parker III MD, Harris H

6/6/2007 8:25:00 AM

Parker III MD, Harris H

6/23/2007 12:42:00 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:42:00 PM

Operative Report

DATE OF OPERATION: 06/05/2007

DATE OF SURGERY: 6/5/07.

PREOPERATIVE DIAGNOSIS: Peritonitis.

POSTOPERATIVE DIAGNOSIS: Peritonitis.

OPERATIVE PROCEDURE: Exploratory celiotomy, gastrostomy, jejunostomy, vacuum-assisted closure device placement.

SURGEON: Harris Parker, MD.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: No observed complications.

No specimens.

General anesthesia.

INDICATIONS: This is a 59-year-old female status post exploration with known small bowel perforation. She has an open abdomen with a VAC in place.

FINDINGS: Succus with a small bowel perforation approximately 15 cm proximal to the small bowel staple line.

DESCRIPTION OF OPERATION: After informed consent was obtained, the patient was taken to the operative suite and placed supine on the table. After adequate induction of general anesthesia, the abdomen was prepped and draped in the usual sterile fashion.

After assuring adequate anesthesia and appropriate landmarks, the VAC was removed. Visualization of bilious succus in the inferior-most aspects of the wound with a small enterotomy identified approximately 10 to 15 cm proximal to the staple line. At this point, the abdomen was prepped and draped in the usual sterile fashion and was copiously irrigated with saline. Hemostasis assured. There appeared to be no further leaks appreciated. The previously-sealed proximal jejunal process appeared to be intact. This was not manipulated given there was no evidence of bile from this site. Given the thickening of the bowel, the associated mesenteric foreshortening, the length of bowel remaining, it was thus

Client Name: FAMECUO HEALIN RICHARD

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Admitting Physician: Williams MD, James A

Age: 59 years

Discharge Date: 6/25/2007

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Parker III MD, Harris H

Performed Date/Time:

6/6/2007 8:25:00 AM

Authenticated By:

Parker III MD, Harris H

Authenticated Date/Time:

6/23/2007 12:42:00 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:42:00 PM

decided, given its friability as well, that this would not be able to be primarily closed and, thus, a 12-French Malecot catheter was placed through the defect, brought out laterally with a jejunostomy drainage tube. At this point, the drain was sewn in place using a 2-0 silk suture and brought out laterally to the inferior aspect of the abdominal wall and sewn to the undersurface of the anterior abdominal wall. At this point, the anterior aspect of the stomach was identified and a purse-string suture placed. Gastrotomy performed and a 28-French Malecot brought to the site, confirmed to be in the stomach, and brought out through the left upper quadrant. It was similarly secured using a second purse-string suture and sewn to the undersurface of the anterior abdominal wall using silk suture in 4 locations. Each drain was sewn on the anterior abdominal wall using silk suture. The abdomen, again, was copiously irrigated with normal saline, hemostasis assured. Bowel bag placed as well as a towel, followed by sponge, and a vacuum-assisted closure device placed.

Patient tolerated the procedure well. Patient taken to post-anesthesia care in satisfactory condition.

HHP:hs

D: 06/06/2007 8:05 A T: 06/06/2007 8:25 A

Job #: 000679635 T Job #: 925939 Dec #: 1034822

cc:: Harris Parker, MD

James A Williams, Jr., MD

Electronically Signed & Verified on 06/23/2007 12:42

by Harris H Parker MD

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

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Age: 59 years

Discharge Date: 6/25/2007

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Parker III MD, Harris H

Performed Date/Time:

6/7/2007 8:47:00 PM

Authenticated By:

Parker III MD, Harris H

Authenticated Date/Time:

6/23/2007 12:41:43 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:41:43 PM

Operative Report

DATE OF OPERATION: 06/07/2007

DATE OF SURGERY: 06/07/2007

PREOPERATIVE DIAGNOSIS: Peritonitis.

POSTOPERATIVE DIAGNOSIS: Peritonitis.

OPERATIVE PROCEDURE:

1. Exploratory celiotomy, bowel resection with ileoascending colostomy, stapled side-to-side functional end-to-end anastomosis.
2. Vacuum-assisted closure device to the abdomen.

SURGEON: Harris Parker, MD

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: No observed complications.

SPECIMENS: Small bowel and colon.

INDICATIONS: A 59-year-old female who presents for re-exploration after a known perforation.

FINDINGS: No evidence of further small bowel perforation. Less edema within the small bowel and colon.

DESCRIPTION OF OPERATION: After informed consent was obtained, the patient was taken to the operating suite and placed supine on the operating table. After adequate induction of general anesthesia, the vacuum-assisted closure device was removed. The abdomen was prepped and draped in the usual standard fashion. After ensuring anesthesia and appropriate landmarks, the abdomen was explored with no evidence of further leak. The abdomen again was copiously irrigated with saline. Hemostasis was assured. At this point, the distal small bowel and the ascending colon were brought side-to-side without evidence of tension and a stapled 75 anastomosis created. It was closed with offset of the staple line using a TA 90 stapler. The staple line was oversewn and the heel-over sewn and secured using interrupted 3-0 silk sutures. There was no evidence of tension. There was a nice, patent anastomosis, and the bowel appeared to be quite healthy. The abdomen, again, was copiously irrigated with saline and hemostasis was assured. Given the fact that

CLIENT NAME: FALGOUT, HEATH, RICHARD

PATIENT NAME: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admitting Physician: Williams MD, James A

Age: 59 years

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

Attending Physician: Williams MD, James A

Date of Birth: 11/3/1947

Discharge Date: 6/25/2007

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Performed Date/Time:

Authenticated By:

Authenticated Date/Time:

Parker III MD, Harris H

6/7/2007 8:47:00 PM

Parker III MD, Harris H

6/23/2007 12:41:43 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:41:43 PM

there was no omentum to be replaced to the site, and given the patient's history, Envicel was placed over the anastomosis staple line to reinforce this. At this point, the bowel bag was perforated and placed over the abdomen, followed by a towel and the VAC sponge, with Ioban dressing. The sponge, needle, instrument counts reported to be correct and the patient taken to the postanesthesia care in satisfactory condition.

HHP:hs

D: 06/07/2007 8:14 P T: 06/07/2007 8:47 P

Job #: 000682142 T Job #: 965884 Doc #: 1035848

cc:: Harris Parker, MD

James A Williams, Jr., MD

Electronically Signed & Verified on 06/23/2007 12:41

by Harris H Parker MD

Client Name: Palmetto Health Richland

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

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Admit Date: 4/25/2007

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Age: 59 years

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Date of Birth: 11/3/1947

Discharge Time: 7:11:00 PM

OPERATIVE REPORT

Performing Physician:

Parker III MD, Harris H

Performed Date/Time:

6/11/2007 11:43:00 AM

Authenticated By:

Parker III MD, Harris H

Authenticated Date/Time:

6/23/2007 12:41:36 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:41:36 PM

Operative Report

DATE OF OPERATION: 06/11/2007

DATE OF SURGERY: 06/11/07

PREOPERATIVE DIAGNOSIS: Peritonitis with incisional hernia.

POSTOPERATIVE DIAGNOSIS: Peritonitis with incisional hernia.

SURGEON: Harris Parker, MD.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None observed.

SPECIMEN: None.

DRAINS: None.

IV FLUIDS: As per anesthesia.

OPERATIVE PROCEDURE:

1. Repair of incisional hernia with 2 pieces of fashioned 4 x 16 alloderm mesh.
2. Vacuum assisted closure device, placement for the anterior abdominal wall.

INDICATIONS: This 59-year-old female with reexploration of known small bowel perforations.

FINDINGS: No evidence of bowel leak. Bowel appeared to be less edematous and healthy in appearance.

DESCRIPTION OF OPERATION: After informed consent was taken the patient was taken to the operative suite and placed in supine on to operating room table. After adequate induction of general endotracheal anesthesia the abdomen was prepped and draped in the usual sterile fashion. After ensuring adequate anesthesia and appropriate landmarks, the VAC had been previously removed. The abdomen was copiously irrigated with normal saline. Hemostasis was assured. There was no evidence of bowel in the field. The bowel was less edematous and appeared to be fairly adhered in a central unit. There was no evidence of leak. The vessel site copiously irrigated with normal saline. Hemostasis was assured. The superior and inferior aspects of the wound were approximated in the fascial level using 0 Prolene suture and 2 piece of presoaked 4 x 16 Alloderm mesh were fashioned and used to approximate the defect using Prolene suture. The wound was copiously irrigated with normal saline, hemostasis was assured. The vacuum assisted closure, device, and sponge was fashioned and placed with the assistance of Ioban dressing. The patient tolerated the procedure well without event and there were no observed complications. Sponge and needle counts reported to be correct. The patient was taken to the postanesthesia care unit in satisfactory condition.

BHP:hs

D: 06/11/2007 11:20 A T: 06/11/2007 11:43 A

Patient Name: ATKINSON, DORIS F

Page 4 of 978

Print Date/Time 7/12/2010 4:00 PM

MRN: R013367701

1003

PHR 0012

Client Name: FARMER, RICHARD

Patient Name: ATKINSON, DORIS F

MRN: R013367701

Client Address: 5 Richland Medical Park

Patient Address: 2251 FOREST BREEZE DR

FIN: R0710700924

Financial Class: Blue Cross PPC

Columbia, SC 29203

HARTSVILLE, SOUTH CAROLINA 29550

Admit Date: 4/25/2007

Admit Time: 2:12:00 AM

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0 0 0 1 1 1 0 0 0 0 1 1

Performing Physician:

Parker III MD, Harris H

Performed Date/Time:

6/11/2007 11:43:00 AM

Authenticated By:

Parker III MD, Harris H

Authenticated Date/Time:

6/23/2007 12:41:36 PM

Electronic Signature(s) Below:

Signed Date/Time:

Parker III MD, Harris H

6/23/2007 12:41:36 PM

Job #: 000685301 T Job #: 115187 Doc #: 1037328

cc:: Harris Parker, MD

James A Williams, Jr., MD

Electronically Signed & Verified on 06/23/2007 12:41

by Harris H Parker MD

DAN H. ALLEN, PH.D.
PO BOX 12518
315, WEST PINE STREET
FLORENCE, SOUTH CAROLINA 29505

CLAIMANT: Doris F. Atkinson

SSN: 250-76-5337

DISABILITY EXAMINER: Patricia R. Meyer

DATE OF EXAMINATION: December 22, 2008

ADULT MENTAL STATUS EXAMINATION

IDENTIFICATION: This claimant is a 61-year-old, married woman brought to the evaluation by her husband, she states that they live in the home, which they are purchasing.

REFERRAL SOURCE: The claimant was seen at the request of the Disability Determination Service (Columbia Regional Office), and seemed aware of the nature of the examination. She was given information regarding the limits of confidentiality and rights to access of information in accordance with HIPAA regulations.

METHODS OF ASSESSMENT: Structured clinical interview; psychosocial history form; brief symptom checklist; mental status checklist; and review of report of contact with the claimant dated November 4, 2008, supplied by disability examiner.

PRESENTING COMPLAINTS: Faye (she prefers to be addressed by her middle name) states that she has been diagnosed with super-short bowel syndrome, and as she related this, she ~~admitted~~ became quite upset, when giving more details about her health situation. She stated that she has had some six surgeries, the first in April 2007. She notes that five surgeries occurred within a few weeks of each other, and there have been several complications, including development of peritonitis. She notes that she has a very little of her large bowel remaining, and she has also developed two hernias, which she had been told are inoperable. Also, she notes diagnosis of both internal and external hemorrhoids. She has been told that her electrolytes are out of a balance and as a result she has a hypertension, and "I can't hold much food or liquid." She notes that she soils herself easily, with no warning and this is very embarrassing to her. She states that it has come to the point where she is very fearful of being out in the public for more than one to two hours at a time. "I just then realized how sick I

didn't

TDN:

Reynolds (from Driggers) 8357

DORIS F. ATKINSON
250-76-5337
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was until I began having those surgery^{ies}. She adds that sometimes she can soil herself up to four times a day, "sometimes I will have bad gas right before this and other times there is no warning at all." She states, "it can just happen at anytime and I guess you can understand why I would be afraid to get far from home."

She is taking multiple medications, and states that these are "of some help." She states that she had had a hysterectomy sometime in the 70s and in 1995, she had had some of her intestines removed, after having developed gangrene. "If the pain hits, I hardly have time to even hang up the phone." She recalled there have been several incidences, when "the feces will be in my shoes even before I know it."

PERSONAL HISTORY: Born in Darlington County, South Carolina, she comes from family of seven, but states, "they are just three of us remaining." Her father died in 1967 of a massive coronary and her mother, now 89, is a double amputee as a result of diabetic complications. She remembers that her father had owned a used automobile lot. After his death, her mother began working at a factory, then at a disabled center. She describes her family as having been very close.

EDUCATIONAL HISTORY: She completed high school and states she was a good student. "I remember I had a trouble only one time and that was for cutting class and that was my first and only offense." She noted that she had taken some courses with related to special needs children at a local community college. After high school, she married and they have a daughter and son. Her husband is employed at Sonoco, a firm, which manufactures paper products. She states she is hoping for early retirement. *packaging*

EMPLOYMENT HISTORY: Faye states that she last worked on March 30, 2007, at which time she was doing substitute teaching with special needs students at a high school level, and had done this off and on since 1979. Also, from the period from 1979 to 1985, she was a teaching assistant.

MENTAL STATUS EXAMINATION:

APPEARANCE AND BEHAVIOR: Faye is a slender woman of average height. She is very neatly, almost meticulously dressed. She has a soft-spoken, very polite manner. After about the first 10 minutes, she found it difficult to compose herself when talking about her health problems, and it was obvious that this was quite embarrassing into her, when she was sharing the frequent bouts of diarrhea. She states, "I just feel like my life is out of control." At several points throughout the interview, she found it difficult to choke back her tears, saying, "I am just somebody who is a prisoner to her body."

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Throughout, thought content was linear, with no indication of impairment in reality testing or other perceptual disturbance. She continued to appear quite sad, almost despairing when describing her physical concerns.

ATTENTION AND CONCENTRATION: Faye was able to repeat five digits forward and only three backwards. She apologized profusely for "not been able to do much better." With a visual-memory task, in which she was presented a page of 10 items to look at for 10 seconds, she could recall seven of these. She seemed encouraged by this, and "I guess I did a little better *at three than when* ~~that things that you have called out to me with those numbers.~~"

With mental calculations, her performance was variable. Although she seemed to recognize the steps needed to come up with the correct solution, she was not able to follow through to completion for five out of eight of these. She assured me that "she had never had any trouble with things like making change."

ORIENTATION: She readily responded to inquiries regarding month, year, day of week, current events, and could easily identify well-known historical political figures and events.

ABSTRACTING TASK: Again, Faye proved to be quite articulate, readily giving proper responses to all five of the proverbs, and also good responses to the four visual abstracting tasks. For example, as to the meaning of "don't count your chickens before they hatch," she replied, "we don't expect anything until you have it at hand." As to "don't judge a book by its cover," she responded "well, you just shouldn't judge by the outside you need to get to know something or someone better."

ACTIVITIES OF DAILY LIFE: Faye states that she is to bed at different times, between 9 and 12, "and only recently I began sleeping through the night with the medications." She is typically up around 7 a.m. "It takes me about 3 hours to get really started in the morning after taking my medications." She states she *does not* ~~take the~~ shower and "I have to eat a light breakfast for my medications." She continues to do the cooking and most of the house chores. "But I sure can't lift anything and I can't push a vacuum sweeper." Much of her day is now spent watching television. She notes that she has to stop eating or drinking at least two and half hours before she leaves the house because of the diarrhea.

With much sadness, she related that she is no longer involved in her Church where she was a charter member. "It seems like my friends have really *joined* ~~joined~~ now and this hurts." She states that most of them have been there all of her life

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PAGE 4

when
and "I guess ~~with~~ this kind of thing in my body goes on and on, people just start wondering away." She has just begun a contact, through e-mail, with a support group for others who have severe intestinal problems. Otherwise, "I read a lot, but I am just not able to focus well." At this point, she noted that she has had increasing difficulty with her right eye, and will have this checked soon."

Near the end of the session, Faye was having much more difficulty controlling her tears, and again made many apologies for this. She shook her head slowly saying "It is really hard to see how this can get better for me since this is a kind of condition that I have always have." She felt that her life "has been completely turned around." She states that most of her thoughts "are just centered around this problem and trying to manage around it, so that I am not a nuisance to myself or others."

SUMMARY: Cognitively, I would conclude that this claimant has a capacity well within the average range. She is generally quite articulate, with good abstracting ability. She does seem to be making almost ~~valuable~~ attempt to maintain some sense of dignity in the face of physical problems, which certainly appears authentic and have been well documented. The pressure, which she describes seems almost totally related to this condition and management. The complications from the physical difficulties would be the primary, and significant hindrance to her employment. She would be able to handle funds in her own best interest.

Reynolds (from Driggers) 0360

DORIS F. ATKINSON
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DIAGNOSES:

Axis I Depression, related to general medical condition.

Axis II No diagnosis.

Axis III (According to claimant) Diagnosis of super short bowel syndrome.

Axis IV 3 to 4 (moderate-to-severe) - limitation in social life; mood disturbance; and increased social isolation.

Axis V GAF = 50 (current).


Dan H. Allen, Ph.D.

DHA/JAG

This is to certify that the above was transcribed from the recorded voice of Dan H. Allen, Ph.D., on December 23, 2008.

LS SERVICES/180ALLEN533865/9311

Reynolds (from Driggers) 0361

59% prior Hgt - 1973
 Ovarian cysts
 1982
 4/6 Bowel rxn 3/07 CEA
 2.7
 HCG 1.7
 CA 125 4.2
 Amylase 85
 CBC, Hct, Hgb, etc
 Lypase 29
 H. pylori ⊕
 UA ⊕

Atkinson Case

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

preop
 Radiology

Spec uls "Women's Ctr of Hartsville" 4/3/07
 mostly cystic mass 12 cm x 9.4 x 9.7 cm
 some internal debris, one small thin septation

CXR 3/07 - "COPD" = hyperinflation

CT abd 3/30/07 - Carolina Pines med Center
 priors

CT head = normal
 mamm = negative

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

preop Hx

4/13/2007 CC: @ flank pain
 pmthx "w/o laparotomy for Bowel rxn / 'gangrenous bowel' 1985 → repeat laparotomy for SBO 20 to address

? date
 ? circumstances
 ? old op Notes

Px 12/16/65 "large vertical midline skin incision"
 Bm → @ solid midline mass 14 cm

Williams Dx: ① Cystic mass of the pelvis
 ② Laparotomy X 3 (Anteriorly 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 kids band + daughter

Op Notes: 4/25/07

extensive adhesions 2 1/2 hrs adhesiolysis out of 3 1/2 hr 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 or 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 cystadenomas"

Postop course

POD # 8

Imaging

~~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: 102 sat

Consultations

POD # 27

5/21/07 Dr Harris Parker (? gen surgery ??) ***
pt. Agile, APD many tubes & peritoneal signs ***
"pt. interest in maximal medical management"

TPN option ???

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

5/28/07 (POD # 34)

Williams re-explains

Loop, assume adhesiolysis x 4 hrs
SB resection & PA
cystotomy

How were these
multiple enterostomies
closed ???

? dye extravasation ??
enterotomy - multiple

? how many ?? ***

"jejunointestinal reanastomosis"

→ only 1 cm of terminal ileum salvaged

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

48 cms of small bowel on port right.
(left)

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

AP III 6/3/07

Lap #3 this hospitalization
Drs. Parker + Prickett — gas surgery
"Requesting MD = Ferry Smith ????" ~~xxxxxx~~
was Smith
on call??

"Specimens from drainings, ~~hematoma~~

leukocytosis + thrombocytosis"

2 SB perforations → high prox jejunum,
just distal to Lig of Treitz
2 liters succus
entericus → distal SB → just prox to
anastomosis.

AP IV 6/5/07

peritonitis SB ileostomy, ileocecal/colon
perforation 10-15 cm prox to staple line
Gastrostomy, jejunostomy
"prox jejunum ok" ~~xxxxxx~~

AP V 6/7/07

Ileoscandy colostomy

overruled Admitted 4/25/07
Discharged 4/8/07 (POD #45)

LAP VI

6/11/07

Washout + Adomir 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 Adhesiotomy
and bowel resection

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

~~When~~ It was already at high risk

* prior Bowel surgery for ? SBO

* massive adhesions described at
initial laparotomy

* malnutrition & ~~immature~~ of
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

- ~~One~~ When it obstructed & didn't get better, gen surgery
consult 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 & Williams doesn't mention re-anastomosis per se — Nightmare Scenario → ~~he forgot to re-connect~~ he got distracted

+ didn't finish resection (re-anastomosis) →
need to pin Williams down on this and/or review CT 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 you surgeon do the case
Need to find out what Harris' testimony is going to be in this regard

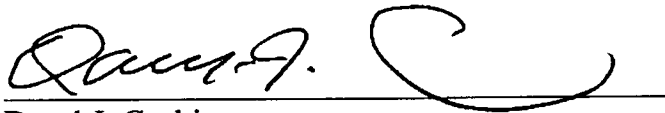
(4) What was pt's Nutritional status ~~at~~ just before 2nd surgery — Albumen, pre-albumen was low on TPN — was thought given to prolonged TPN instead of reoperation? Why did Williams choose reoperation?

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

CERTIFICATE OF APPELLANTS

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material. In addition, the undersigned hereby certifies that the Record on Appeal in the above-captioned case complies with the South Carolina Supreme Court Order dated August 13, 2007.

RESPECTFULLY SUBMITTED

A handwritten signature in black ink, appearing to read "Daryl J. Corbin", is written over a horizontal line.

Daryl J. Corbin
Corbin Law Firm
Post Office Box 447
Florence, SC 29503
(843)667-6119
Attorney for Appellant

Florence, South Carolina

April 10, 2014

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.

PROOF OF SERVICE

I, Daryl J. Corbin, counsel for the Appellants, certify that I have served the
within Record on Appeal and a copy of the Proof of Service on April 10, 2014, via
hand-delivery, addressed to the following:

R. Hawthorn Barrett, Esquire
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Turner Padgett Graham & Laney
Post Office Box 1473
1901 Main Street, Suite 1700
Columbia, SC 29202

Honorable Jenny Abbott Kitchings
SC Court of Appeals
Post Office Box 11629
1015 Sumter Street
Columbia, SC 29211

William C. McDow, Esquire
Richardson Plowden
Post Office Drawer 7788
1900 Barnwell Street
Columbia, SC 29202

RECEIVED

APR 10 2014

SC Court of Appeals

RESPECTFULLY SUBMITTED,

CORBIN LAW FIRM

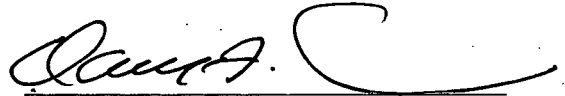
227 West Evans Street

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(843)667-6119

BY:

A handwritten signature in black ink, appearing to read 'Daryl J. Corbin', written over a horizontal line.

DARYL J. CORBIN

Attorney for Appellants

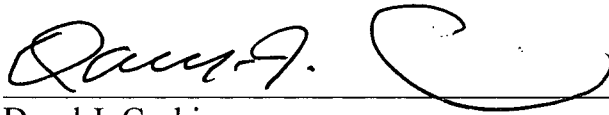
Florence, South Carolina

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April 10, 2014

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