

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Case No. 2011-CP-10-0934

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S.C. SUPREME COURT

Virginia L. Marshall and
Todd W. Marshall, ... Appellants,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A., ... Respondents.

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STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Kenneth A. Dodds, MD, Charleston
Nephrology Associates, LLC,

Defendants.

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Georgia Roane, M.D. and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS

C/A: 11-CP-10-934 and 11-CP-10-4057

C/A: 11-CP-10-2587 and 11-CP-10-5897

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JULIE J. HIGHTS
CLERK OF COURT
BY

ORDER GRANTING PLAINTIFF'S
MOTION TO CONSOLIDATE/MERGE
ABOVE CASES TO C/A: 11-CP-10-934

This matter comes before the Court on Plaintiffs' Motion to Consolidate and for an Order of Protection filed with this Court on June 13, 2013, requesting that these cases be consolidated for purposes of trial and that they not be called for trial until the parties have an opportunity to have a status conference with the Court for scheduling purposes.

The Court grants the Plaintiffs' motions.

Previously the Court had consolidated the cases for the purposes of discovery and the two cases involve general allegations of medical negligence with overlapping time periods. The witnesses for both cases are, for the most part similar.

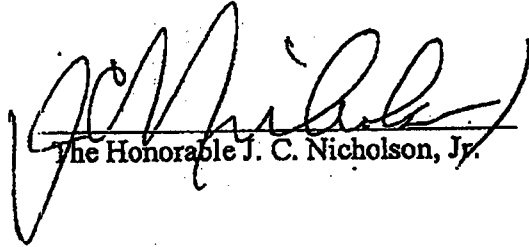
Consolidation of these cases for trial will prevent unnecessary duplication of costs and

prevent inconsistent verdicts and would allow the parties to prepare for one trial.

The Court has also determined that there is no prejudice to any of the parties and that consolidation is appropriate.

Therefore, after considering all parties positions, it is ordered that the four cases (11-CP-10-934, 11-CP-10-4057, 11-CP-10-2587 and 11-CP-10-5897) be consolidated/merged under Civil Action No. 11-CP-10-934, and that the parties are to arrange with the Court for a status conference to obtain scheduling for a trial date.

IT IS SO ORDERED.



The Honorable J. C. Nicholson, Jr.

November 13, 2013
Charleston, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

KENNETH A. DODDS, MD,
CHARLESTON NEPHROLOGY
ASSOCIATES, LLC,

Defendants.

VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

GEORGIA ROANE, M.D. AND
RHEUMATOLOGY ASSOCIATES,
P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT

CASE NO. 2011-CP-10-934

ORDER GRANTING SUMMARY
JUDGMENT AS TO DEFENDANTS
GEORGIA ROANE, M.D. AND
RHEUMATOLOGY ASSOCIATES, P.A.

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JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

FILED

This matter is before the Court upon Defendants Georgia Roane, M.D. and Rheumatology Associates, P.A.'s (hereinafter "these Defendants" or "Defendants") Motion for Summary Judgment. A motions hearing was held on March 3, 2014. Defendants contend that the Plaintiffs' claims are time-barred as the Plaintiffs failed to timely commence this action within the applicable statute of repose as set forth in S.C. Code Ann. § 15-3-545(A). Having fully considered the issues before the Court, the Court finds that Defendants' Motion should be GRANTED.

BRIEF STATEMENT OF THE FACTS

Virginia and Todd Marshall (collectively, the "Plaintiffs") filed the above-captioned lawsuit against these Defendants on April 8, 2011, asserting a medical malpractice and loss of consortium claim. Plaintiffs not only filed a Notice of Intent to File Suit ("NOI") and contemporaneous expert affidavit in accordance with S.C. Code Ann. §§ 15-79-125 and 15-36-100 but also a Summons and Complaint. On August 19, 2011, after completing pre-suit mediation in accordance with S.C. Code Ann. § 15-79-125, Plaintiffs in fact filed a second Summons and Complaint that was identical to the prior pleading they filed in this case. However, the two actions were consolidated for purposes of discovery and trial by consent of the parties and Order of the Honorable Roger M. Young, Sr. on July 17, 2013. This Order is applicable to and disposes of all actions filed by the Plaintiffs against these Defendants.

On November 8, 2013, this action was consolidated with that of *Virginia L. Marshall and Todd W. Marshall v. Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, C/A* No. 2011-CP-10-934 and C/A No. 2011-CP-10-4057.

Plaintiffs' Complaint against Dr. Roane and her practice alleges that from 2000 until 2005, Plaintiff Virginia Marshall was "diagnosed and treated" by Dr. Roane for mixed connective tissue disease ("MCTD"). (Compl. p. 2 at ¶ 4). Plaintiff asserts the diagnosis was based upon "various factors," including "elevated sedimentation (SED) rates," and "nonspecific symptoms." (Compl., at ¶'s 4, 5). Dr. Roane continued to treat Plaintiff for MCTD until October 2007 and her treatment continued in accordance with this diagnosis. (Compl. at ¶ 12).

Plaintiff was referred to a nephrologist, Dr. Eric Pride, on January 7, 2010—nearly three years after last seeing Dr. Roane. (Compl. at ¶'s 12, 14). Dr. Pride conducted a "UPEP" test to

evaluate the type of protein in Plaintiff's urine; that test revealed she had cancerous myeloma protein. (Compl. at ¶ 14). A subsequent bone marrow biopsy confirmed Plaintiff was suffering from lymphoplasmatic lymphoma. (Compl. at ¶ 14). This was Plaintiff's first indication of cancer. *Id.*

Plaintiffs allege that the cancer "should have been detected as early as April 29, 2005" by Dr. Roane, and that the Plaintiff was diagnosed and treated for a disease she did not have from 2000 through 2007. (Compl. at ¶'s 14-15; 4). Plaintiffs contend this April treatment date should be the operative date for purposes of analyzing the applicable statute of repose. Of course, as a lay person, Plaintiff is unqualified to opine on such matters and must refer to a qualified expert.

On September 16, 2013, Plaintiffs' sole liability expert against these Defendants, Dr. Thomas M. Zizic, M.D., testified that Dr. Roane breached the standard of care in 2002 and again in 2003 for failing to perform a proper work up that would have discovered Virginia Marshall's cancer. Specifically, Dr. Zizic provided the following opinion:

Q: Okay. Are you—and so you believe part of your expert opinion is that as far as that February 2002 that Dr. Roane breached the standard of care by not doing a re-workup of the patient?

A: Yes. A reconsideration of where she was in the treatment of the patient.

(See Deposition Excerpt of Dr. Zizic, Page 77, Lines 25—Page 78, Lines 1-5)(emphasis added).

Dr. Zizic also testified as follows:

Q: But you, I presume, based on what you told me from February 2002, if a reworkup were done in August of '03, you believe it would have discovered—it would have led you to discovering the true underlying illness, the lymphoma?

A: Yeah.

Q: And you believe that was a breach of the standard of care, that failure to re-workup in August of '03?

A: I do.

(See Deposition Excerpt of Dr. Zizic, Page 78, Line 25—Page 79, Lines 1-10).

Based on this testimony, Defendants have moved for summary judgment pursuant to the six year statute of repose set forth in S.C. Code Ann. § 15-3-545(A) contending that Plaintiffs failed to file this suit until April of 2011, over nine years after the first occurrence of negligence proffered by Plaintiffs' expert.

STANDARD OF REVIEW

Pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, summary judgment may be granted if there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law. Rule 56, SCRPC; Town of Summerville v. City of N. Charleston, 378 S.C. 107, 109-10, 662 S.E.2d 40, 41 (2008). The statute of limitations or statute of repose defense may be raised in a summary judgment motion. See McDonnell v. Consolidated School Dist. of Aiken, 315 S.C. 487, 445 S.E.2d 638 (1994).

In response to a properly supported motion for summary judgment, the non-moving party may not rest on the mere allegations or denial of the pleadings, but must set forth or point to specific facts showing there is a genuine issue of material fact. The existence of a mere scintilla of evidence in support of the non-moving party's position is not sufficient to overcome a motion for summary judgment. *Thomas v. Waters*, 315 S.C. 524, 445 S.E.2d 659, 661 (Ct. App. 1994). A court must grant summary judgment if the non-moving party fails to make a showing sufficient to establish the existence of an element essential to the party's case upon which the party will bear the burden of proof at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986) (citing Fed. R. Civ. P. 56, which is identical to S.C.R. Civ. P. 56.)

The moving party need not support its motion with affidavits or other similar materials negating the opponent's claim but must clearly establish by the record the absence of a triable issue of fact. *Baughman v. Am. Tel. & Tel. Co.*, 306 S.C. 101, 410 S.E.2d 537, 545-46 (1991).

LAW/ANALYSIS

I. PLAINTIFFS' CLAIMS ARE BARRED BY THE SIX-YEAR STATUTE OF REPOSE FOR MEDICAL MALPRACTICE ACTIONS.

Based on the testimony of Dr. Zizic, the Court finds Plaintiffs' claims are time-barred by the applicable statute of repose. Medical malpractice claims are subject to a six-year statute of repose. S.C. Code Ann. § 15-3-545(A). Specifically, § 15-3-545 of the South Carolina Code provides:



[T]o recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation by any licensed health care provider . . . acting within the scope of his profession must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date of discovery or when it reasonably ought to have been discovered, not to exceed six years from date of occurrence, or as tolled by this section.

S.C. Code Ann. § 15-3-545 (emphasis added).

The six-year period constitutes an "outer limit beyond which a medical malpractice claim is barred, regardless of when it is discovered." *O'Tuel v. Villani*, 318 S.C. 24, 455 S.E.2d 698 (Ct.App. 1995) (overruled in part and on other grounds by *I'on, LLC v. Town of Mt. Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000)). Unlike the statute of limitations, the statute of repose for medical malpractice actions begins to run at the first occurrence of a *negligent act*. *Id.* The statute of repose ignores the discovery, knowledge, and even the existence of any injury in barring claims; instead, its focus centers squarely on that first act of negligence underlying the claim. *Hoffman v. Powell*, 298 S.C. 338, 339-40, 380 S.E.2d 821 (1989) (the medical malpractice statute of repose bars claims "regardless of whether [the claim] has or should have

been discovered" or "whether [the claimant's] injuries are latent or readily apparent."). The expiration of a statute of repose extinguishes all causes of action, including those that may later accrue and those that have already accrued. *Columbia/CSA-HS Greater Columbia Healthcare System v. South Carolina Medical Malpractice Liability Joint Underwriting Ass'n*, 394 S.C. 68, 713 S.E.2d 639 (Ct. App. 2011); *Capco of Summerville, Inc. v. J.H. Gayle Constr. Co.*, 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006); *Langley v. Pierce*, 313 S.C. 401, 438 S.E.2d 242 (1993). These statutes of repose create a substantive right, designed to protect the economic balance struck by the legislative body in this state. *Langley*, 313 S.C. at 404, 438 S.E.2d at 243-44.

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The Court finds that the six year statute of repose began to run in February of 2002, the time at which Dr. Zizic opined that Plaintiff's cancer could have been discovered had proper tests been ordered and conducted. Thus, Plaintiffs were required to bring the instant action against these Defendants no later than February of 2008, six years from the date of alleged negligent treatment. Plaintiffs' untimely Complaint (and NOI) filed on April 8, 2011, is therefore barred as a matter of law pursuant to § 15-3-545.

The Court further finds that Plaintiffs may not advance their otherwise time-barred claims simply because they allege that Dr. Roane's treatment and alleged negligence continued over a seven year span and "reoccurred" thereby renewing the time within which to commence this action. South Carolina has judicially rejected such notions, recognizing that to adopt either the continuous treatment or continuous tort rule would run contravene the adopted legislative policy of our General Assembly in establishing a statute of repose for medical negligence actions. *Harrison v. Bevilacqua*, 354 S.C. 129, 580 S.E.2d 109 (2003); *Dunbar v. Carlson*, 341 S.C. 261 533 S.E. 919 (2000); *Shadwell v. Craigie*, 361 S.C. 492, 605 S.E.2d 567 (2004). Therefore, despite Dr. Roane's continued treatment of the Plaintiff and alleged recurring negligence, the

Court finds the operative date for purposes of determining the timeliness of this action remains the first alleged act of negligence as identified by Dr. Zizic.

Plaintiffs argue that Dr. Zizic's testimony and affidavit actually focus on April of 2005 as the time period of importance for this action and that such treatment should be deemed a separate and distinct act of negligence from the treatment in 2002 and 2003 thereby rendering Plaintiffs' Complaint timely under the statute of repose. However, this Court finds that Dr. Zizic's own deposition testimony draws no distinction between the alleged failures in February of 2002 and those in 2005 going forward. The Court finds that what Plaintiffs contend is a "distinct event" in this case is nothing more than a continuation of the same course of treatment. While Plaintiff may have presented with different symptoms or protein levels at subsequent visits, and while Plaintiff's condition may have worsened, the proper inquiry for examining a statute of repose issue is simply when the first act of negligence or misdiagnosis occurred. Because Plaintiff's only liability expert has represented that date was February of 2002, Plaintiff's Complaint is untimely.

In fact, the Court finds that a close examination of Dr. Zizic's following testimony negates Plaintiffs' argument that the treatment in 2005 was separate and distinct event:

Q: Were there any other points along the time line of events that you have particular concerns? You've identified a couple, 2002, 2003. Were there any other points in time along that spectrum that you believe you're going to be particularly critical of?

A: Well, I think just like we take care of our patients with annual exams, physicals, and we're more appropriately doing that than their internists in patients with systemic rheumatic diseases such as an undifferentiated connective tissue disease. And so most rheumatologists will yearly do a more complete evaluation with laboratory studies, particularly when there's some features that are atypical and may not be fitting with our normal patients have. So I would say from 2004, 2005, 2006, 2007 *she should have had yearly exams looking at the laboratory studies we've been talking about.....* (emphasis added)

(See Deposition Excerpt of Dr. Zizic, Page 125, Lines 8-25.).

Importantly, these yearly exams which Dr. Zizic references are the same tests which he testified should have been conducted in 2002 and 2003:

Q: What would the re-workup [in February of 2002] include, in your opinion? What would need to be done to --you say rework the patient, what are we talking about?

A: Well, a whole complete antibody profile: ANA, anti-DNA, single-strand, double-strand, ENA, RNP, SM, RO, LA, p-ANCA, c-ANCA, and we can go on. But that's basically the antibodies I do. I would be looking at--I would get an SPEP, I would get a UPEP, because I've got proteinuria which I know, and I've got these low complements which I don't have explanation for. So I've got to go back through this.

Q: Do you have an opinion as to whether the SPEP or the UPEP would have revealed anything by this point [in February of 2002]?

A: I do.

Q: You think it would have?

A: I would. I do.

Q: Waldrenstrom's or something that --

A: Some abnormality that would lead you to do a bone marrow biopsy and go forward.

(See Deposition Excerpt of Dr. Zizic, Page 76, Lines 16-25—Page 77, Lines 1-11.) Dr. Zizic's testimony fails to articulate any discernible difference in Dr. Roane's treatment from 2002 to 2007 which supports Plaintiffs' arguments to this Court.

The Court is further persuaded by the Georgia Court of Appeals' holding in *Howell v. Zottoli*, 302 Ga. App. 477 (2010) in which summary judgment was granted in favor of a defendant physician. Importantly, the South Carolina Supreme Court has cited to Georgia law when rejecting the continuous tort rule in the *Harrison v. Bevilacqua* 354 S.C. 129 (2003). In *Howell*, the plaintiff was treated over a five year span by the defendant physician but never was properly diagnosed with coronary artery disease. After five years of treatment, the plaintiff died of this very same condition that was never diagnosed. The plaintiff's estate filed the action outside the Georgia five year statute

of repose if calculated from the first failure to diagnose but argued that the statute began to run anew upon a subsequent misdiagnosis thereby rendering the action timely. The Court disagreed and stated that:

"although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition."

Howell, 302 Ga. App. at 479.

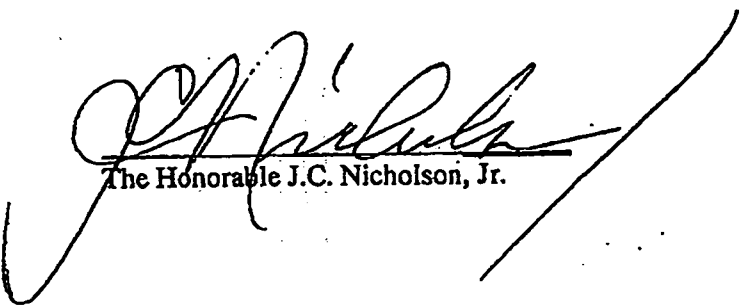
The Court finds that based on Dr. Zizic's testimony, Defendants' negligent act in 2005, if any, was the same negligent act alleged to have been committed in February of 2002.

CONCLUSION

For the reasons set forth above, this Court finds that Defendants' Motion for Summary Judgment should be GRANTED and grants judgment in this matter (including both actions Plaintiffs filed against these Defendants) in favor of these Defendants as to the entirety of the Plaintiffs' claims as a matter of law.

AND IT IS SO ORDERED.

5/1, 2014
Charleston, South Carolina


The Honorable J.C. Nicholson, Jr.

IN THE COURT OF COMMON PLEAS

)

) C/A No. 2011-CP-10-934
) (consolidated)

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FACTUAL BACKGROUND

At all relevant times to this matter, Defendant Dr. Kenneth Dodds ("Dr. Dodds") was an employee with Defendant Charleston Nephrology Associates, LLC. See Defendant Dodds' Answer, at ¶ 2. In total, the Plaintiff Virginia L. Marshall ("Ms. Marshall") saw Dr. Dodds four times between September of 2004 and September of 2005.

On September 15, 2004, Ms. Marshall presented to Dr. Dodds with complaints of proteinuria, or increased proteins in her urine. Dep. of Robert Luke, MD, 133:16-21; Aff. of Robert Luke, MD, at 5. This visit was the first time Dr. Dodds had seen the Plaintiff since 1999. Id. During this visit, Dr. Dodds noted that

the Plaintiff had a 24-hour urine test conducted on August 6, 2004 which revealed that the protein levels in her urine were at 3.5 g/day. Dep. of Barry Singer, MD, 77:1-4. Dr. Dodds did not order additional testing for Ms. Marshall's proteinuria.

The Plaintiff presented to Dr. Dodds again on November 11, 2004. Dep. of Barry Singer, MD, 78:5-18. At this visit, Ms. Marshall had no complaints and indicated that her appetite had improved. Id. Dr. Dodds also did not order additional testing for Ms. Marshall's proteinuria at this visit.

At Ms. Marshall's February 7, 2005 visit to these Defendants, Dr. Dodds ordered another 24-hour urine test to be conducted on Ms. Marshall, and on February 9, 2005, Dr. Dodds noted that her protein levels were at approximately 3.1 g/day and treated her for proteinuria. Plaintiffs' Complaint, at ¶ 4; see Dep. of Robert Luke, MD, 146:1-8. Again, no additional testing was done by Dr. Dodds.

At her last visit with Dr. Dodds on September 15, 2005, Ms. Marshall's 24-hour urine test indicated that the protein levels in her urine had increased to 4.2 g/day, and Dr. Dodds continued to treat her proteinuria. Plaintiffs' Complaint, at ¶ 5; see Dep. of Barry Singer, MD, 87:8-15. No additional testing was done at this visit either, and Ms. Marshall did not see these Defendants again after this visit.

On January 7, 2010, Dr. Eric Pride, a nephrologist, conducted a urine protein electrophoresis ("UPEP") test on Ms. Marshall's urine to evaluate her proteinuria. Plaintiffs' Complaint, at ¶ 7. The UPEP test and a serum protein electrophoresis ("SPEP") test revealed she had cancerous myeloma protein. Id. Ms. Marshall was referred to Dr. James Orcutt, an oncologist, in February 2010, and she was subsequently diagnosed with lymphoplasmatic lymphoma. Id.

The Plaintiffs allege that Dr. Dodds was negligent "in failing to recognize the signs and symptoms of elevated protein in the urine" and "in failing to order the proper testing, to include but not be limited to a UPEP test and a SPEP, to determine the type of protein in the Plaintiff's urine." Plaintiffs' Complaint, at ¶ 12. The Plaintiffs allege that the earliest Ms. Marshall's cancer was present and could have been detected by Dr. Dodds was in "February 9, 2005 when significantly high levels of protein were discovered in her urine." Plaintiffs' Complaint, at ¶ 8.

However, Robert Luke, M.D., Plaintiffs' nephrology expert, testified that from 2003 onward, there were cancerous protein chains in Ms. Marshall's urine that were not tested. Robert Luke, MD, 25:7-12. Plaintiffs' expert in oncology, Barry L. Singer, M.D., stated in his deposition that it was more likely than not that Ms. Marshall's cancer was present and could have been detected at her first visit with Dr. Dodds on September 15, 2004 when her 24-hour urine test showed 3.5 g/day of protein. Dep. of Barry Singer, MD, 61:20-62:6; 68:17-68:23. Dr. Singer stated that if an UPEP test or an SPEP test would have been performed on September 15, 2004, then Mr. Marshall's cancer could have been diagnosed at that point. Dep. of Barry Singer, MD, 8:22-9:1; 69:9-12. Dr. Singer could give no reason why he did not include the September 15, 2004 visit on his affidavit filed in this case. Dep. of Barry Singer, MD, 62:7-25.

PROCEDURAL BACKGROUND

On February 7, 2011, the Plaintiffs filed a Notice of Intent to File Suit and a contemporaneous expert affidavit in accordance with S.C. Code Ann. §§ 15-79-125 and 15-36-100 along with a Summons and Complaint asserting a medical malpractice and loss of consortium claim against these Defendants. After completing pre-suit mediation, the Plaintiffs filed and served a second, identical

Summons and Complaint on these Defendants on June 8, 2011. These Defendants moved to dismiss the Plaintiff's first Complaint arguing that it was improperly filed simultaneously with the Notice of Intent. After a hearing, the Court allowed the Plaintiffs to amend the first Complaint to only assert allegations of negligence occurring before the July 1, 2005 effective date of the Medical Malpractice Act and to amend the second Complaint to only assert allegations of negligence occurring after July 1, 2005.

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By Order filed November 18, 2013, these cases were consolidated with the Plaintiffs' suit against Georgia Roane, M.D. and Rheumatology Associates, P.A., and the actions were consolidated under C/A No.: 2011-CP-10-934. Prior to these cases being consolidated, on October 23, 2013, these Defendants filed this motion seeking summary judgment on the grounds that this case was barred by the applicable six-year statute of repose for medical malpractice cases set forth in S.C. Code Ann. § 15-33-545(A). A hearing was held on March 3, 2014, and all parties submitted supplemental briefing to the Court following the hearing. On March 4, 2014, the Plaintiffs submitted a letter to the Court that addressed arguments made by these Defendants at the hearing and also attached Dr. Dodds' deposition transcript and the Plaintiffs' experts' depositions. On March 5, 2014, these Defendants filed their Memorandum in Support of their Motion for Summary Judgment. In response, the Plaintiffs submitted another letter to the Court on March 7, 2014.

Having reviewed the motions, arguments, and relevant case law, the Court grants summary judgment to these Defendants.

LEGAL STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Rule 56(c), S.C.R.C.P. The moving party has the initial responsibility of demonstrating the absence of a genuine issue of material fact. Baughman v. American Tel. and Tel. Co., 306 S.C. 101, 115, 410 S.E.2d 537 (1991). However, the moving party may demonstrate this "with or without supporting affidavits," and may point out that there is a lack of evidence to support the nonmoving party's case. Rule 56(b), S.C.R.C.P.; see Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986).

Once the party moving for summary judgment meets the initial burden of showing an absence of evidentiary support for the opponent's case, the nonmoving party "may not rest upon the mere allegations or denials of his pleading." Rule 56(e), S.C.R.C.P. Instead, the nonmoving party "must set forth specific facts showing that there is a genuine issue for trial." Id. In order to preclude a grant of summary judgment, "the court must determine that a genuine issue of material fact exists for each essential element of the plaintiffs claim." Hansson v. Scalise Builders of S.C., 374 S.C. 352, 358, 650 S.E.2d 68, 71 (2007). When making this determination, "the evidence and all inferences which can be reasonably drawn therefrom must be viewed in the light most favorable to the nonmoving party." Lanham v. Blue Cross & Blue Shield of S. Carolina, Inc., 349 S.C. 356, 361-62, 563 S.E.2d 331, 333 (2002).

DISCUSSION

The statute of repose governing medical malpractice actions set forth within S.C. Code Ann. § 15-3-545(A) provides:

In any action . . . to recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation by any licensed health care provider . . . acting within the scope of his profession must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date of discovery or when it reasonably ought to have been discovered, *not to exceed six years from date of occurrence*

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S.C. Code Ann. § 15-3-545(A) (1976) (emphasis added). "A statute of repose creates a substantive right in those protected to be free from liability after a legislatively-determined period of time." Langley v. Pierce, 313 S.C. 401, 404, 438 S.E.2d 242, 243 (1993) (quoting First United Methodist Church v. U.S. Gypsum Co., 882 F.2d 862, 865-66 (4th Cir. 1989)). As such, this six-year statute of repose "constitutes an outer limit beyond which a medical malpractice claim is barred, regardless of whether it has or should have been discovered." Hoffman v. Powell, 298 S.C. 338, 339-40, 380 S.E.2d 821 (1989).

The six-year time limit under the statute of repose cannot be extended, and South Carolina has refused to adopt the "continuous treatment rule" in medical malpractice cases. Harrison v. Bevilacqua, 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003); Kaminer, 653 S.E.2d at 832. The "continuous treatment rule" states:

[I]f the treatment by the doctor is a continuing course and the patient's illness, injury or condition is of such a nature as to impose on the doctor a duty of continuing treatment and care, the statute does not commence running until treatment by the doctor for the particular disease or condition involved has terminated—unless during treatment the patient learns or should learn of negligence, in which case the statute runs from the time of discovery, actual or constructive.

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Preer v. Mims, 323 S.C. 516, 519, 476 S.E.2d 472, 474 (1996) (quoting David W. Louisell & Harold Williams, Medical Malpractice, § 13.02[3] (1996)). South Carolina declines to adopt this rule because "judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set through statute, including the statute of repose." Shadwell v. Craigie, 361 S.C. 492, 499, 605 S.E.2d 567, 570 (Ct. App. 2004) (quoting Harrison, 354 S.C. at 138, 580 S.E.2d at 114). While Plaintiffs argue that the "continuous treatment rule" is a tolling provision and that they have not sought to toll the statute of repose, the Supreme Court's refusal to adopt the doctrine is illustrative of the strict interpretation South Carolina courts have given the statute of repose. See Plaintiffs' March 4, 2014 Letter to the Court.

As an absolute boundary for medical practice actions, the six-year statute of repose begins to run from the first negligent act or omission. See O'Tuel v. Villani, 318 S.C. 24, 27, 455 S.E.2d 698, 700 (Ct. App. 1995) overruled in part and on other grounds by ION, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 526 S.E.2d 716 (2000) (finding that the statute of repose began to run from the date of a child's birth even though his injuries were not discovered until he began school). Thus, in a case where the negligent act is the failure to diagnose an underlying condition, the statute of repose begins to run on the date of the *initial* misdiagnosis. Kaminer v. Canas, 653 S.E.2d 691, 697 (Ga. 2007); see Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009) (finding that the statute of repose began to run from the date of a physician's misdiagnosis of a plaintiff). In other words, "although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose

where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition." Howell v. Zottoli, 691 S.E.2d 564, 566 (Ga. Ct. App. 2010) (citing Kaminer, 653 S.E.2d at 697-98).

Plaintiffs contend that in Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 678 S.E.2d 809 (2009), where the Court found that a plaintiff's claims against a hospital for misdiagnosing a cancerous mole as benign were barred by the statute of repose, only involved one misdiagnosis. See Plaintiffs' March 4, 2014 Letter to the Court. While the only alleged negligent act in Kerr was the initial misreading of the pathology slides by the pathologist, this fact does not lend any support to Plaintiffs' argument that a subsequent misdiagnosis would have constituted a new negligent act or a "separate and independent act of negligence" and thus a new "occurrence" under the statute of repose. Id. Allowing plaintiffs to reallege a claim for medical malpractice at each subsequent visit to their physician after an initial misdiagnosis, would be contrary to the legislative intent of the statute of repose to be an "absolute outer limit" in medical malpractice cases. Kerr, 383 S.C. at 148, 678 S.E.2d at 810.

The Plaintiffs also attempt to distinguish this case from Howell v. Zottoli, 691 S.E.2d 564 (Ga. Ct. App. 2010). See Plaintiffs' March 7, 2014 Letter to the Court. Howell involved a physician who failed to diagnose and treat a patient with high risk for coronary artery disease at the patient's initial visit in October of 1996. Howell, 691 S.E.2d at 565. The physician subsequently provided the patient many referrals and prescriptions, but the patient never came back for an in-office visit. Id. The patient later died of coronary heart disease on April 13, 2001. The Georgia Court of Appeals held that the later acts by the physician in his treatment of the patient could not serve as the starting point for the statute of repose, and the

statute "ran from the initial date of misdiagnosis and failure to treat." Id. at 567. Contrary to the Plaintiffs contentions, this case is exactly like Howell, and the Court finds the reasoning persuasive.

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The Plaintiffs claim that these Defendants deviated from the standard of care when they failed to properly diagnose Ms. Marshall's cancer after seeing elevated protein levels in Ms. Marshall's 24-hour urine test and not ordering additional testing, such as a UPEP test and/or an SPEP test, which they claim would have revealed the cancerous protein. Plaintiffs' Complaint, at ¶ 12. While the Plaintiffs assert that the earliest Ms. Marshall's cancer could have been detected was at her February 9, 2005 visit with these Defendants, the record reveals that the first alleged misdiagnosis of Ms. Marshall by these Defendants occurred on September 15, 2004 at her initial visit. Dep. of Barry Singer, MD, 61:20-62:6; see Dep. of Robert Luke, MD, 25:7-12. The alleged misdiagnosis of Ms. Marshall on February 9, 2005 was simply the continuation of these Defendants' initial misdiagnosis of Ms. Marshall from September 15, 2004 and cannot serve as the trigger of the statute of repose.

The 24-hour urine test analyzed at Ms. Marshall's February 9, 2005 visit with these Defendants indicated that Ms. Marshall had elevated protein levels in her urine at 3.1 g/day at that time, and Plaintiffs claim that these Defendants were negligent for not ordering additional testing and properly diagnosing and treating Ms. Marshall's cancer at this time. Plaintiffs' Complaint, at ¶ 4; see Dep. of Robert Luke, MD, 146:1-8. At Ms. Marshall's subsequent visit to these Defendants on September 15, 2005, the 24-hour urine test indicated that the protein levels in Ms. Marshall's urine had increased to 4.2 g/day, and Plaintiffs again claim these

Defendants were negligent for not performing the additional tests. Plaintiffs' Complaint, at ¶ 5; see Dep. of Barry Singer, MD, 87:8-15.

However, the 24-hour urine test analyzed at Ms. Marshall's initial visit with these Defendants on September 15, 2004 revealed that Ms. Marshall's protein levels in her urine were at 3.5 g/day—a higher level of protein than the 3.1 g/day found on February 9, 2005. See Aff. of Robert Luke, MD, at 5. These Defendants also did not perform a UPEP test or an SPEP test at the September 15, 2004 visit and did not diagnose Ms. Marshall with cancer.

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Barry L. Singer, M.D., Plaintiffs' expert and a specialist in oncology, testified that based on this evidence it was more likely than not that Ms. Marshall had cancer in September of 2004 when she saw Dr. Dodds. Singer Dep. 68:17-68:23. As such, Dr. Singer stated that these Defendants initially failed to properly diagnose and treat Ms. Marshall on September 15, 2004:

Q: We established earlier that you're aware that Mrs. Marshall saw Doctor Dodds in September of 2004?

A: Yes, sir.

Q: And it would be your testimony that she had cancerous protein in her urine at that time as well?

A: I believe she did.

Q: And it would be your opinion that Doctor Dodds failed to diagnose the cancerous protein at that time as well?

A: Yes, sir.

Dep. of Barry Singer, MD, 61:20-62:6. Plaintiff's other expert, Dr. Robert Luke, also agreed that cancer was present and not diagnosed by these Defendants at Ms. Marshall's first visit on September 15, 2004. Dep. of Robert Luke, MD, 25:7-12. Dr. Singer went on to say that he believed "if that had been done, an SPEP then or UPEP, she would have been diagnosed with her disease" in September of 2004. Singer Dep. 69:9-12. In fact, Ms. Marshall had elevated protein levels at all times she saw these Defendants. See Aff. of Robert Luke, MD.

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In their March 7, 2014 letter to the Court, the Plaintiffs attempt to rely on the January 28, 2011 Affidavit of Dr. Luke that was submitted with their Notice of Intent and prior to Dr. Luke's deposition to recharacterize their claims of negligence against these Defendants. See Plaintiffs' March 7, 2014 Letter to the Court. Plaintiffs state that Dr. Luke opined in his affidavit that Dr. Dodds continuing to prescribe Diovan without properly monitoring Ms. Marshall's response to the medication and his failure to change the treatment plan in light of the continuous high protein count were "separate and distinct acts of negligence." Id. However, Dr. Luke also stated that the standard of care for a nephrologist requires that "[i]f a patient has significant proteinuria, the treating nephrologist must determine the cause of the proteinuria." Aff of Robert Luke, MD, at 2. Dr. Luke then asserted that "if a UPEP and SPEP test is performed initially and reveals cancerous protein, then Diovan would not have been the proper medication to treat the patient's condition or disease." Id. at 3. Thus, these "separate and distinct acts of negligence" in Dr. Dodds' treatment of Ms. Marshall actually stem from Dr. Dodds alleged initial misdiagnosis and mistreatment of Ms. Marshall's condition and cannot serve as new trigger points for the statute of repose.

Moreover, Dr. Luke's affidavit was submitted at the very beginning of this litigation prior to Dr. Luke testifying at his deposition on April 5, 2013. In none of their filings in opposition to this motion for summary judgment, have Plaintiffs offered any new testimony or facts outside of their initial Complaint and expert affidavits filed with their Notice of Intent. In his deposition, Dr. Luke explicitly stated that cancerous proteins were present in Ms. Marshall's urine at her first visit with Dr. Dodds on September 15, 2004. Dep. of Robert Luke, MD, 25:7-12. In fact,

when asked in his deposition, Dr. Singer could think of no reason to not include the September 15, 2004 visit in his own affidavit. Dep. of Barry Singer, MD, 62:7-25. Dep. of Robert Luke, MD, 25:7-12. Plaintiffs have done nothing to refute these facts, and offer no additional evidence to the Court. They cannot rest on the "the mere allegations or denials of [their] pleading" and hope to withstand summary judgment. Rule 56(e), S.C.R.C.P.

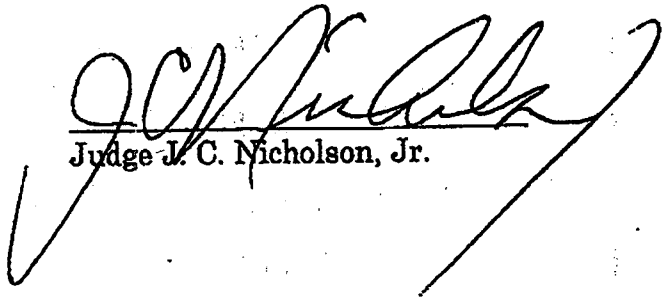
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While the Plaintiffs' arguments are insightful, the Court must evaluate this case based on all the evidence, and even taken in the light most favorable to the Plaintiffs, the record shows that the alleged misdiagnosis and mistreatment of Plaintiff Virginia Marshall's cancer by these Defendants initially occurred on September 15, 2004 rather than February 9, 2005. See Lanham v. Blue Cross & Blue Shield of S. Carolina, Inc., 349 S.C. 356, 361-62, 563 S.E.2d 331, 333 (2002). While Ms. Marshall did subsequently visit these Defendants for treatment on February 9, 2005 and was not diagnosed with cancer, this later alleged misdiagnosis cannot serve as the starting point for the statute of repose and is not a "separate and independent act" of negligence as claimed by Plaintiffs.

As such, the six-year statute of repose period ran from September 15, 2004 until September 15, 2010. Because the Plaintiffs did not file their Notice of Intent and Complaint until February 7, 2011, this action falls outside of the applicable statute of repose, and these Defendants are entitled to summary judgment on all claims.

IT IS THEREFORE ORDERED that these Defendants', Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC, Motion for Summary Judgment is GRANTED and the case is DISMISSED with prejudice as to Defendants Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC.

IT IS SO ORDERED.

5/1, 2014
Charleston, South Carolina


Judge J. C. Nicholson, Jr.

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

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO. 2011- CP-10-934

Virginia L. Marshall, et al.
PLAINTIFF(S)

Kenneth A. Dodds, MD, et al.
DEFENDANT(S)

Submitted by: _____

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

DISPOSITION TYPE (CHECK ONE)

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

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

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court: Plaintiff's motion to reconsider, filed on May 21, 2014, came before this Court on July 16, 2014, for a rehearing on the issues raised in Defendants' motions for summary judgment, of which this Court granted. Upon further review of the parties' arguments and relevant case law, this Court denies the Plaintiff's motion to reconsider and affirms its decision in the Court's orders of May 2, 2014, granting the Defendants' motions for summary judgment.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

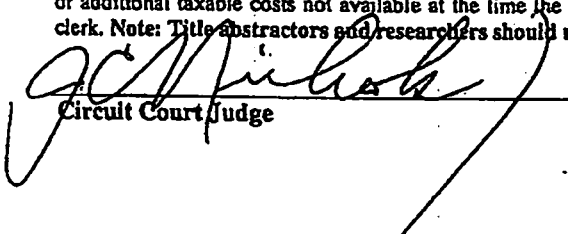
Additional Information for the Clerk : _____

INFORMATION FOR THE JUDGMENT INDEX

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

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
N/A		\$
If applicable, describe the property, including tax map information and address, referenced in the order: _____		

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.


Circuit Court Judge

2117
Judge Code

8/6/14
Date

STATE OF SOUTH CAROLINA		IN THE COURT OF COMMON PLEAS	
COUNTY OF CHARLESTON		CIVIL ACTION NO. 2011-CP-10-933	
VIRGINIA L. MARSHALL AND TODD W. MARSHALL, PLAINTIFFS, VS. KENNETH A. DODDS, M.D. AND CHARLESTON NEPRHOLOGY ASSOCIATES, LLC, DEFENDANTS.		NOTICE OF INTENT TO FILE SUIT IN A MEDICAL MALPRACTICE CASE (§15-79-125 SCCA)	

2011 FEB -7 PM 2:29
 JULIE J. ARMSBONE
 CLERK OF COURT

FILED

The Plaintiff does hereby submit this Notice of Intent to File Suit pursuant to §15-79-125 of the 1976 SC Code of Laws as amended.

- I. Venue is proper in this court because at least one Defendant, Charleston Nephrology Associates, LLC, is located in the County of Charleston and the most substantial part of the alleged acts or omissions giving rise to this cause of action occurred in this County.
- II. An affidavit of an expert witnesses, subject to the Affidavit requirements established in §15-36-100 1976 SC Code of Laws as amended, are attached hereto under Tab 1.
- III. A short and plain statement of the facts showing that the Plaintiff is entitled to the relief is:

- a. The Plaintiff Virginia Marshall, who is currently 47 years old, was treated by Dr. Kenneth A. Dodds at Charleston Nephrology Associates, LLC in February 2005 and September 2005 with complaints of proteinuria. The Plaintiff is informed and believes that Dr. Dodds was acting individually and as an agent, servant and/or employee of Charleston Nephrology Associates, LLC during the time of the events in question.
- b. On February 7, 2005, the Plaintiff had a 24-hour urine test, ordered by Dr. Dodds, which revealed approximately 3045 mg/day (3.1 g/day) of protein in her urine. The Plaintiff had a follow up appointment with Dr. Dodds on February 9, 2005. Despite the continued high protein found in the Plaintiff's urine, Dr. Dodds failed to order further testing on February 9, 2005 to determine the cause of the Plaintiff's high protein. Instead, he continued her on the medication Diovan, even though there was no obvious response to the medication, and advised her to follow up in six months for another 24-hour urine test. Dr. Dodds' failure to recognize that the continued elevation of protein in her urine could indicate cancerous protein. In addition, Dr. Dodds' failure to properly monitor the Plaintiff's response to the medication Diovan and to order additional testing to determine the reason for the high protein constitutes negligence.
- c. On September 12, 2005, seven months later, the Plaintiff had another 24-hour urine test ordered by Dr. Dodds. This urine test indicated that the Plaintiff's urine contained 4169.3 mg/day of protein. The Plaintiff saw Dr. Dodds on September 15, 2005, and Dr. Dodds' notes state that the 24-hour urine collection done on February 12, 2005 showed that she had 4.2 grams of

protein in her urine. Thus, the protein in her urine had increased from 3045 mg/day in February 2005 to 4169.3 mg/day of protein on September 15, 2005.

Dr. Dodds' failure to recognize the fact that the continued elevation of protein in her urine could contain cancerous protein constitutes negligence. In addition, based on the fact that the Plaintiff had increasing protein in her urine, Dr. Dodds had a duty to order additional testing to determine the reason for the increase in the high amounts of protein in her urine, and his failure to do so constitutes negligence.

d. In addition, in September 2005, Dr. Dodds performed two routine tests – an Albustix strip test and a 24-hour urine test. The Albustix strip test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.3 grams of protein in her urine. The discrepancy between these two test results should have further suggested to Dr. Dodds that he needed to look for cancer protein in the urine. The proper way for Dr. Dodds to test for the cancerous protein would have been to perform a UEP and SPEP test. Failure of Dr. Dodds to perform the proper testing, including a UEP and/or SPEP test, constitutes negligence.

e. Specifically, from February 2005 through September 2005, the protein found in the Plaintiff's urine had significantly increased further indicating that additional testing should have been performed. Failure of Dr. Dodds to recognize that the increased protein could constitute cancer and his failure to perform additional testing given the increase of protein in her urine from February 2005 to September 2005 constitutes negligence.

- f. In the latter part of 2009, the Plaintiff was referred to Dr. Eric Pride, another nephrologist, for her longstanding history of proteinuria. On January 7, 2010, Dr. Pride noted that the Plaintiff's last 24-hour urine test showed 3.05 grams of protein in 2005. Based on this history, Dr. Pride ordered a repeat 24-hour urine test for protein and a UEP test to evaluate the type of protein. In January 2010, when the proper UEP and SPEP tests were finally performed, cancerous myeloma protein was revealed. This was the first time the Plaintiff was ever informed that she had cancer. The Plaintiff was subsequently referred to an oncologist and diagnosed with lymphoplasmacytic lymphoma.
- g. This cancerous protein could easily have been identified and detected beginning in 2005 had Dr. Dodds performed a UEP and SPEP test. If the proper testing would have been performed in 2005, it is more likely than not that the Plaintiff's cancer would have been treated at an earlier stage thereby increasing her life expectancy. Dr. Dodd's failure to recognize that the elevated protein could indicate cancer and his failure perform the appropriate tests to determine if there was cancerous protein in the Plaintiff's urine constitutes negligence.
- h. Dr. Dodds' negligent actions and/or omissions have caused and are continuing to cause the Plaintiff to endure continuous and unnecessary pain and suffering and has led to a further decline in her medical condition.
- i. Additionally, it is more likely than not the above actions caused the Plaintiff to require and continue to receive medical treatment and incur additional medical expenses and costs.

IV. Standard interrogatories and responses are attached under Tab 2.

V. Please take notice that pursuant to the *South Carolina Court-Annexed ADR Rule (Rule 4)* you are advised that this dispute is subject to pre-suit mediation within 120 days and that the names of the primary and secondary mediators are:

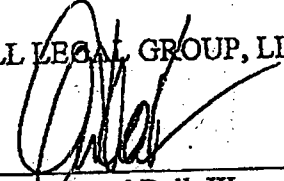
Marvin Infinger, Esquire
Primary Mediator

Thomas Wills, Esquire
Secondary Mediator

As appointed by the Clerk of Court of Charleston County the ____ day of _____, 20__.

(Notwithstanding the Clerk of Court's appointment, the parties by agreement may choose a different mediator at any time.)

BELL LEGAL GROUP, LLC

By: 

J. Edward Bell, III
C. Carter Elliott, Jr.
Deloris K. Cromartie
232 King Street
Post Office Box 2590
Georgetown, SC 29442
(843)546-2408

Georgetown, South Carolina
February 7, 2011

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Kenneth A. Dodds, MD, Charleston
Nephrology Associates, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 2011-CP-10-934

COMPLAINT
(Jury Trial Requested)
(Medical Malpractice)

BY

2011 FEB -7 PM 12:32
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

The Plaintiffs, Virginia and Todd Marshall, bring this Action against the Defendants, Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, and would respectfully show unto this Honorable Court:

PARTIES

1. The Plaintiffs are citizens and residents of the County of Charleston, State of South Carolina.
2. The Defendant, Kenneth A. Dodds, MD (hereinafter referred to as "Dodds"), upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina. At all times hereinafter mentioned, this Defendant was acting individually and as an employee of the Defendant Nephrology Associates, LLC. Additionally, this Defendant had a doctor/patient relationship with the Plaintiff, Virginia Marshall.
3. The Defendant, Charleston Nephrology Associates, LLC, upon information and belief, is a corporation organized and existing under the laws of the State of South Carolina, with

its principal place of business in Charleston, South Carolina. At all times mentioned herein this Defendant was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, MD, and had a doctor-patient relationship with the Plaintiff, Virginia Marshall.

FACTS

4. On or about February 7, 2005, the Plaintiff, Virginia Marshall, had a 24-hour urine test, ordered by the Defendant Dodds, which revealed approximately 3045 mg/day (3.1 g/day) of protein in her urine. On February 9, 2005, Mrs. Marshall was treated by the Defendants for chronic proteinuria and her recent 24-hour urine test indicated 3.1 g/day of protein in her urine. At that time, the Defendant Dodds did not order any additional testing to determine the cause of Mrs. Marshall's high protein, including but not limited to a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test. Instead, he continued her on the medication Diovan and advised her to follow up in six months for another 24-hour urine test.

5. On or about September 12, 2005, seven months later, the Defendant Dodds ordered another 24-hour urine test. This urine test indicated that Mrs. Marshall's urine contained 4169.3 mg/day of protein. Thereafter, Mrs. Marshall saw the Defendant Dodds on September 15, 2005, and the Defendants' notes indicate that the 24-hour urine collection done on February 12, 2005 showed that Mrs. Marshall had 4.2 grams of protein in her urine. Thus, the protein in Mrs. Marshall's urine had increased from 3045 mg/day in February 2005 to 4169.3 mg/day of protein on September 15, 2005. However, there was no additional testing performed by the Defendants, including but not limited to a UPEP or a SPEPT test, to determine the cause or type of protein in Mrs. Marshall's urine.

6. In addition, on September 15, 2005, the Defendant Dodds performed two routine tests – an Albustix strip test and a 24-hour urine test. The Albustrix strip test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.3 grams of protein in her urine. Despite the discrepancy between the two test results, the Defendants did not order any additional testing, including but not limited to a UPEP and/or a SPEP test, to determine the cause or type of protein in Mrs. Marshall's urine.

7. On or about January 7, 2010, the Plaintiff was referred to another nephrologist, Dr. Eric Pride, for her longstanding history of proteinuria. Based on her last 24-hour urine test in September 2005 which revealed 3.05 grams of protein, Dr. Pride ordered a UPEP test to evaluate the type of protein in Mrs. Marshall's urine. In January 2010, the UPEP and SPEP test revealed cancerous myeloma protein, and this was the first time Mrs. Marshall was ever informed she had cancer. Thereafter, Mrs. Marshall was referred to Dr. James M. Orcutt, an oncologist, in February 2010 for follow up of the cancerous protein. Mrs. Marshall was subsequently diagnosed with lymphoplasmacytic lymphoma.

8. The Plaintiffs are informed and believe that Mrs. Marshall's cancer was present and should have been detected as early as February 9, 2005 when significantly high levels of protein were discovered in her urine. The cancer could have been detected by the proper testing, including but not limited to a UPEP and/or SPEP test, to determine the type of urine protein. If her cancer had been detected in 2005, treatment could have been started immediately to prevent the cancer from spreading thereby increasing her life expectancy.

9. In addition, the Plaintiffs are informed and believe that if Mrs. Marshall's cancer would have been detected as early as February 2005, then her cancer treatment, to include but not limited to Rituxin therapy, could have been started immediately. Rituxan therapy would

have slowed the disease down in 2005, but instead, Mrs. Marshall's cancer remained untreated for five more years until she was properly tested in 2010. Therefore, if the cancerous protein had been detected by the proper testing in 2005, Mrs. Marshall's prognosis would be better and her life expectancy longer.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(Negligence)

10. The Plaintiffs reallege the allegations contained within paragraphs one (1) through nine (9) as if repeated verbatim.

11. The above set forth incidents and the Plaintiff Virginia Marshall's resulting injuries and damages were proximately caused by the negligent, grossly negligent, reckless, willful, and wanton acts of the Defendants, by and through their agents, servants, and/or employees in one, more, or all of the following particulars:

- a) in failing to properly care for and treat the Plaintiff's condition;
- b) in failing to properly diagnose the Plaintiff's condition;
- c) in failing to properly recognize that the elevated protein in the Plaintiff's urine could contain cancerous protein;
- d) in failing to treat the Plaintiff for her true and correct medical condition;
- e) in failing to recognize the signs and symptoms of elevated protein in the urine;
- f) in failing to recognize the signs and symptoms of cancerous protein in the urine;
- g) in failing to order the proper testing, to include but not be limited to a UPEP test and a SPEP, to determine the type of protein in the Plaintiff's urine;

- h) in failing to properly monitor the Plaintiff's medication;
- i) in failing to provide the proper follow up treatment after discovering high levels of protein in the Plaintiff's urine.

12. As a direct and proximate result of the aforementioned acts on behalf of the Defendants, the decedent unjustifiably suffered and died, and further, the Plaintiff has suffered ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES.

FOR A SECOND CAUSE OF ACTION
AGAINST THE DEFENDANT NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

13. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through twelve (12) as if repeated verbatim.

14. Upon information and belief, at the time of the incidents, the Defendant Dodds was an employee of Charleston Nephrology Associates, LLC, acting within the scope of his employment.

15. The Defendant, Charleston Nephrology Associates, LLC, is strictly liable for the negligent acts of its employee/servant Dr. Kenneth A. Dodds acting within the scope of his employment under the doctrine of Respondent Superior.

16. The above set forth medical care or lack thereof by the Defendants caused the Plaintiff Virginia Marshall to suffer unnecessarily and as a direct and proximate result, the Plaintiff has been injured and damaged and is entitled to receive ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES.

FOR A THIRD CAUSE OF ACTION
AGAINST THE DEFENDANTS
(Loss of Consortium)

17. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through

sixteen (16) as if repeated verbatim.

18. The Plaintiffs, Virginia Marshall and Todd Marshall were married in 1982 and are still married.

19. As a result of the Defendants' actions which adversely affected the Plaintiff, Virginia Marshall, the Plaintiff, Todd Marshall, has been injured and damaged and is entitled to ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES as follows:

- (a) pre-trial medical expenses;
- (b) post-trial and future medical expenses;
- (c) pre-trial lost wages;
- (d) post-trial lost wages;
- (e) pre-trial mental pain and suffering, mental anguish and shock; and
- (f) post-trial mental pain and suffering, mental anguish and sock.

WHEREFORE, the Plaintiff prays judgment against the Defendants, both jointly and severally for ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES, together with costs of this action, and for such other and further relief as this Court may deem fit, just and proper.

(Signature page follows)

BELL LEGAL GROUP, LLC

Deloris K. Cromartie

J. Edward Bell, III
C. Carter Elliott, Jr.
Deloris K. Cromartie
Attorneys for the Plaintiff
232 King Street
Georgetown, SC 29440
(843) 546-2408

Georgetown, South Carolina
February 1, 2011

STATE OF SOUTH CAROLINA		IN THE COURT OF COMMON PLEAS	
COUNTY OF CHARLESTON		CIVIL ACTION NO. 11-CP-10-2586	
VIRGINIA L. MARSHALL AND TODD W. MARSHALL, PLAINTIFFS, VS. GEORGIA ROANE, M.D. AND RHEUMATOLOGY ASSOCIATES, P.A., DEFENDANTS.		NOTICE OF INTENT TO FILE SUIT IN A MEDICAL MALPRACTICE CASE (§15-79-125 SCCA)	
		BY _____ JULIE J. ARMSTRONG CLERK OF COURT 2011 APR -8 PM 2:53 FILED	

The Plaintiff does hereby submit this Notice of Intent to File Suit pursuant to §15-79-125 of the 1976 SC Code of Laws as amended.

- I. Venue is proper in this court because at least one Defendant, Rheumatology Associates, P.A., is located in the County of Charleston and the most substantial part of the alleged acts or omissions giving rise to this cause of action occurred in this County.
- II. An affidavit of an expert witnesses, subject to the Affidavit requirements established in §15-36-100 1976 SC Code of Laws as amended, are attached hereto under Tab 1.
- III. A short and plain statement of the facts showing that the Plaintiff is entitled to the relief is:

- a. The Plaintiff Virginia Marshall, who is currently 47 years old, was treated by Dr. Georgia Roane at Rheumatology Associates, P.A. from April 29, 2005 through October 2007 for suspected mixed connective tissue disease. The Plaintiff is informed and believes that Dr. Roane was acting individually and as an agent, servant and/or employee of Rheumatology Associates, P.A., during the time of the events in question.
- b. On April 29, 2005 and June 29, 2005, Dr. Roane continued the Plaintiff on a high dosage of CellCept, a potent immunosuppressant, for mixed connective tissue disease – 1000 mg in the morning and 1500 mg in the evening. During this time, Dr. Roane failed to properly diagnosis the Plaintiff as the prior diagnosis of mixed connective tissue disease was never confirmed and was based on nonspecific symptoms of prior fever, rigors, and chills and persistently high SED rates, pain and fatigue. Not only did Dr. Roane fail to properly diagnose the Plaintiff, but she continued to prescribe potent immunosuppressants, such as Cellcept, which constitutes negligence. In addition, Dr. Roane's failure to recognize the misdiagnosis of mixed connective tissue disease and consider other possibilities for the Plaintiff's symptoms constitutes a breach of the standard of care.
- c. The Plaintiff was being followed by a nephrologist, Dr. Kenneth Dodds, for her chronic proteinuria until September 2005. After September 2005 when the Plaintiff was not seeing a nephrologist on a regular basis, Dr. Roane had an obligation to look for renal disease and mitigate renal damage in addition to treating the Plaintiff for any rheumatic involvement and/or disease. This would include but not be limited to making a firm diagnosis and determining

the cause of the Plaintiff's proteinuria. As such, Dr. Roane had a duty to continue pursuing the Plaintiff's high protein and order the proper testing. During this time after September 2005, Dr. Roane made no changes to the treatment plan and continued the Plaintiff's medication (to include CellCept) without properly monitoring her response to the medications. Furthermore, Dr. Roane failed to order additional testing to include a 24-hour urine test and/or a UPEP test to determine the cause of the Plaintiff's proteinuria. Failure of Dr. Roane to properly treat the Plaintiff's condition and order the proper testing constitutes negligence.

- d. Specifically, on September 29, 2005, Dr. Roane noted that the Plaintiff's urine revealed 4.2 grams of protein in 24 hours which had increased from 3.5 grams the year before. Dr. Roane continued the Plaintiff on her medications, to include CellCept, but failed to order any additional testing. Failure of Dr. Roane to recognize that the increasing protein levels could indicate cancerous protein and her failure to order or perform additional testing, including a UPEP test, constitutes a breach of the standard of care.
- e. From April 2005 through October 2007, Dr. Roane failed to properly diagnose the Plaintiff's condition. The Plaintiff's consistent symptoms of high fever, rigors, chills and persistent lymphadenopathy (i.e., enlarged lymph nodes) were most likely signs of a malignant infection, meaning the Plaintiff was most likely suffering from an occult malignancy and/or lymphoma instead of the previously misdiagnosed mixed connective tissue disorder. Failure of Dr. Roane to recognize symptoms of a malignant infection and/or lymphoma constitutes negligence.

- f. The Plaintiff was diagnosed with unidentified mixed connective tissue disorder despite negative antibodies and atypical symptoms and was treated aggressively for a disease which she did not have. Failure of Dr. Roane to properly diagnose the Plaintiff's true medical condition, and Dr. Roane's persistent and aggressive treatment for an illness which the Plaintiff did not have, constitutes negligence.
- g. In addition, the Plaintiff's SED rate remained strikingly elevated and did not change throughout her treatment with Dr. Roane. The Plaintiff's SED rate remained high despite potent medications, which should not have been used to treat the Plaintiff's symptoms of fatigue and joint pain without a firm diagnosis. Failure of Dr. Roane to recognize that the Plaintiff's elevated SED rate and proteinuria could indicate cancer beginning in April 2005, and her failure to properly monitor the Plaintiff's response to medications, constitutes negligence.
- h. Further, Dr. Roane noted throughout her treatment that the Plaintiff had lymphadenopathy. Since the Plaintiff had enlarged lymph nodes from April 2005 forward, Dr. Roane should have performed a biopsy of the lymph nodes especially when considering the Plaintiff's symptoms of unexplained fever, chills and rigors. Failure of Dr. Roane to order additional testing, to include and not limited to a lymph node biopsy, constitutes negligence.
- i. In the latter part of 2009, the Plaintiff was seen by Dr. Eric Pride, a nephrologist, for her longstanding history of proteinuria. On January 7, 2010, Dr. Pride noted that the Plaintiff's last 24-hour urine test showed 3.05 grams of protein in 2005. Based on this history, Dr. Pride ordered a repeat 24-hour

urine test for protein and a UEP test to evaluate the type of protein. In January 2010, when the proper UEP was finally performed, cancerous myeloma protein was revealed. In addition, a bone marrow biopsy revealed lymphoma. This was the first time the Plaintiff was ever informed that she had cancer. The Plaintiff was subsequently referred to an oncologist and diagnosed with lymphoplasmacytic lymphoma.

j. This cancerous protein could easily have been identified and detected beginning in April 2005 had Dr. Roane properly diagnosed the Plaintiff and ordered additional testing, to include a UPEP test and/or a lymph node biopsy. If the proper testing would have been performed as early as April 29, 2005, it is more likely than not that the Plaintiff's cancer would have been treated at an earlier stage thereby increasing her life expectancy. Dr. Roane's failure to recognize that the Plaintiff's symptoms of high fever, chills, rigors, lymphadenopathy, and persistently elevated SED and protein levels could indicate cancer, and her failure perform the appropriate testing constitutes negligence.

k. Dr. Roane's negligent actions and/or omissions have caused and are continuing to cause the Plaintiff to endure continuous and unnecessary pain and suffering and have led to a further decline in her medical condition.

l. Additionally, it is more likely than not the above actions caused the Plaintiff to require and continue to receive medical treatment and incur additional medical expenses and costs.

IV. Standard interrogatories and responses are attached under Tab 2.

V. Please take notice that pursuant to the *South Carolina Court-Annexed ADR Rule (Rule 4)* you are advised that this dispute is subject to pre-suit mediation within 120 days and that the names of the primary and secondary mediators are:

Marvin Infinger, Esquire
Primary Mediator

Thomas Wills, Esquire
Secondary Mediator

As appointed by the Clerk of Court of Charleston County the ____ day of _____, 20__.

(Notwithstanding the Clerk of Court's appointment, the parties by agreement may choose a different mediator at any time.)

BELL LEGAL GROUP, LLC

By: Deloris K. Cromartie
J. Edward Bell, III
C. Carter Elliott, Jr.
Deloris K. Cromartie
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(843)546-2408

Georgetown, South Carolina
April 6, 2011

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

vs.

Georgia Roane, M.D. and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 11-CP-10-2587

SUMMONS

Jury Trial Requested

2011 APR-8 PM 2:49
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

FILED

TO THE DEFENDANTS ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, of which a copy is herewith served upon you, and to serve a copy of your Answer to said Complaint in the subscribed to J. Edward Bell, III, BELL LEGAL GROUP, 232 KING STREET, GEORGETOWN, SOUTH CAROLINA, 29440 within THIRTY (30) DAYS after the service hereof, exclusive of the date of such service; and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

(Signature on Next Page)

Deloris K. Cromartie

J. Edward Bell, III, Esquire
C. Carter Elliott, Jr., Esquire
Deloris K. Cromartie, Esquire
BELL LEGAL GROUP, LLC
232 King Street
Georgetown, SC 29440
TEL: (843) 546-2408
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Georgetown, South Carolina
April 6, 2011

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Georgia Roane, M.D. and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 11-CR-40-2587

COMPLAINT
(Jury Trial Requested)
(Medical Malpractice)

2011 APR -8 PM 2:49
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

The Plaintiffs, Virginia and Todd Marshall, bring this Action against the Defendants, Georgia Roane, M.D., and Rheumatology Associates, P.A., and would respectfully show unto this Honorable Court:

PARTIES

1. The Plaintiffs are citizens and residents of the County of Charleston, State of South Carolina.
2. The Defendant, Georgia Roane, M.D. (hereinafter referred to as "Roane"), upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina. At all times hereinafter mentioned, this Defendant was acting individually and as an employee of the Defendant Rheumatology Associates, P.A. Additionally, this Defendant had a doctor/patient relationship with the Plaintiff, Virginia Marshall.
3. The Defendant, Rheumatology Associates, P.A., upon information and belief, is a corporation organized and existing under the laws of the State of South Carolina, with its

principal place of business in Charleston, South Carolina. At all times mentioned herein, this Defendant was acting by and through its agents, servants, and/or employees including but not limited to Georgia Roane, M.D., and had a doctor-patient relationship with the Plaintiff, Virginia Marshall.

FACTS

4. From 2000-2005, the Plaintiff Virginia Marshall, currently 47 years old, was diagnosed and treated by the Defendant Roane for mixed connective tissue disease. During that time period, the diagnosis of mixed connective tissue disease was based on various factors to include elevated sedimentation (SED) rates.

5. Thereafter, on or about April 29, 2005, the Defendant Roane continued treatment of the Plaintiff for mixed connective tissue disease and prescribed CellCept, a potent immunosuppressant. The Defendant Roane's continuous diagnosis of mixed connective tissue disease was made based on atypical symptoms to include but not limited to fever, chills and rigors. During this time in April 2005, the Defendant Roane failed to properly diagnose the Plaintiff's condition as the prior diagnosis of mixed connective tissue disease was never confirmed and was based on nonspecific symptoms.

6. In addition to the above symptoms, the Plaintiff continued to have significantly elevated sedimentation (SED) rates, lymphadopathy (i.e., enlarged lymph nodes) and increasingly high protein levels in her urine. During this time, the Defendant Roane failed to recognize the misdiagnosis of mixed connective tissue disease and consider other possibilities for the Plaintiff's persistent unresolved symptoms, to include the elevated SED rate, enlarged lymph nodes and increasing urine protein.

7. In addition to seeing Dr. Roane, the Plaintiff was treating with a nephrologist, Dr.

Kenneth Dodds, for her chronic proteinuria until mid-September 2005. After September 2005 when the Plaintiff was no longer under the care of a nephrologist, the Defendant Roane had an obligation to look for renal disease and mitigate renal damage in addition to any rheumatologic involvement. As such, the Defendant Roane had a duty to continue to pursue the Plaintiff's high protein and order the proper testing to evaluate and determine the cause of the Plaintiff's proteinuria.

8. On or about September 29, 2005, the Defendant Roane noted that the Plaintiff's urine revealed 4.2 grams of protein in 24 hours which was a significant increase from 3.5 grams a year earlier. At that time, the Defendant Roane continued the Plaintiff on the same treatment plan as before which included the same medications, to include the potent immunosuppressant CellCept. In addition, the Defendant Roane failed to order any additional testing, to include but not limited to a UPEP test, or refer the Plaintiff to a specialist for evaluation of the significantly elevated urine protein.

9. On or about April 5, 2006, Dr. Roane noted that the Plaintiff's SED rate was somewhat lower and continued the Plaintiff on CellCept, Plaquenil and Celebrex. However, the Plaintiff's SED rate remained consistently high despite the medications, and while the potent medications caused to SED rate to decrease somewhat at times, it was obvious that the medications failed to treat the Plaintiff's underlying condition.

10. In April 2006, the Defendant Roane's diagnosis was "mixed connective tissue disease with primary manifestation of proteinuria." Despite the increasingly high protein in the Plaintiff's urine during this time, the Defendant Roane continued to prescribe the same medications as before. Instead of ordering the proper testing or referring the Plaintiff to a specialist to determine the cause of her elevated protein, the Defendant Roane continued to

misdiagnose mixed connective tissue disorder as the cause of the Plaintiff's proteinuria and other symptoms instead of considering alternative possibilities such as a malignant infection and/or cancer.

11. In addition to the above, the Plaintiff's SED rate remained strikingly elevated (60-140 range) which should have suggested to the Defendant Roane that there was a potential protein problem. Instead, the Defendant Roane continued to treat the Plaintiff's symptoms of fatigue and joint pain with potent immunosuppressants which were ineffective in treating the Plaintiff's underlying condition.

12. From April 2005 through October 2007, the Defendant Roane continued to aggressively treat the Plaintiff for mixed connective tissue disease, a disease with the Plaintiff did not have and which was never confirmed. The Defendant failed to order additional testing to confirm the mixed connective tissue disease diagnosis or evaluate the Plaintiff's other symptoms, to include her significantly elevated urine protein.

13. Additionally, the Defendant Roane continued to note that the Plaintiff had lymphadenopathy, but she failed to order any additional testing, to include a biopsy, to determine the cause of the Plaintiff's enlarged lymph nodes.

14. On or about January 7, 2010, the Plaintiff was referred to a nephrologist, Dr. Eric Pride, for her longstanding history of proteinuria. Based on her last 24-hour urine test in September 2005 which revealed 3.05 grams of protein, Dr. Pride ordered a repeat 24-hour urine test and a UPEP test to evaluate the type of protein in the Plaintiff's urine. In January 2010, the UPEP test revealed cancerous myeloma protein, and this was the first time the Plaintiff was ever informed she had cancer. In addition, a subsequent bone marrow biopsy revealed lymphoma. Thereafter, the Plaintiff was referred to Dr. James M. Orcutt, an oncologist, in February 2010 for

follow up and was subsequently diagnosed with lymphoplasmacytic lymphoma.

15. The Plaintiffs are informed and believe that Mrs. Marshall's cancer was present and should have been detected as early as April 29, 2005 when her documented symptoms included but were not limited to enlarged lymph nodes, elevated SED rates, and significantly high levels of protein, and her diagnosis of mixed connective tissue disease was never confirmed. The Plaintiff's cancer could have been detected by ordering and/or performing the proper testing, including but not limited to a UPEP test and/or a lymph node biopsy. If her cancer had been detected in 2005, treatment could have been started immediately to prevent the cancer from spreading thereby increasing her life expectancy.

16. In addition, the Plaintiffs are informed and believe that if Mrs. Marshall's cancer would have been detected as early as April 29, 2005, then her cancer treatment, to include but not limited to Rituxin therapy, could have been started immediately. Rituxan therapy would have slowed the disease down in 2005, but instead, Mrs. Marshall's cancer remained untreated for five more years until she was properly tested in 2010. Therefore, if the cancerous protein had been detected by the proper testing in 2005, Mrs. Marshall's prognosis would be better and her life expectancy longer.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(Negligence)

17. The Plaintiffs reallege the allegations contained within paragraphs one (1) through sixteen (16) as if repeated verbatim.

18. The above set forth incidents and the Plaintiff Virginia Marshall's resulting injuries and damages were proximately caused by the negligent, grossly negligent, reckless, willful, and wanton acts of the Defendants, by and through their agents, servants, and/or employees in one, more, or all of the following particulars:

Page 5 of 9

- a) in failing to properly care for and treat the Plaintiff's condition;
- b) in failing to properly evaluate, assess and diagnose the Plaintiff's condition;
- c) in failing to recognize the symptoms of malignant infection and/or lymphoma;
- d) in diagnosing the Plaintiff with a disease based on nonspecific symptoms;
- e) in prescribing potent immunosuppressants, to include CellCept and Immuran, to treat a patient with persistently high SED rates and poorly characterized mixed connective tissue disorder;
- f) in prescribing potent immunosuppressants, to include CellCept and Immuran, to treat symptoms of fatigue and joint pain without determining the cause for such symptoms;
- g) in failing to treat the Plaintiff for her true and correct medical condition;
- h) in misdiagnosing the Plaintiff with mixed connective tissue disorder as the cause of the Plaintiff's symptoms;
- i) in failing to recognize the signs and symptoms of elevated protein in the urine;
- j) in failing to properly evaluate and diagnose the cause of the Plaintiff's proteinuria;
- k) in failing to refer the Plaintiff to a specialist for the proper testing and treatment for her proteinuria;
- l) in failing to recognize the signs and symptoms of cancerous protein in the urine;

- m) in failing to recognize that the elevated protein in the Plaintiff's urine could contain cancerous protein;
- n) in failing to order the proper testing, to include but not be limited to a UPEP test, to determine the type of protein in the Plaintiff's urine;
- o) in failing to prescribe the proper medications to treat the Plaintiff's condition;
- p) in failing to properly monitor the Plaintiff's medication;
- q) in failing to provide the proper follow up treatment after discovering high levels of protein in the Plaintiff's urine; and
- r) in failing to order additional testing to include a lymph node biopsy given the Plaintiff's symptoms of unexplained fever, chills, rigors and lymphadenopathy.

19. As a direct and proximate result of the aforementioned acts on behalf of the Defendants, the decedent unjustifiably suffered and died, and further, the Plaintiff has suffered ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES.

FOR A SECOND CAUSE OF ACTION
AGAINST THE DEFENDANT RHEUMATOLOGY ASSOCIATES, P.A.
(Respondent Superior)

20. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through nineteen (19) as if repeated verbatim.

21. Upon information and belief, at the time of the incidents, the Defendant Roane was an employee of Rheumatology Associates, P.A., acting within the scope of his employment.

22. The Defendant, Rheumatology Associates, P.A., is strictly liable for the negligent acts of its employee/servant, Dr. Georgia Roane, acting within the scope of her employment

under the doctrine of Respondent Superior.

23. The above set forth medical care or lack thereof by the Defendants caused the Plaintiff Virginia Marshall to suffer unnecessarily and as a direct and proximate result, the Plaintiff has been injured and damaged and is entitled to receive ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES.

FOR A THIRD CAUSE OF ACTION
AGAINST THE DEFENDANTS
(Loss of Consortium)

24. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through twenty-three (23) as if repeated verbatim.

25. The Plaintiffs, Virginia Marshall and Todd Marshall were married in 1982 and are still married.

26. As a result of the Defendants' actions which adversely affected the Plaintiff, Virginia Marshall, the Plaintiff, Todd Marshall, has been injured and damaged and is entitled to ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES as follows:

- (a) pre-trial medical expenses;
- (b) post-trial and future medical expenses;
- (c) pre-trial lost wages;
- (d) post-trial lost wages;
- (e) pre-trial mental pain and suffering; mental anguish and shock; and
- (f) post-trial mental pain and suffering, mental anguish and sock.

WHEREFORE, the Plaintiff prays judgment against the Defendants, both jointly and severally for ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES, together with costs of this action, and for such other and further relief as this Court may deem fit, just and proper.

Page 8 of 9

BELL LEGAL GROUP, LLC

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Georgetown, South Carolina
April 6, 2011

Page 9 of 9

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Kenneth A. Dodds, MD, Charleston
Nephrology Associates, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 2011-CP-10-4057

COMPLAINT

(Jury Trial Requested)
(Medical Malpractice)

FILED
2011 JUN -8 AM 11:26
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

The Plaintiffs, Virginia and Todd Marshall, bring this Action against the Defendants, Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, and would respectfully show unto this Honorable Court:

PARTIES

1. The Plaintiffs are citizens and residents of the County of Charleston, State of South Carolina.

2. The Defendant, Kenneth A. Dodds, MD (hereinafter referred to as "Dodds"), upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina. At all times hereinafter mentioned, this Defendant was acting individually and as an employee of the Defendant Nephrology Associates, LLC. Additionally, this Defendant had a doctor/patient relationship with the Plaintiff, Virginia Marshall.

3. The Defendant, Charleston Nephrology Associates, LLC, upon information and belief, is a corporation organized and existing under the laws of the State of South Carolina, with

its principal place of business in Charleston, South Carolina. At all times mentioned herein this Defendant was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, MD, and had a doctor-patient relationship with the Plaintiff, Virginia Marshall.

FACTS

4. On or about February 7, 2005, the Plaintiff, Virginia Marshall, had a 24-hour urine test, ordered by the Defendant Dodds, which revealed approximately 3045 mg/day (3.1 g/day) of protein in her urine. On February 9, 2005, Mrs. Marshall was treated by the Defendants for chronic proteinuria and her recent 24-hour urine test indicated 3.1 g/day of protein in her urine. At that time, the Defendant Dodds did not order any additional testing to determine the cause of Mrs. Marshall's high protein, including but not limited to a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test. Instead, he continued her on the medication Diovan and advised her to follow up in six months for another 24-hour urine test.

5. On or about September 12, 2005, seven months later, the Defendant Dodds ordered another 24-hour urine test. This urine test indicated that Mrs. Marshall's urine contained 4169.3 mg/day of protein. Thereafter, Mrs. Marshall saw the Defendant Dodds on September 15, 2005, and the Defendants' notes indicate that the 24-hour urine collection done on February 12, 2005 showed that Mrs. Marshall had 4.2 grams of protein in her urine. Thus, the protein in Mrs. Marshall's urine had increased from 3045 mg/day in February 2005 to 4169.3 mg/day of protein on September 15, 2005. However, there was no additional testing performed by the Defendants, including but not limited to a UPEP or a SPEPT test, to determine the cause or type of protein in Mrs. Marshall's urine.

6. In addition, on September 15, 2005, the Defendant Dodds performed two routine tests – an Albustix strip test and a 24-hour urine test. The Albustrix strip test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.3 grams of protein in her urine. Despite the discrepancy between the two test results, the Defendants did not order any additional testing, including but not limited to a UPEP and/or a SPEP test, to determine the cause or type of protein in Mrs. Marshall's urine.

7. On or about January 7, 2010, the Plaintiff was referred to another nephrologist, Dr. Eric Pride, for her longstanding history of proteinuria. Based on her last 24-hour urine test in September 2005 which revealed 3.05 grams of protein, Dr. Pride ordered a UPEP test to evaluate the type of protein in Mrs. Marshall's urine. In January 2010, the UPEP and SPEP test revealed cancerous myeloma protein, and this was the first time Mrs. Marshall was ever informed she had cancer. Thereafter, Mrs. Marshall was referred to Dr. James M. Orcutt, an oncologist, in February 2010 for follow up of the cancerous protein. Mrs. Marshall was subsequently diagnosed with lymphoplasmacytic lymphoma.

8. The Plaintiffs are informed and believe that Mrs. Marshall's cancer was present and should have been detected as early as February 9, 2005 when significantly high levels of protein were discovered in her urine. The cancer could have been detected by the proper testing, including but not limited to a UPEP and/or SPEP test, to determine the type of urine protein. If her cancer had been detected in 2005, treatment could have been started immediately to prevent the cancer from spreading thereby increasing her life expectancy.

9. In addition, the Plaintiffs are informed and believe that if Mrs. Marshall's cancer would have been detected as early as February 2005, then her cancer treatment, to include but not limited to Rituxin therapy, could have been started immediately. Rituxan therapy would

have slowed the disease down in 2005, but instead, Mrs. Marshall's cancer remained untreated for five more years until she was properly tested in 2010. Therefore, if the cancerous protein had been detected by the proper testing in 2005, Mrs. Marshall's prognosis would be better and her life expectancy longer.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(Negligence)

10. The Plaintiffs reallege the allegations contained within paragraphs one (1) through nine (9) as if repeated verbatim.

11. The above set forth incidents and the Plaintiff Virginia Marshall's resulting injuries and damages were proximately caused by the negligent, grossly negligent, reckless, willful, and wanton acts of the Defendants, by and through their agents, servants, and/or employees in one, more, or all of the following particulars:

- a) in failing to properly care for and treat the Plaintiff's condition;
- b) in failing to properly diagnose the Plaintiff's condition;
- c) in failing to properly recognize that the elevated protein in the Plaintiff's urine could contain cancerous protein;
- d) in failing to treat the Plaintiff for her true and correct medical condition;
- e) in failing to recognize the signs and symptoms of elevated protein in the urine;
- f) in failing to recognize the signs and symptoms of cancerous protein in the urine;
- g) in failing to order the proper testing, to include but not be limited to a UPEP test and a SPEP, to determine the type of protein in the Plaintiff's urine;

- h) in failing to properly monitor the Plaintiff's medication;
- i) in failing to provide the proper follow up treatment after discovering high levels of protein in the Plaintiff's urine.

12. As a direct and proximate result of the aforementioned acts on behalf of the Defendants, the decedent unjustifiably suffered and died, and further, the Plaintiff has suffered ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES.

FOR A SECOND CAUSE OF ACTION
AGAINST THE DEFENDANT NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

13. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through twelve (12) as if repeated verbatim.

14. Upon information and belief, at the time of the incidents, the Defendant Dodds was an employee of Charleston Nephrology Associates, LLC, acting within the scope of his employment.

15. The Defendant, Charleston Nephrology Associates, LLC, is strictly liable for the negligent acts of its employee/servant Dr. Kenneth A. Dodds acting within the scope of his employment under the doctrine of Respondent Superior.

16. The above set forth medical care or lack thereof by the Defendants caused the Plaintiff Virginia Marshall to suffer unnecessarily and as a direct and proximate result, the Plaintiff has been injured and damaged and is entitled to receive ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES.

FOR A THIRD CAUSE OF ACTION
AGAINST THE DEFENDANTS
(Loss of Consortium)

17. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through

sixteen (16) as if repeated verbatim.

18. The Plaintiffs, Virginia Marshall and Todd Marshall were married in 1982 and are still married.

19. As a result of the Defendants' actions which adversely affected the Plaintiff, Virginia Marshall, the Plaintiff, Todd Marshall, has been injured and damaged and is entitled to ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES as follows:

- (a) pre-trial medical expenses;
- (b) post-trial and future medical expenses;
- (c) pre-trial lost wages;
- (d) post-trial lost wages;
- (e) pre-trial mental pain and suffering, mental anguish and shock; and
- (f) post-trial mental pain and suffering, mental anguish and sock.

WHEREFORE, the Plaintiff prays judgment against the Defendants, both jointly and severally for ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES, together with costs of this action, and for such other and further relief as this Court may deem fit, just and proper.

(Signature page follows)

BELL LEGAL GROUP, LLC

Deloris K. Cromartie

J. Edward Bell, III
C. Carter Elliott, Jr.
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Georgetown, South Carolina
June 6, 2011

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Kenneth A. Dodds, MD, Charleston
Nephrology Associates, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 2011-CP-10-934

AMENDED COMPLAINT

(Pre-July 1, 2005 Allegations)

(Jury Trial Requested)

(Medical Malpractice)



FILED
JULIE J. ARISTON
CLERK OF COURT

2011 DEC 28 PM 4:16

FILED

The Plaintiffs, Virginia and Todd Marshall, bring this Action against the Defendants, Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, and would respectfully show unto this Honorable Court:

PARTIES

1. The Plaintiffs are citizens and residents of the County of Charleston, State of South Carolina.
2. The Defendant, Kenneth A. Dodds, MD (hereinafter referred to as "Dodds"), upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina. At all times hereinafter mentioned, this Defendant was acting individually and as an employee of the Defendant Nephrology Associates, LLC. Additionally, this Defendant had a doctor/patient relationship with the Plaintiff, Virginia Marshall.
3. The Defendant, Charleston Nephrology Associates, LLC, upon information and belief, is a corporation organized and existing under the laws of the State of South Carolina, with

its principal place of business in Charleston, South Carolina. At all times mentioned herein this Defendant was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, MD, and had a doctor-patient relationship with the Plaintiff, Virginia Marshall.

FACTS

4. On or about February 7, 2005, the Plaintiff, Virginia Marshall, had a 24-hour urine test, ordered by the Defendant Dodds, which revealed approximately 3045 mg/day (3.1 g/day) of protein in her urine. On February 9, 2005, Mrs. Marshall was treated by the Defendants for chronic proteinuria and her recent 24-hour urine test indicated 3.1 g/day of protein in her urine. At that time, the Defendant Dodds did not order any additional testing to determine the cause of Mrs. Marshall's high protein, including but not limited to a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test. Instead, he continued her on the medication Diovan and advised her to follow up in six months for another 24-hour urine test.

5. On or about September 12, 2005, seven months later, the Defendant Dodds ordered another 24-hour urine test. This urine test indicated that Mrs. Marshall's urine contained 4169.3 mg/day of protein. Thereafter, Mrs. Marshall saw the Defendant Dodds on September 15, 2005, and the Defendants' notes indicate that the 24-hour urine collection done on February 12, 2005 showed that Mrs. Marshall had 4.2 grams of protein in her urine. Thus, the protein in Mrs. Marshall's urine had increased from 3045 mg/day in February 2005 to 4169.3 mg/day of protein on September 15, 2005. However, there was no additional testing performed by the Defendants, including but not limited to a UPEP or a SPEPT test, to determine the cause or type of protein in Mrs. Marshall's urine.

6. In addition, on September 15, 2005, the Defendant Dodds performed two routine tests – an Albustix strip test and a 24-hour urine test. The Albustrix strip test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.3 grams of protein in her urine. Despite the discrepancy between the two test results, the Defendants did not order any additional testing, including but not limited to a UPEP and/or a SPEP test, to determine the cause or type of protein in Mrs. Marshall's urine.

7. On or about January 7, 2010, the Plaintiff was referred to another nephrologist, Dr. Eric Pride, for her longstanding history of proteinuria. Based on her last 24-hour urine test in September 2005 which revealed 3.05 grams of protein, Dr. Pride ordered a UPEP test to evaluate the type of protein in Mrs. Marshall's urine. In January 2010, the UPEP and SPEP test revealed cancerous myeloma protein, and this was the first time Mrs. Marshall was ever informed she had cancer. Thereafter, Mrs. Marshall was referred to Dr. James M. Orcutt, an oncologist, in February 2010 for follow up of the cancerous protein. Mrs. Marshall was subsequently diagnosed with lymphoplasmacytic lymphoma.

8. The Plaintiffs are informed and believe that Mrs. Marshall's cancer was present and should have been detected as early as February 9, 2005 when significantly high levels of protein were discovered in her urine. The cancer could have been detected by the proper testing, including but not limited to a UPEP and/or SPEP test, to determine the type of urine protein. If her cancer had been detected in 2005, treatment could have been started immediately to prevent the cancer from spreading thereby increasing her life expectancy.

9. In addition, the Plaintiffs are informed and believe that if Mrs. Marshall's cancer would have been detected as early as February 2005, then her cancer treatment, to include but not limited to Rituxin therapy, could have been started immediately. Rituxan therapy would

have slowed the disease down in 2005, but instead, Mrs. Marshall's cancer remained untreated for five more years until she was properly tested in 2010. Therefore, if the cancerous protein had been detected by the proper testing in 2005, Mrs. Marshall's prognosis would be better and her life expectancy longer.

10. This Complaint includes causes of action from February 9, 2005 through June 30, 2005 – which is prior to the July 1, 2005 effective date of the South Carolina Medical Malpractice Act, § 15-79-110 et seq. There is a second Complaint (Civil Action Number 2011-10-4057) filed by the Plaintiffs against the Defendants as to causes of action occurring after July 1, 2005. The second Complaint was filed after the Notice of Intent (Civil Action No. 2011-CP-10-4057) and pre-suit procedural requirements were met (including mediation) in regard to the post-July 1, 2005 allegations.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(From February 9, 2005 through June 30, 2005)
(Negligence)

11. The Plaintiffs reallege the allegations contained within paragraphs one (1) through ten (10) as if repeated verbatim.

12. The above set forth incidents and the Plaintiff Virginia Marshall's resulting injuries and damages were proximately caused by the negligent, grossly negligent, reckless, willful, and wanton acts of the Defendants, by and through their agents, servants, and/or employees in one, more, or all of the following particulars:

- a) in failing to properly care for and treat the Plaintiff's condition;
- b) in failing to properly diagnose the Plaintiff's condition;
- c) in failing to properly recognize that the elevated protein in the Plaintiff's urine could contain cancerous protein;

- d) in failing to treat the Plaintiff for her true and correct medical condition;
- e) in failing to recognize the signs and symptoms of elevated protein in the urine;
- f) in failing to recognize the signs and symptoms of cancerous protein in the urine;
- g) in failing to order the proper testing, to include but not be limited to a UPEP test and a SPEP, to determine the type of protein in the Plaintiff's urine;
- h) in failing to properly monitor the Plaintiff's medication;
- i) in failing to provide the proper follow up treatment after discovering high levels of protein in the Plaintiff's urine.

13. As a direct and proximate result of the aforementioned acts on behalf of the Defendants, the decedent unjustifiably suffered and died, and further, the Plaintiff has suffered ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES.

FOR A SECOND CAUSE OF ACTION
AGAINST THE DEFENDANT NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

14. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through thirteen (13) as if repeated verbatim.

15. Upon information and belief, at the time of the incidents, the Defendant Dodds was an employee of Charleston Nephrology Associates, LLC, acting within the scope of his employment.

16. The Defendant, Charleston Nephrology Associates, LLC, is strictly liable for the negligent acts of its employee/servant Dr. Kenneth A. Dodds acting within the scope of his

employment under the doctrine of Respondent Superior.

17. The above set forth medical care or lack thereof by the Defendants caused the Plaintiff Virginia Marshall to suffer unnecessarily and as a direct and proximate result, the Plaintiff has been injured and damaged and is entitled to receive ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES.

FOR A THIRD CAUSE OF ACTION
AGAINST THE DEFENDANTS
(Loss of Consortium)

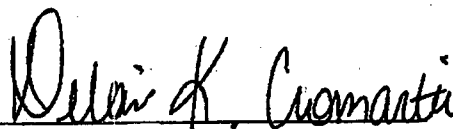
18. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through seventeen (17) as if repeated verbatim.

19. The Plaintiffs, Virginia Marshall and Todd Marshall were married in 1982 and are still married.

20. As a result of the Defendants' actions which adversely affected the Plaintiff, Virginia Marshall, the Plaintiff, Todd Marshall, has been injured and damaged and is entitled to ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES as follows:

- (a) pre-trial medical expenses;
- (b) post-trial and future medical expenses;
- (c) pre-trial lost wages;
- (d) post-trial lost wages;
- (e) pre-trial mental pain and suffering, mental anguish and shock; and
- (f) post-trial mental pain and suffering, mental anguish and sock.

WHEREFORE, the Plaintiff prays judgment against the Defendants, both jointly and severally for ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES, together with costs of this action, and for such other and further relief as this Court may deem fit, just and proper.



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Attorneys for the Plaintiff

Georgetown, South Carolina
December 22, 2011

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CIVIL ACTION NO.2011-CP-10-4057

Virginia L. Marshall and Todd W.
Marshall,

Plaintiff,

vs.

Kenneth A. Dodds, MD, Charleston
Nephrology Associates, LLC,

Defendants.

AMENDED COMPLAINT
(Post-July 1, 2005 Allegations)
(Jury Trial Requested)
(Medical Malpractice)

2011 DEC 28 PM 4:16
JULIE A. ANDERSON
CLERK OF COURT



The Plaintiffs, Virginia and Todd Marshall, bring this Action against the Defendants, Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, and would respectfully show unto this Honorable Court:

PARTIES

1. The Plaintiffs are citizens and residents of the County of Charleston, State of South Carolina.
2. The Defendant, Kenneth A. Dodds, MD (hereinafter referred to as "Dodds"), upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina. At all times hereinafter mentioned, this Defendant was acting individually and as an employee of the Defendant Nephrology Associates, LLC. Additionally, this Defendant had a doctor/patient relationship with the Plaintiff, Virginia Marshall.
3. The Defendant, Charleston Nephrology Associates, LLC, upon information and belief, is a corporation organized and existing under the laws of the State of South Carolina, with

its principal place of business in Charleston, South Carolina. At all times mentioned herein this Defendant was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, MD, and had a doctor-patient relationship with the Plaintiff, Virginia Marshall.

FACTS

4. On or about February 7, 2005, the Plaintiff, Virginia Marshall, had a 24-hour urine test, ordered by the Defendant Dodds, which revealed approximately 3045 mg/day (3.1 g/day) of protein in her urine. On February 9, 2005, Mrs. Marshall was treated by the Defendants for chronic proteinuria and her recent 24-hour urine test indicated 3.1 g/day of protein in her urine. At that time, the Defendant Dodds did not order any additional testing to determine the cause of Mrs. Marshall's high protein, including but not limited to a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test. Instead, he continued her on the medication Diovan and advised her to follow up in six months for another 24-hour urine test.

5. On or about September 12, 2005, seven months later, the Defendant Dodds ordered another 24-hour urine test. This urine test indicated that Mrs. Marshall's urine contained 4169.3 mg/day of protein. Thereafter, Mrs. Marshall saw the Defendant Dodds on September 15, 2005, and the Defendants' notes indicate that the 24-hour urine collection done on February 12, 2005 showed that Mrs. Marshall had 4.2 grams of protein in her urine. Thus, the protein in Mrs. Marshall's urine had increased from 3045 mg/day in February 2005 to 4169.3 mg/day of protein on September 15, 2005. However, there was no additional testing performed by the Defendants, including but not limited to a UPEP or a SPEPT test, to determine the cause or type of protein in Mrs. Marshall's urine.

6. In addition, on September 15, 2005, the Defendant Dodds performed two routine tests – an Albustix strip test and a 24-hour urine test. The Albustix strip test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.3 grams of protein in her urine. Despite the discrepancy between the two test results, the Defendants did not order any additional testing, including but not limited to a UPEP and/or a SPEP test, to determine the cause or type of protein in Mrs. Marshall's urine.

7. On or about January 7, 2010, the Plaintiff was referred to another nephrologist, Dr. Eric Pride, for her longstanding history of proteinuria. Based on her last 24-hour urine test in September 2005 which revealed 3.05 grams of protein, Dr. Pride ordered a UPEP test to evaluate the type of protein in Mrs. Marshall's urine. In January 2010, the UPEP and SPEP test revealed cancerous myeloma protein, and this was the first time Mrs. Marshall was ever informed she had cancer. Thereafter, Mrs. Marshall was referred to Dr. James M. Orcutt, an oncologist, in February 2010 for follow up of the cancerous protein. Mrs. Marshall was subsequently diagnosed with lymphoplasmacytic lymphoma.

8. The Plaintiffs are informed and believe that Mrs. Marshall's cancer was present and should have been detected as early as February 9, 2005 when significantly high levels of protein were discovered in her urine. The cancer could have been detected by the proper testing, including but not limited to a UPEP and/or SPEP test, to determine the type of urine protein. If her cancer had been detected in 2005, treatment could have been started immediately to prevent the cancer from spreading thereby increasing her life expectancy.

9. In addition, the Plaintiffs are informed and believe that if Mrs. Marshall's cancer would have been detected as early as February 2005, then her cancer treatment, to include but not limited to Rituxin therapy, could have been started immediately. Rituxan therapy would

have slowed the disease down in 2005, but instead, Mrs. Marshall's cancer remained untreated for five more years until she was properly tested in 2010. Therefore, if the cancerous protein had been detected by the proper testing in 2005, Mrs. Marshall's prognosis would be better and her life expectancy longer.

10. This Complaint includes causes of action from July 1, 2005 through September 15, 2005 – which is after the July 1, 2005 effective date of the South Carolina Medical Malpractice Act. On February 7, 2011, a Notice of Intent with attached Expert Affidavits were filed in regard to these allegations in compliance with § 15-79-110 et seq. With regard to the Notice of Intent (Civil Action No. 2011-CP-10-933), the pre-suit procedural requirements were met including mediation. Thereafter, the Plaintiffs filed this Summons and Complaint. There is an additional Complaint (Civil Action No. 2011-CP-10-934) which was filed by the Plaintiffs on February 7, 2011 with regard to the causes of action occurring prior to July 1, 2005.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(From July 1, 2005 through September 15, 2005)
(Negligence)

11. The Plaintiffs reallege the allegations contained within paragraphs one (1) through ten (10) as if repeated verbatim.

12. The above set forth incidents and the Plaintiff Virginia Marshall's resulting injuries and damages were proximately caused by the negligent, grossly negligent, reckless, willful, and wanton acts of the Defendants, by and through their agents, servants, and/or employees in one, more, or all of the following particulars:

- a) in failing to properly care for and treat the Plaintiff's condition;
- b) in failing to properly diagnose the Plaintiff's condition;
- c) in failing to properly recognize that the elevated protein in the Plaintiff's

urine could contain cancerous protein;

- d) in failing to treat the Plaintiff for her true and correct medical condition;
- e) in failing to recognize the signs and symptoms of elevated protein in the urine;
- f) in failing to recognize the signs and symptoms of cancerous protein in the urine;
- g) in failing to order the proper testing, to include but not be limited to a UPEP test and a SPEP, to determine the type of protein in the Plaintiff's urine;
- h) in failing to properly monitor the Plaintiff's medication;
- i) in failing to provide the proper follow up treatment after discovering high levels of protein in the Plaintiff's urine.

13. As a direct and proximate result of the aforementioned acts on behalf of the Defendants, the decedent unjustifiably suffered and died, and further, the Plaintiff has suffered ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES.

FOR A SECOND CAUSE OF ACTION
AGAINST THE DEFENDANT NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

14. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through thirteen (13) as if repeated verbatim.

15. Upon information and belief, at the time of the incidents, the Defendant Dodds was an employee of Charleston Nephrology Associates, LLC, acting within the scope of his employment.

16. The Defendant, Charleston Nephrology Associates, LLC, is strictly liable for the

negligent acts of its employee/servant Dr. Kenneth A. Dodds acting within the scope of his employment under the doctrine of Respondent Superior.

17. The above set forth medical care or lack thereof by the Defendants caused the Plaintiff Virginia Marshall to suffer unnecessarily and as a direct and proximate result, the Plaintiff has been injured and damaged and is entitled to receive ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES.

FOR A THIRD CAUSE OF ACTION
AGAINST THE DEFENDANTS
(Loss of Consortium)

18. The Plaintiffs reallege the allegations set forth within paragraphs one (1) through seventeen (17) as if repeated verbatim.

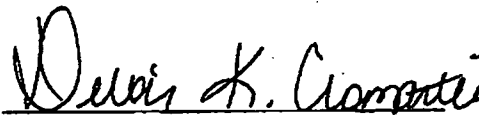
19. The Plaintiffs, Virginia Marshall and Todd Marshall were married in 1982 and are still married.

20. As a result of the Defendants' actions which adversely affected the Plaintiff, Virginia Marshall, the Plaintiff, Todd Marshall, has been injured and damaged and is entitled to ACTUAL, CONSEQUENTIAL, AND PUNITIVE DAMAGES as follows:

- (a) pre-trial medical expenses;
- (b) post-trial and future medical expenses;
- (c) pre-trial lost wages;
- (d) post-trial lost wages;
- (e) pre-trial mental pain and suffering, mental anguish and shock; and
- (f) post-trial mental pain and suffering, mental anguish and sock.

WHEREFORE, the Plaintiff prays judgment against the Defendants, both jointly and

severally for ACTUAL, CONSEQUENTIAL, and PUNITIVE DAMAGES, together with costs of this action, and for such other and further relief as this Court may deem fit, just and proper.



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Attorneys for the Plaintiff

Georgetown, South Carolina
December 22 2011

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

Versus

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC,

Defendants.

) IN THE COURT OF COMMON PLEAS

)

)

) C/A No. 2011-CP-10-934

)

)

) DEFENDANT KENNETH A. DODDS,
) M.D.'S ANSWER TO PLAINTIFFS'
) AMENDED COMPLAINT

) (Pre-July 1, 2005 Allegations)

) (Jury Trial Requested)

)

)

)

FILED
2012 JAN -3 PM 1:00
JULIE J. ARMS, CLERK OF COURT

Comes now, the Defendant, Kenneth A. Dodds, M.D. (hereinafter this Defendant"), responds to the allegations contained in the Plaintiffs' Amended Complaint (Pre-July 1, 2005 Allegations) as follows:

1. Each and every allegation not specifically admitted herein is denied.

AS TO PARTIES

2. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of the Plaintiffs' Amended Complaint, and therefore denies the same.

3. In response to the allegations contained in Paragraph 2 of the Plaintiffs' Amended Complaint, this Defendant admits that Dr. Dodds is a citizen and resident of the County of Charleston, State of South Carolina and at the times referenced in the Plaintiffs' Amended Complaint was acting individually and as an employee of Defendant Charleston Nephrology Associates, LLC. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

4. In response to the allegations contained in Paragraph 3 of the Plaintiffs' Amended Complaint, this Defendant admits that Charleston Nephrology Associates, LLC is a corporation organized and existing under the laws of the State of South Carolina with a principal place of business in Charleston, South Carolina and it was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, M.D. at the times referenced in the Plaintiff's medical records. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

AS TO THE FACTS

5. This Defendant denies the allegations contained in Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Amended Complaint and craves reference to the Plaintiff's medical records for a complete and accurate description of the care and treatment rendered to the Plaintiff.

6. This Defendant denies the allegations contained in Paragraphs 8 and 9 of the Plaintiffs' Amended Complaint.

7. The allegations contained in Paragraph 10 of the Plaintiffs' Amended Complaint contain conclusions of law to which no response is necessary. To the extent a response is necessary, this Defendant admits the Plaintiffs have filed separate Amended Complaints in this action – the first Amended Complaint includes facts and allegations before July 1, 2005 and the second Amended Complaint includes facts and allegations after July 1, 2005.

AS TO THE FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(Negligence)

8. In response to the allegations contained in Paragraph 11 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

9. This Defendant denies the allegations contained in Paragraphs 12 including subparts (a) through (i), and 13 of the Plaintiffs' Amended Complaint.

AS TO THE SECOND CAUSE OF ACTION AGAINST DEFENDANT
NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

10. In response to the allegations contained in Paragraph 14 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

11. This Defendant admits the allegations contained in Paragraph 15 of the Plaintiffs' Amended Complaint.

12. This Defendant denies the allegations contained in Paragraphs 16 and 17 of the Plaintiffs' Amended Complaint.

AS TO THE THIRD CAUSE OF ACTION AGAINST THE DEFENDANTS
(Loss of Consortium)

13. In response to the allegations contained in Paragraph 18 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

14. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in Paragraph 19 of the Plaintiffs' Amended Complaint, and therefore denies the same.

15. This Defendant denies the allegations contained in Paragraph 20 of the Plaintiffs' Amended Complaint, including subparts (a) through (f), and the Wherefore paragraph, such being allegations of the Plaintiffs' Amended Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Failure to State a Claim)

16. The allegations contained in Plaintiffs' Amended Complaint fail to state a claim upon which relief may be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Statute of Limitations)

17. That the Plaintiffs' causes of action against this Defendant is barred having been brought more than three years since the date of treatment or date of discovery of the alleged injury or the date the alleged injury reasonably ought to have been discovered, as a result of the alleged negligence.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Statute of Repose)

18. Plaintiffs' action against this Defendant is barred by the applicable statute of repose.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Comparative Negligence)

19. That, upon information and belief, even if this Defendant was negligent as described in the Complaint, which is specifically denied, the Plaintiffs' alleged injuries and damages, if any, resulted from, or were due to the negligence of the Plaintiffs, which combined and concurred with any negligence on the part of this Defendant, which is specifically denied, to bring about the said damages, if any, as a proximate cause thereof and without which the same would not have occurred.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Sole Negligence)

20. That, upon information and belief, whatever injuries and damages, if any, which may have been sustained by the Plaintiffs, as described in the Complaint, were due solely to, cause wholly by, and were the direct and proximate result of the negligence, carelessness and recklessness of the Plaintiffs, so far as to bar the Plaintiffs from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Natural Disease Process)

21. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by the Plaintiffs were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant plead such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(No Deviation from Standard of Care)

22. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within acceptable medical standards and methods, and, at no time pertinent hereto, did this Defendant deviate from any medical standard while caring for or tending to the Plaintiffs. Consequently, the Plaintiffs are barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(No Proximate Cause)

23. That, even if this Defendant was negligent, as alleged in the Complaint, which is specifically denied, the negligence of this Defendant is not the direct or proximate cause of any injury alleged by the Plaintiffs and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Punitive Damages Unconstitutional)

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

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Noneconomic Damages Award)

25. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, et. seq. This Defendant is a health care provider as defined by S.C. Code Ann. § 15-32-210 and pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Reservation and Non-Waiver)

26. This Defendant reserves any additional and affirmative defenses as may be revealed or become available to it during the course of their investigation

and/or discovery in the case and is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered the Plaintiffs' Amended Complaint (Pre-July 1, 2005 Allegations), and having asserted these affirmative defenses, the Defendant, Kenneth A. Dodds, M.D., prays that the Plaintiffs' Amended Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter, and such other relief as the Court may deem just and proper.

HOOD LAW FIRM, LLC
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Robert H. Hood (SC #2599)
James B. Hood (SC #70212)
H. Cooper Wilson, III (SC #74939)

Attorneys for the Defendant
Kenneth A. Dodds, M.D.

12/30, 2011
Charleston, South Carolina
J:\docs\242 111\Answer (Amended Complaint [pre 7 01 06] 12 22 11) doc

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 30 day of December, 2011.



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

Versus

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC,

Defendants.

) IN THE COURT OF COMMON PLEAS

) C/A No. 2011-CP-10-4057

) DEFENDANT KENNETH A. DODDS,
) M.D.'S ANSWER TO PLAINTIFFS'
) AMENDED COMPLAINT

) (Post-July 1, 2005 Allegations)

) (Jury Trial Requested)

2012 JAN -3 PM 1:00
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

Comes now, the Defendant, Kenneth A. Dodds, M.D. (hereinafter "Defendant"), responds to the allegations contained in the Plaintiffs' Amended Complaint (Post-July 1, 2005 Allegations) as follows:

1. Each and every allegation not specifically admitted herein is denied.

AS TO PARTIES

2. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of the Plaintiffs' Amended Complaint, and therefore denies the same.

3. In response to the allegations contained in Paragraph 2 of the Plaintiffs' Amended Complaint, this Defendant admits that Dr. Dodds is a citizen and resident of the County of Charleston, State of South Carolina and at the times referenced in the Plaintiffs' Amended Complaint was acting individually and as an employee of Defendant Charleston Nephrology Associates, LLC. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

4. In response to the allegations contained in Paragraph 3 of the Plaintiffs' Amended Complaint, this Defendant admits that Charleston Nephrology Associates, LLC is a corporation organized and existing under the laws of the State of South Carolina with a principal place of business in Charleston, South Carolina and it was acting by and through its agents, servants, and/or employees including but not limited to Kenneth A. Dodds, M.D. at the times referenced in the Plaintiffs' medical records. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

AS TO THE FACTS

5. This Defendant denies the allegations contained in Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Amended Complaint and craves reference to the Plaintiffs' medical records for a complete and accurate description of the care and treatment rendered to the Plaintiff.

6. This Defendant denies the allegations contained in Paragraphs 8 and 9 of the Plaintiffs' Amended Complaint.

7. The allegations contained in Paragraph 10 of the Plaintiffs' Amended Complaint contain conclusions of law to which no response is necessary. To the extent a response is necessary, this Defendant admits the Plaintiffs have filed separate Amended Complaints in this action – the first Amended Complaint includes facts and allegations before July 1, 2005 and the second Amended Complaint includes facts and allegations after July 1, 2005.

AS TO THE FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS
(Negligence)

8. In response to the allegations contained in Paragraph 11 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

9. This Defendant denies the allegations contained in Paragraphs 12 including subparts (a) through (i), and 13 of the Plaintiffs' Amended Complaint.

AS TO THE SECOND CAUSE OF ACTION AGAINST DEFENDANT
NEPHROLOGY ASSOCIATES, LLC
(Respondent Superior)

10. In response to the allegations contained in Paragraph 14 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

11. This Defendant admits the allegations contained in Paragraph 15 of the Plaintiffs' Amended Complaint.

12. This Defendant denies the allegations contained in Paragraphs 16 and 17 of the Plaintiffs' Amended Complaint.

AS TO THE THIRD CAUSE OF ACTION AGAINST THE DEFENDANTS
(Loss of Consortium)

13. In response to the allegations contained in Paragraph 18 of the Plaintiffs' Amended Complaint, this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

14. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in Paragraph 19 of the Plaintiffs' Amended Complaint, and therefore denies the same.

15. This Defendant denies the allegations contained in Paragraph 20 of the Plaintiffs' Amended Complaint, including subparts (a) through (f), such being all the remaining allegations of the Plaintiffs' Amended Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Failure to State a Claim)

16. The allegations contained in Plaintiffs' Amended Complaint fail to state a claim upon which relief may be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Statute of Limitations)

17. That the Plaintiffs' causes of action against this Defendant is barred having been brought more than three years since the date of treatment or date of discovery of the alleged injury or the date the alleged injury reasonably ought to have been discovered, as a result of the alleged negligence.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Statute of Repose)

18. Plaintiffs' action against this Defendant is barred by the applicable statute of repose.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Comparative Negligence)

19. That, upon information and belief, even if this Defendant was negligent as described in the Amended Complaint, which is specifically denied, the Plaintiffs' alleged injuries and damages, if any, resulted from, or were due to the negligence of the Plaintiffs, which combined and concurred with any negligence on the part of this Defendant, which is specifically denied, to bring about the said

damages, if any, as a proximate cause thereof and without which the same would not have occurred.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Sole Negligence)

20. That, upon information and belief, whatever injuries and damages, if any, which may have been sustained by the Plaintiffs, as described in the Amended Complaint, were due solely to, cause wholly by, and were the direct and proximate result of the negligence, carelessness and recklessness of the Plaintiffs, so far as to bar the Plaintiffs from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(Natural Disease Process)

21. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by the Plaintiffs were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant plead such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THIS DEFENDANT ALLEGES:
(No Deviation from Standard of Care)

22. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within acceptable medical standards and methods, and, at no time pertinent hereto, did this Defendant deviate from any medical standard while caring for or tending to the Plaintiffs. Consequently, the Plaintiffs are barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THIS DEFENDANT ALLEGES:
(No Proximate Cause)

23. That, even if this Defendant was negligent, as alleged in the Complaint, which is specifically denied, the negligence of this Defendant is not the direct or proximate cause of any injury alleged by the Plaintiffs and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THIS DEFENDANT ALLEGES:
(Punitive Damages Unconstitutional)

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

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THIS DEFENDANT ALLEGES:
(Noneconomic Damages Award)

25. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, et. seq. This Defendant is a health care provider as defined by S.C. Code Ann. § 15-32-210 and pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THIS DEFENDANT ALLEGES:
(Reservation and Non-Waiver)

26. This Defendant reserves any additional and affirmative defenses as may be revealed or become available to it during the course of their investigation

and/or discovery in the case and is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered the Plaintiffs' Amended Complaint (Post-July 1, 2005 Allegations), and having asserted these affirmative defenses, the Defendant, Kenneth A. Dodds, M.D., prays that the Plaintiffs' Amended Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter, and such other relief as the Court may deem just and proper.

HOOD LAW FIRM, LLC
172 Meeting Street
Post Office Box 1508
Charleston, SC 29402
Phone: (843) 577-4435
Facsimile: (843) 722-1630
Email: Info@hoodlaw.com


Robert H. Hood (SC #2599)
James B. Hood (SC #70212)
H. Cooper Wilson, III (SC #74939)

Attorneys for the Defendant
Kenneth A. Dodds, M.D.

12/30, 2011
Charleston, South Carolina

J:\docs\242 111\Answer (Amended Complaint [post 7.01 05] 12 22 11) doc

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 30 day of December, 2011.

SM Redman

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

VIRGINIA L. MARSHALL and
TODD MARSHALL,

Plaintiffs,

vs.

KENNETH A. DODDS, M.D.,
CHARLESTON NEPHROLOGY
ASSOCIATES, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT

Civil Action File No.: 2011-CP-10-934

DEFENDANT CHARLESTON
NEPHROLOGY ASSOCIATES, LLC'S
ANSWER TO AMENDED COMPLAINT
(Pre-July 1, 2005 Allegations)

(Jury Trial Requested)

FILED
2012 JAN 23 PM 12:48
JULIE J. ARMSTRONG
CLERK OF COURT

**ANSWER OF DEFENDANT CHARLESTON NEPHROLOGY ASSOCIATES, LLC TO
PLAINTIFFS' AMENDED COMPLAINT (PRE-JULY 1, 2005 ALLEGATIONS)**

COMES NOW, the Defendant, Charleston Nephrology Associates, LLC, hereinafter "Defendant", and responds to the allegations contained in the Plaintiffs' Amended Complaint (pre-July 1, 2005 allegations).

1. Each and every allegation not specifically admitted herein is denied.

PARTIES

2. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained within Paragraph 1 of the Plaintiffs' Amended Complaint and therefore denies the same.

3. In response to the allegations contained in Paragraph 2 of the Plaintiffs' Amended Complaint this Defendant admits that Dr. Dodds is a citizen and resident of the County of Charleston, State of South Carolina and at all times referenced in the Plaintiffs' Amended Complaint was acting individually and as an employee of Defendant Charleston Nephrology Associates, LLC. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff

Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

4. In response to the allegations contained in Paragraph 3 of the Plaintiffs' Amended Complaint this Defendant admits that Charleston Nephrology Associates, LLC is a limited liability corporation organized and existing under the laws of the State of South Carolina with a principal place of business in Charleston, South Carolina and that it was acting by and through its agents, servants and/or employees including but not limited to Kenneth A. Dodds, M.D. at the time referenced in Plaintiff's medical records. This Defendant further admits that the physicians that it employed had a doctor/patient relationship with Virginia L. Marshall consistent with that identified within Plaintiff Virginia L. Marshall's medical records with this Defendant. However such doctor/patient relationship is limited to the time in which Dr. Dodds and/or any other agents, servants or employees of this Defendant provided care and treatment to the Plaintiff as further described in the medical records of this Defendant.

FACTS

5. In response to Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Complaint this Defendant craves reference to and incorporates the medical records from Charleston Nephrology Associates, LLC. This Defendant would further show that the medical records reflect the treatment provided and the interactions between the providers and the patient and would refer Plaintiffs to the medical records for a more specific response and denies any allegations of this paragraph inconsistent with the medical records and information contained therein. This Defendant denies any and all allegations inconsistent with said medical records contained in Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Amended Complaint.

6. This Defendant denies the allegations contained in Paragraph 8 of the Plaintiffs' Amended Complaint.

7. This Defendant denies the allegations contained in Paragraph 9 of the Plaintiffs' Amended Complaint.

8. The allegations contained in Paragraph 10 of the Plaintiffs' Amended Complaint contain conclusions of law to which no response is required. To the extent a response is required this Defendant admits the Plaintiffs have filed separate amended complaints in this action, the first amended complaint includes facts and allegations before July 1, 2005 and the second amended complaint includes facts and allegations after July 1, 2005.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS

(From February 9, 2005 through June 30, 2005)

(Negligence)

9. In response to the allegations contained in Paragraph 11 of the Plaintiffs' Amended Complaint this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

10. This Defendant denies the allegations contained in Paragraph 12 of the Plaintiffs' Amended Complaint including subparts (a) through (i).

11. This Defendant denies the allegations contained in paragraph 13 of the Plaintiffs' Amended Complaint.

FOR A SECOND CAUSE OF ACTION AGAINST THE DEFENDANT NEPHROLOGY

ASSOCIATES, LLC

(Respondeat Superior)

12. In response to Paragraph 14 of the Plaintiffs' Amended Complaint this Defendant reasserts and realleges the above paragraphs as if fully set forth herein verbatim.

13. This Defendant admits the allegations contained in Paragraph 15 of the Plaintiffs' Amended Complaint.

14. This Defendant denies the allegations contained in Paragraphs 16 and 17 of the Plaintiffs' Amended Complaint.

FOR A THIRD CAUSE OF ACTION AGAINST THE DEFENDANTS

(Loss of Consortium)

15. In response to the allegations contained in Paragraph 18 of the Plaintiffs' Amended Complaint this Defendant repeats and realleges the above paragraphs as if fully restated herein verbatim.

16. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in paragraph 19 of the Plaintiffs' Amended Complaint and therefore denies the same.

17. This Defendant denies the allegations contained in Paragraph 20 of the Plaintiffs' Complaint including subparts (a) through (f).

18. This Defendant denies any and all remaining allegations contained in the Plaintiffs' Amended Complaint including but not limited to the Plaintiffs' prayer for relief.

19. All other allegations contained within the Plaintiffs' Amended Complaint not specifically admitted herein are denied.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Failure to state a claim)

20. The Plaintiffs' Amended Complaint fails to state a claim upon which relief can be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Statute of Limitations)

21. All or part of the Plaintiffs' causes of action against this Defendant are barred having been brought more than three (3) years since the date of discovery of the alleged injury or the date the alleged injury reasonably ought to have been discovered as a result of the alleged negligence.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Statute of Repose)

22. The Plaintiffs' action against this Defendant is barred by the applicable statute of repose.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Comparative Negligence)

23. That, upon information and belief, even if this Defendant was negligent as described in the Amended Complaint, which is specifically denied, the Plaintiffs' alleged injuries and damages, if any, resulted from or were due to the negligence of the Plaintiffs, which combined and concurred with any negligence on the part of this Defendant, which is specifically denied, to bring about the

said damages, if any, as a proximate cause thereof and without which the same would not have occurred.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Sole Negligence)

24. That, upon information and belief, whatever injuries and damages, if any, which may have been sustained by the Plaintiffs, as described in the Amended Complaint, were due solely to, caused wholly by, and were the direct and proximate result of the negligence, carelessness and recklessness of the Plaintiffs, so far as to bar Plaintiffs from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Natural Disease Process)

25. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by the Plaintiffs were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant pleads such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(No Deviation from the Standard of Care)

26. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within accepted medical standards and methods, and, at no time pertinent hereto, did this

Defendant deviate from any medical standard while caring for or tending to the Plaintiffs. Consequently, the Plaintiffs are barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(No Proximate Cause)

27. That, even if this Defendant was negligent, as alleged in the Plaintiffs' Amended Complaint, which is specifically denied, the negligence of or attributable to this Defendant is not a direct or proximate cause of any injury alleged by the Plaintiffs and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Punitive Damages -- Unconstitutional)

28. That any award or assessment of punitive damages as prayed for by the Plaintiffs in the Amended Complaint would violate this Defendant's constitutional rights under the Fifth, Sixth, Eighth, and Fourteenth Amendments of the United States Constitution and the comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Non-Economic Damages Award)

29. No award for economic damages shall exceed the statutory limits contained in the Non-Economic Damages Awards Act of 2005, S.C. Code Ann. § 15-32-200, et. seq. This Defendant is a health care provider defined by S.C. Code Ann. § 15-32-210 and pursuant to § 15-32-220 of the

Non-Economic Damages Awards Act of 2005, any potential recovery of non-economic damages is limited to the amount stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT
ALLEGES

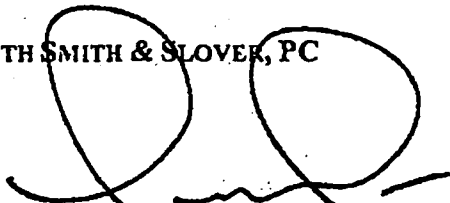
(Reservation and Non-Waiver)

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

WHEREFORE, having fully answered the Plaintiffs' Amended Complaint (post July 1, 2005 allegations) and having asserted these affirmative defenses, the Defendant Charleston Nephrology Associates, LLC prays that the Plaintiffs' Amended Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter and such other relief as the Court may deem just and proper.

Defendant demands a trial by jury.

HALL BOOTH SMITH & SLOVER, PC



Jack G. Gresh, South Carolina Bar No. 75188
Elizabeth Schwartz Corn, South Carolina Bar No. 71120
Attorneys for the Defendant,
Charleston Nephrology Associates, LLC
2113 Middle Street, Suite 305
Sullivan's Island, SC 29482
Phone: (843) 883-7412
Fax: (678) 539-1561
Email: jgresh@hbss.net
ecorn@hbss.net

Dated: January 20th, 2012
Sullivan's Island, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

VIRGINIA L. MARSHALL and
TODD MARSHALL,

Plaintiffs,

vs.

KENNETH A. DODDS, M.D.,
CHARLESTON NEPHROLOGY
ASSOCIATES, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT

Civil Action File No.: 2011-CP-10-4057

DEFENDANT CHARLESTON
NEPHROLOGY ASSOCIATES, LLC'S
ANSWER TO AMENDED COMPLAINT
(Post-July 1, 2005 Allegations)

(Jury Trial Requested)

FILED
2012 JAN 23 PM 12:05
JULIE J. ARMSTRONG
CLERK OF COURT

**ANSWER OF DEFENDANT CHARLESTON NEPHROLOGY ASSOCIATES, LLC'S
PLAINTIFFS' AMENDED COMPLAINT (PRE-JULY 1, 2005 ALLEGATIONS)**

COMES NOW, the Defendant, Charleston Nephrology Associates, LLC, hereinafter "Defendant", and responds to the allegations contained in the Plaintiffs' Amended Complaint (pre-July 1, 2005 allegations).

1. Each and every allegation not specifically admitted herein is denied.

PARTIES

2. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained within Paragraph 1 of the Plaintiffs' Amended Complaint and therefore denies the same.

3. In response to the allegations contained in Paragraph 2 of the Plaintiffs' Amended Complaint this Defendant admits that Dr. Dodds is a citizen and resident of the County of Charleston, State of South Carolina and at all times referenced in the Plaintiffs' Amended Complaint was acting individually and as an employee of Defendant Charleston Nephrology Associates, LLC. This Defendant further admits that Dr. Dodds had a doctor/patient relationship with Plaintiff

Virginia L. Marshall but that relationship is limited to the time in which Dr. Dodds provided care and treatment to the Plaintiff Virginia L. Marshall.

4. In response to the allegations contained in Paragraph 3 of the Plaintiffs' Amended Complaint this Defendant admits that Charleston Nephrology Associates, LLC is a limited liability corporation organized and existing under the laws of the State of South Carolina with a principal place of business in Charleston, South Carolina and that it was acting by and through its agents, servants and/or employees including but not limited to Kenneth A. Dodds, M.D. at the time referenced in Plaintiff's medical records. This Defendant further admits that the physicians that it employed had a doctor/patient relationship with Virginia L. Marshall consistent with that identified within Plaintiff Virginia L. Marshall's medical records with this Defendant. However such doctor/patient relationship is limited to the time in which Dr. Dodds and/or any other agents, servants or employees of this Defendant provided care and treatment to the Plaintiff as further described in the medical records of this Defendant.

FACTS

5. In response to Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Complaint this Defendant craves reference to and incorporates the medical records from Charleston Nephrology Associates, LLC. This Defendant would further show that the medical records reflect the treatment provided and the interactions between the providers and the patient and would refer Plaintiffs to the medical records for a more specific response and denies any allegations of this paragraph inconsistent with the medical records and information contained therein. This Defendant denies any and all allegations inconsistent with said medical records contained in Paragraphs 4, 5, 6 and 7 of the Plaintiffs' Amended Complaint.

6. This Defendant denies the allegations contained in Paragraph 8 of the Plaintiffs' Amended Complaint.

7. This Defendant denies the allegations contained in Paragraph 9 of the Plaintiffs' Amended Complaint.

8. The allegations contained in Paragraph 10 of the Plaintiffs' Amended Complaint contain conclusions of law to which no response is required. To the extent a response is required this Defendant admits the Plaintiffs have filed separate amended complaints in this action, the first amended complaint includes facts and allegations before July 1, 2005 and the second amended complaint includes facts and allegations after July 1, 2005.

FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS

(From February 9, 2005 through June 30, 2005)

(Negligence)

9. In response to the allegations contained in Paragraph 11 of the Plaintiffs' Amended Complaint this Defendant reasserts and realleges the above paragraphs as if fully restated herein verbatim.

10. This Defendant denies the allegations contained in Paragraph 12 of the Plaintiffs' Amended Complaint including subparts (a) through (i).

11. This Defendant denies the allegations contained in paragraph 13 of the Plaintiffs' Amended Complaint.

FOR A SECOND CAUSE OF ACTION AGAINST THE DEFENDANT NEPHROLOGY

ASSOCIATES, LLC

(Respondent Superior)

12. In response to Paragraph 14 of the Plaintiffs' Amended Complaint this Defendant reasserts and realleges the above paragraphs as if fully set forth herein verbatim.

13. This Defendant admits the allegations contained in Paragraph 15 of the Plaintiffs' Amended Complaint.

14. This Defendant denies the allegations contained in Paragraphs 16 and 17 of the Plaintiffs' Amended Complaint.

FOR A THIRD CAUSE OF ACTION AGAINST THE DEFENDANTS

(Loss of Consortium)

15. In response to the allegations contained in Paragraph 18 of the Plaintiffs' Amended Complaint this Defendant repeats and realleges the above paragraphs as if fully restated herein verbatim.

16. This Defendant lacks sufficient information upon which to form a belief as to the allegations contained in paragraph 19 of the Plaintiffs' Amended Complaint and therefore denies the same.

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18. This Defendant denies any and all remaining allegations contained in the Plaintiffs' Amended Complaint including but not limited to the Plaintiffs' prayer for relief.

19. All other allegations contained within the Plaintiffs' Amended Complaint not specifically admitted herein are denied.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Failure to state a claim)

20. The Plaintiffs' Amended Complaint fails to state a claim upon which relief can be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Statute of Limitations)

21. All or part of the Plaintiffs' causes of action against this Defendant are barred having been brought more than three (3) years since the date of discovery of the alleged injury or the date the alleged injury reasonably ought to have been discovered as a result of the alleged negligence.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Statute of Repose)

22. The Plaintiffs' action against this Defendant is barred by the applicable statute of repose.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Comparative Negligence)

23. That, upon information and belief, even if this Defendant was negligent as described in the Amended Complaint, which is specifically denied, the Plaintiffs' alleged injuries and damages, if any, resulted from or were due to the negligence of the Plaintiffs, which combined and concurred with any negligence on the part of this Defendant, which is specifically denied, to bring about the

said damages, if any, as a proximate cause thereof and without which the same would not have occurred.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Sole Negligence)

24. That, upon information and belief, whatever injuries and damages, if any, which may have been sustained by the Plaintiffs, as described in the Amended Complaint, were due solely to, caused wholly by, and were the direct and proximate result of the negligence, carelessness and recklessness of the Plaintiffs, so far as to bar Plaintiffs from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Natural Disease Process)

25. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by the Plaintiffs were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant pleads such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(No Deviation from the Standard of Care)

26. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within accepted medical standards and methods, and, at no time pertinent hereto, did this

Defendant deviate from any medical standard while caring for or tending to the Plaintiffs. Consequently, the Plaintiffs are barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(No Proximate Cause)

27. That, even if this Defendant was negligent, as alleged in the Plaintiffs' Amended Complaint, which is specifically denied, the negligence of or attributable to this Defendant is not a direct or proximate cause of any injury alleged by the Plaintiffs and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Punitive Damages -- Unconstitutional)

28. That any award or assessment of punitive damages as prayed for by the Plaintiffs in the Amended Complaint would violate this Defendant's constitutional rights under the Fifth, Sixth, Eighth, and Fourteenth Amendments of the United States Constitution and the comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT

ALLEGES

(Non-Economic Damages Award)

29. No award for economic damages shall exceed the statutory limits contained in the Non-Economic Damages Awards Act of 2005, S.C. Code Ann. § 15-32-200, et. seq. This Defendant is a health care provider defined by S.C. Code Ann. § 15-32-210 and pursuant to § 15-32-220 of the

Non-Economic Damages Awards Act of 2005, any potential recovery of non-economic damages is limited to the amount stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE THIS DEFENDANT
ALLEGES

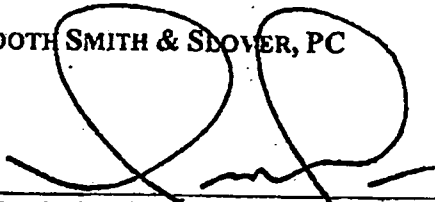
(Reservation and Non-Waiver)

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

WHEREFORE, having fully answered the Plaintiffs' Amended Complaint (post July 1, 2005 allegations) and having asserted these affirmative defenses, the Defendant Charleston Nephrology Associates, LLC prays that the Plaintiffs' Amended Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter and such other relief as the Court may deem just and proper.

Defendant demands a trial by jury.

HALL BOOTH SMITH & SDOVER, PC



Jack G. Gresh, South Carolina Bar No. 75188
Elizabeth Corn, South Carolina Bar No. 71120
Attorneys for the Defendant,
Charleston Nephrology Associates, LLC
2113 Middle Street, Suite 305
Sullivan's Island, SC 29482
Phone: (843) 883-7412
Fax: (678) 539-1561
Email: jgresh@hbss.net

Dated: January 20th, 2012
Sullivan's Island, South Carolina

IN THE COURT OF COMMON PLEAS

)

) C/A No. 2011-CP-10-934 and
) 2011-CP-10-4057

)

)

)

)

RECEIVED
OCT 23 PM 4:55
J. ARNSTROM
CLERK OF COURT
ATTORNEYS FOR

77-13

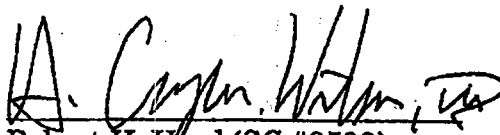
Specifically, the Defendants are entitled to summary judgment because the Plaintiffs' Complaint was filed outside of the six-year statute of repose period for medical malpractice cases outlined in S.C. Code Ann. § 15-3-545(A). The statute of repose begins to run on the date of occurrence of a physician's alleged negligent act or omission. Id. The six-year statute of repose "applies as an absolute outer limit applicable in *any* medical malpractice action." Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009).

The Plaintiff presented to Defendant Dodds four times between September, 2004 and September, 2005. During each of those visits, she presented with elevated levels of protein in her urine. As a result of this condition, the Plaintiff alleges that Defendant Dodds should have ordered additional testing, such as a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test, to determine whether she had signs of cancer.

The Plaintiffs' oncology expert testified the Plaintiff more likely than not had cancer in September, 2004 when Defendant Dodds first saw her which would have been discovered had Defendant Dodds ordered additional testing. The Plaintiffs' claim that Defendant Dodds breached the standard of care began in September, 2004 yet the Plaintiffs did not bring an action against Defendant Dodds until February, 2011 – more than six (6) years after the alleged medical malpractice first occurred. As a result, this case is barred by the statute of repose.

This Motion is supported by statutory and common law of the state of South Carolina and other applicable authority and may be supported by a memorandum of law or other supporting material as permitted under the South Carolina Rules of Civil Procedure.

HOOD LAW FIRM, LLC
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Phone: (843) 577-4435
Facsimile: (843) 722-1630
Email: Info@hoodlaw.com



Robert H. Hood (SC #2599)
James B. Hood (SC #70212)
H. Cooper Wilson, III (SC #74939)

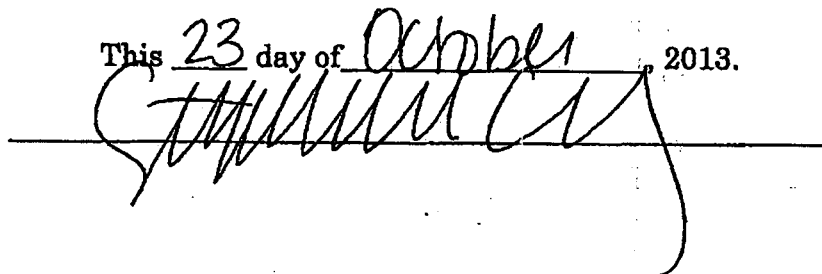
Attorneys for the Defendants
Kenneth A. Dodds, M.D. and Charleston
Nephrology Associates, LLC

10/22, 2013
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing
was served on each party or counsel of record by ☒ ~~mailing~~, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in
the manner prescribed by the applicable Rule of Civil
Procedure.

This 23 day of October, 2013.



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

Versus

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC,

Defendants.

) IN THE COURT OF COMMON PLEAS
)
)

) C/A No. 2011-CP-10-934
)

) DEFENDANTS' MEMORANDUM IN
) OPPOSITION TO PLAINTIFFS'
) MOTION TO CONSOLIDATE
)

FILED
2013 OCT 30 PM 2:34
JULIE J. ARMSTRONG
CLERK OF COURT

The Defendants, Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC (hereinafter "the Defendants"), by and through their undersigned counsel, respectfully submit this Memorandum in Opposition to the Plaintiffs' Motion to Consolidate this action with the case captioned Virginia L. Marshall and Todd W. Marshall v. Georgia Roane, MD and Rheumatology Associates, PA, C/A Nos. 2011-CP-10-2587 & 2011-CP-10-5897, for purposes of trial.

STATEMENT OF FACTS

In 2010, Plaintiff Virginia L. Marshall was diagnosed with lymphoplasmacytic lymphoma. On February 7, 2011, Ms. Marshall and her husband Todd W. Marshall brought this suit for medical malpractice against the Defendants alleging that they were negligent for, *inter alia*, failing to diagnose Ms. Marshall with signs of cancer. See Exhibit A. Subsequently, on April 8, 2011, the Plaintiffs filed the action Virginia L. Marshall and Todd W. Marshall v. Georgia Roane, MD and Rheumatology Associates, PA, C/A Nos. 2011-CP-10-2587 & 2011-CP-10-5897. See Exhibit B.

Defendant Dr. Kenneth Dodds is an employee with Defendant Charleston Nephrology Associates, LLC. The Plaintiffs allege that on February 7, 2005, Ms.

Marshall visited the Defendants, and Dr. Dodds ordered a 24-hour urine test to be conducted, which indicated elevated levels of protein in her urine. The Plaintiffs claim that additional testing, such as a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test, could have been performed at this time and possibly shown signs of cancer. Additionally, at her follow-up visit on September 15, 2005, the Plaintiffs allege that Ms. Marshall's protein levels were again elevated, but the Defendants failed to do any of the additional tests. The Plaintiffs now claim that this alleged misdiagnosis and mistreatment of Ms. Marshall's cancer by the Defendants constituted negligence.

The Plaintiffs seek to consolidate this action with Virginia L. Marshall and Todd W. Marshall v. Georgia Roane, MD and Rheumatology Associates, PA, C/A Nos. 2011-CP-10-2587 & 2011-CP-10-5897. While the Plaintiffs are the same in that case, and allege that the Defendant Georgia Roane, MD and Rheumatology Associates, PA misdiagnosed and mistreated her cancer, the case involves many different allegations than are set forth in this case and contains allegations that are not a part of the same time frame involved in this case. As such, the Defendant oppose consolidation of these cases for trial.

ARGUMENT

The Plaintiffs have moved pursuant to Rule 42(a) of the South Carolina Rules of Civil Procedure for an order consolidating the two above-referenced cases for purposes of trial. Determining whether to consolidate actions "is within the broad discretion of the trial court," and "[t]he moving party has the burden of persuading the court that consolidation is desirable." Keels v. Pierce, 315 S.C. 339, 342, 433 S.E.2d 902, 904 (Ct. App. 1993). Generally, a court may consolidate two actions "involving a common question of law or fact" if consolidation of the actions will

"avoid unnecessary costs or delay." Rule 42(a), S.C.R.C.P. However, before consolidating the actions, the court must weigh the prejudice that will result to the parties and the risks of possible juror confusion. See Arnold v. E. Air Lines, Inc., 681 F.2d 186, 193 (4th Cir. 1982); see also Rule 42(b), S.C.R.C.P. (stating that a court may order separate trials "in furtherance of convenience or to avoid prejudice, or when separate trials will be conducive to expedition and economy"). If the risk of prejudice or juror confusion outweigh the other considerations, then the actions should not be consolidated. See Winchester v. United Ins. Co., 231 S.C. 288, 294, 98 S.E.2d 530, 533 (1957) (upholding a trial court's refusal to order two actions consolidated where there was a risk of juror confusion); Plaza Dev. Servs. v. Joe Hardin Builder, Inc., 294 S.C. 430, 434, 365 S.E.2d 231, 233 (Ct. App. 1988) (stating that a party opposing consolidation should provide evidence of prejudice that would occur from consolidation).

First of all, while both complaints allege negligence on the part of the defendant parties for failing to properly diagnose and treat Ms. Marshall, these alleged acts of negligence involve different defendants, occurred on different occasions, and some of them occurred within completely different time frames. The underlying events that comprise the allegations against the Defendants all occurred from September 15, 2004 until they last saw Ms. Marshall on September 15, 2005. However, Ms. Marshall continuously sought treatment from Dr. Roane from 1999 through October 10, 2007—more than four (4) years before she began treatment with the Defendants and more than two (2) years after she had stopped treatment with the Defendants. The alleged negligence asserted against Dr. Roane includes the two-year period in which Ms. Marshall no longer saw the Defendants. Moreover, the Defendants and Dr. Roane never treated Ms. Marshall on the same

occasion or even on the same date. In fact, the complaint against Dr. Roane claims that Ms. Marshall's cancer was present and could have been detected by Dr. Roane as early as Ms. Marshall's visit with her on April 29, 2005, while the complaint against the Defendants asserts that it could have been detected by them as early as their February 9, 2005 appointment with Ms. Marshall. Additionally, the Plaintiffs make allegations for negligence against Dr. Roane that are not alleged against the Defendants. They claim that Dr. Roane was negligent for failing to conduct a biopsy of Ms. Marshall's lymph nodes and for prescribing potent immunosuppressants—neither of which is claimed against the Defendants. As such, there simply is not enough of a common question of law or fact to consolidate these actions for trial.

Even if there was, any commonality is outweighed by the severe risk of prejudice that the Defendants in this action would face from a consolidated trial. As stated above, the alleged negligence asserted against Dr. Roane includes her treatment of Ms. Marshall during the two years following her last visit with the Defendants. During this time, as alleged by the Plaintiffs, the protein in Ms. Marshall's urine continued to increase, but Dr. Roane still consistently misdiagnosed Ms. Marshall with mixed connective tissue disease. Dr. Roane also allegedly failed to recognize her misdiagnosis during this time when the Plaintiff presented with elevated sedimentation (SED) rates and lymphadenopathy (i.e., enlarged lymph nodes), and allegedly gave Ms. Marshall the wrong treatment for her fatigue and joint pain when she prescribed potent immunosuppressants.

In a consolidated trial, these additional allegations of negligence against Dr. Roane would do nothing but prejudice the Defendants. The jury would hear that Ms. Marshall's cancer was getting worse and more prevalent during these two

years, and her protein levels continued to increase. The Plaintiffs would show the additional signs (increased SED rates and enlarged lymph nodes) that Dr. Roane missed or failed to investigate that should have indicated her misdiagnosis of Ms. Marshall. Hearing such evidence against Dr. Roane, the jury may attribute this alleged negligence to the Defendants, even though they were not involved with Ms. Marshall's treatment during that time. The jury could also form a negative bias against Dr. Roane based on this evidence and allow this bias to carryover to other treating physicians and find the Defendants negligent or increase the amount of damages awarded to the Plaintiffs from the Defendants. Such action would deprive the Defendants of a fair trial and work great prejudice against them. There is an enormous risk of this happening if these two cases are consolidated for trial.

There is also an enormous risk of jury confusion if these two actions are consolidated. The jurors in a consolidated trial will be asked to keep separate a dizzying amount of complex and highly technical medical evidence as to the alleged negligence of Dr. Roane and the Defendants. The jurors will have to evaluate each visit Ms. Marshall took to Dr. Roane and the Defendants and determine whether any negligence occurred at these visits. The jurors also will have to hear all of the additional allegations brought against Dr. Roane concerning the two-year period in which the Defendants were not treating Ms. Marshall. All the while, the jurors will be asked to keep all of this complex medical evidence as it pertains to the Defendants separate from the evidence that pertains to Dr. Roane. With so many allegations involving different defendants, different facts, and different circumstances involved in these cases, it is almost inevitable that a jury may become confused throughout this process. While separate trials may also contain evidence of negligence on the part of unnamed parties, the individual trials will be

much more straightforward and will be easier for a jury to handle than a complex consolidated medical malpractice trial.

CONCLUSION

Therefore, in the interests of justice and judicial economy, the Defendants respectfully request that the Court deny the Plaintiffs' Motion to Consolidate this action with the case captioned Virginia L. Marshall and Todd W. Marshall v. Georgia Roane, MD and Rheumatology Associates, PA, C/A Nos. 2011-CP-10-2587 & 2011-CP-10-5897, for purposes of trial.

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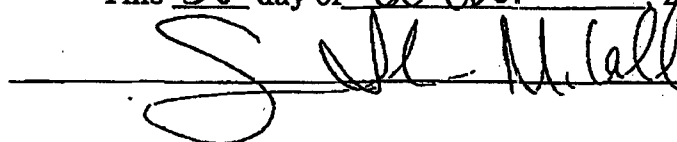
Attorneys for the Defendants
Kenneth A. Dodds, M.D. and
Charleston Nephrology Associates, LLC

10/30, 2013
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 30 day of October, 2013.



STATE OF SOUTH CAROLINA)

COUNTY OF CHARLESTON)

VIRGINIA L. MARSHALL AND TODD)
W. MARSHALL,)

Plaintiffs,)

vs.)

KENNETH A. DODDS, M.D.,)
CHARLESTON NEPHROLOGY)
ASSOCIATES, LLC,)

Defendants.)

VIRGINIA L. MARSHALL AND TODD)
W. MARSHALL,)

Plaintiffs,)

GEORGIA ROANE, M.D. AND)
RHEUMATOLOGY ASSOCIATES,)
P.A.,)

Defendants.)

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT

CASE NO. 2011-CP-10-0934

DEFENDANTS GEORGIA ROANE,
M.D. AND RHEUMATOLOGY
ASSOCIATES, P.A.'S MOTION
FOR SUMMARY JUDGMENT

TO: J. EDWARD BELL, III, AND C. CARTER ELLIOT, JR., ATTORNEYS FOR
PLAINTIFFS:

YOU WILL PLEASE TAKE NOTICE that ten days after service hereof or soon thereafter as counsel may be heard the Defendants Georgia Roane, M.D. and Rheumatology Associates P.A., by and through their undersigned counsel, will move before this Honorable Court for an Order granting the Defendants' Motion For Summary Judgment and dismissing the Plaintiff's Complaint pursuant to Rule 56 of the South Carolina Rules of Civil Procedure. The grounds for this Motion are that the evidence produced through discovery show that there is no

genuine issue as to any material fact which would entitle the Plaintiff to recovery against the Defendants.

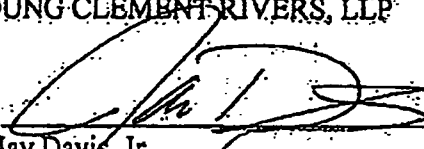
More specifically, Plaintiffs' claims against Dr. Roane and her practice are barred by the statute of repose. (See S.C. Code Ann. § 15-3-545(A)). The six-year period under the statute of repose constitutes an "outer limit beyond which a medical malpractice claim is barred, regardless of when it is discovered." *O'Tuel v. Villani*, 318 S.C. 24, 455 S.E.2d. 698 (Ct.App. 1995) (overruled in part and on other grounds by *I'on, LLC v. Town of Mt. Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000)). Unlike the statute of limitations, the statute of repose for medical malpractice actions begins to run at the first occurrence of a negligent act. *Id.*

The evidence confirms Plaintiffs' contention that Dr. Roane breached the standard of care beginning in 2002 by failing to diagnose Plaintiff's true medical condition. However, no action was filed by Plaintiffs until April 2011—some 9 years after the alleged malpractice first occurred. For this reason the case is barred under the applicable statute of repose.

This motion will be supplemented by a memorandum of law.

[signature block on following page]

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Georgia Roane, M.D. and

Rheumatology Associates P.A.

Charleston, South Carolina

Dated: 12/11/13

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to
all counsel of record in this proceeding this 11 day of

December, 2013



STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

KENNETH A. DODDS, MD,
CHARLESTON NEPHROLOGY
ASSOCIATES, LLC,

Defendants.

VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

GEORGIA ROANE, M.D. AND
RHEUMATOLOGY ASSOCIATES,
P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-934

DEFENDANTS GEORGIA ROANE,
M.D. AND RHEUMATOLOGY
ASSOCIATES, P.A.'S
MEMORANDUM IN SUPPORT OF
SUMMARY JUDGMENT

FILED
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JULIE J. ARMSTRONG
CLERK OF COURT

The Defendants, Georgia Roane, M.D. and Rheumatology Associates, P.A. (hereinafter referred to as "Dr. Roane" and "Rheumatology" or collectively referred as "these Defendants"), by and through their undersigned counsel, hereby submit this Memorandum in Support of their Motion for Summary Judgment pursuant to Rule 56 of the South Carolina Rules of Civil Procedure. The grounds for this motion are that the Plaintiffs claims are 1) time-barred by the statute of repose set forth in S.C. Code Ann. § 15-3-545 (A).

FACTUAL & PROCEDURAL BACKGROUND

Virginia and Todd Marshall (collectively, the "Plaintiffs") filed the above-captioned lawsuit against these Defendants on April 8, 2011, asserting a medical malpractice and loss of consortium claim. Plaintiffs not only properly filed a Notice of Intent to File Suit ("NOI") and contemporaneous expert affidavit in accordance with S.C. Code Ann. §§ 15-79-125 and 15-36-100 but also a Summons and Complaint with identical allegations and requests for relief. Each of these pleadings seeks recovery for a single, indivisible injury and concerns the same course of treatment entirely. On August 19, 2011, after completing pre-suit mediation in accordance with S.C. Code Ann. § 15-79-125, Plaintiffs in fact filed a second, identical Summons and Complaint to the prior pleading they filed in this case. Thus, Plaintiffs pursued two identical complaints filed against these Defendants, with no distinction between them, which assert entitlement to relief for the same injury. However, the two actions were consolidated for purposes of discovery and trial by consent of the parties and Order of the Honorable Roger M. Young, Sr. on July 17, 2013. The purpose behind Plaintiffs' procedural tactic was based on the premise that some of Dr. Roane's alleged negligent acts and omissions occurred before the July 1, 2005 enactment of South Carolina's Medical Malpractice Act, S.C. Code Ann. § 15-79-110 et. seq.

On November 8, 2013, this action was consolidated with that of *Virginia L. Marshall and Todd W. Marshall v. Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, C/A* No. 11-CP-10-934 and 11-CP-1-4057.

Plaintiffs' Complaint against these Defendants alleges that from 2000 until 2005, Plaintiff Virginia Marshall was "diagnosed and treated" by Dr. Roane for mixed connective tissue disease ("MCTD"). (Compl. p. 2 para 4). Allegedly, the diagnosis was based upon "various factors," including "elevated sedimentation (SED) rates," and "nonspecific symptoms." (Complaint, ¶ 4,

5). Dr. Roane continued to treat Plaintiff for MCTD until October 2007 and her treatment continued in accordance with this diagnosis. (Complaint, ¶ 12).

Plaintiff was referred to a nephrologist, Dr. Eric Pride, on January 7, 2010—nearly three years after last seeing Dr. Roane. (Complaint, ¶ 12, 14). Dr. Pride conducted a “UPEP” test to evaluate the type of protein in Plaintiff’s urine; that test revealed she had cancerous myeloma protein. (Complaint, ¶ 14). A subsequent bone marrow biopsy confirmed Plaintiff was suffering from lymphoplasmatic lymphoma. (Complaint, ¶ 14). This was Plaintiff’s first indication of cancer. *Id.*

Plaintiff alleges that the cancer “should have been detected as early as April 29, 2005” by Dr. Roane, and that she was diagnosed and treated for a disease she did not have from 2000 through 2007. (Complaint, ¶ 14-15; 4). Quite certainly, Plaintiffs themselves take issue with Dr. Roane’s treatment of the Plaintiff prior to April of 2005 by expressly alleging that improper treatment occurred as early as 2000; however, they have arbitrarily selected this April date to revive an otherwise time-bared claim. Curiously, Plaintiffs, in their Complaint, assert that in April 2005, Roane “failed to properly diagnose” Plaintiff’s condition, because Dr. Roane’s prior diagnosis of Plaintiff was “never confirmed.” (Complaint, ¶ 5). In other words, Plaintiff alleges that Dr. Roane’s negligence occurred on or after April 2005—not when the original misdiagnosis was made or at any time during the prior seven years of treatment. (Complaint, ¶ 12). Of course, as a lay person, Plaintiff is unqualified to opine on such matters and must refer to a qualified expert.

On September 16, 2013, Plaintiffs’ sole liability expert against this Defendant, Dr. Thomas M. Zizic, M.D., testified that Dr. Roane breached the standard of care in 2002 and again in 2003 for failing to perform a proper work up that would have discovered Virginia Marshall’s

cancer. Based on this testimony, Plaintiff's action is time-barred by the statute of repose set forth in S.C. Code Ann. § § 15-3-545 (A).

STANDARD FOR SUMMARY JUDGMENT

The statute of limitations or statute of repose defense may be raised in a summary judgment motion. See *McDonnell v. Consolidated School Dist. of Aiken*, 315 S.C. 487, 445 S.E.2d 638 (1994). Pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, if there is no genuine issue as to any material fact on the timeliness of Plaintiff's claims, the moving party is entitled to a judgment as a matter of law. Rule 56, SCRPC.

In response to a properly supported motion for summary judgment, the non-moving party may not rest on the mere allegations or denial of the pleadings, but must set forth or point to specific facts showing there is a genuine issue of material fact. The existence of a mere scintilla of evidence in support of the non-moving party's position is not sufficient to overcome a motion for summary judgment. *Thomas v. Waters*, 315 S.C. 524, 445 S.E.2d 659, 661 (Ct. App. 1994). A court must grant summary judgment if the non-moving party fails to make a showing sufficient to establish the existence of an element essential to the party's case upon which the party will bear the burden of proof at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986) (citing Fed. R. Civ. P. 56, which is identical to S.C.R. Civ. P. 56.)

The moving party need not support its motion with affidavits or other similar materials negating the opponent's claim but must clearly establish by the record the absence of a triable issue of fact. *Baughman v. Am. Tel. & Tel. Co.*, 306 S.C. 101, 410 S.E.2d 537, 545-46 (1991).

ARGUMENT AND CITATION OF AUTHORITY

I. Medical Malpractice Actions Must Be Commenced Within Six Years From the Date of Occurrence

Medical malpractice actions are governed by a six-year statute of repose. Under this statute,

an action for medical malpractice must be commenced not more than six years from the "date of occurrence":

"...any action...to recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation...must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date of discovery or when it reasonably ought to have been discovered, not to exceed six years from date of occurrence, or as tolled by this section." S.C. Code Ann. § 15-3-545(A)(emphasis added).

The six-year period constitutes an "outer limit beyond which a medical malpractice claim is barred, regardless of when it is discovered." *O'Tuel v. Villani*, 318 S.C. 24, 455 S.E.2d. 698 (Ct.App. 1995) (overruled in part and on other grounds by *I'on, LLC v. Town of Mt. Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000)). Unlike the statute of limitations, the statute of repose for medical malpractice actions begins to run at the first occurrence of a *negligent act*. *Id.* The statute of repose ignores the discovery, knowledge, and even the existence of any injury in barring claims; instead, its focus centers squarely on that first act of negligence underlying the claim. *Hoffman v. Powell*, 298 S.C. 338, 339-40, 380 S.E.2d 821 (1989) (the medical malpractice statute of repose bars claims "regardless of whether [the claim] has or should have been discovered" or "whether [the claimant's] injuries are latent or readily apparent."). The expiration of a statute of repose extinguishes all causes of action, including those that may later accrue and those that have already accrued. *Columbia/CSA-HS Greater Columbia Healthcare System v. South Carolina Medical Malpractice Liability Joint Underwriting Ass'n*, 394 S.C. 68, 713 S.E.2d 639 (Ct. App. 2011); *Capco of Summerville, Inc. v. J.H. Gayle Constr. Co.*, 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006); *Langley v. Pierce*, 313 S.C. 401, 438 S.E.2d 242 (1993). These statutes of repose create a substantive right, designed to protect the economic balance struck by the legislative body in this state. *Langley*, 313 S.C. at 404, 438 S.E.2d at 243-44.

II. South Carolina has Refused to Adopt the "Continuous Treatment/Continuous Tort" Doctrine

Plaintiffs may not advance their otherwise time-barred claims simply because they allege that Dr. Roane's treatment, and alleged negligence continued over a seven year span and "reoccurred" thereby renewing the time within which to commence this action. South Carolina has judicially rejected such notions, recognizing that to adopt either the continuous treatment or continuous tort rule would run contravene the adopted legislative policy of our General Assembly in establishing a statute of repose for medical negligence actions. *Harrison v. Bevilacqua*, 354 S.C. 129, 580 S.E.2d 109 (2003); *Dunbar v. Carlson*, 341 S.C. 261 533 S.E. 919 (2000); *Shadwell v. Craigie*, 361 S.C. 492, 605 S.E.2d 567 (2004). Therefore, despite Dr. Roane's continued treatment of the Plaintiff and alleged recurring negligence, the operative date for purposes of determining the timeliness of this action remains the first alleged act of negligence.

III. Plaintiffs' Action Must be Dismissed Because Their Sole Liability Expert Testified That Dr. Roane Breached the Standard of Care as Early as 2002

It is black letter law that a Plaintiff must establish by expert testimony that the defendant breached the applicable standard of care. *Botehlo v. Bycura*, 282 S.C. 578, 583, 320 S.E.2d 59, 62 (Ct. App. 1984); *Armstrong v. Weiland*, 267 S.C. 12, 225 S.E.2d 851 (1976). Plaintiff is unqualified to provide such testimony. Because Plaintiffs' expert testified that Dr. Roane breached the standard of care as early as 2002 and again in 2003, Plaintiffs' action violates the six-year statute of repose.

In his deposition, Dr. Zizic explicitly stated that Dr. Roane breached the standard of care in 2002 for failing to review her prior diagnosis and perform another full work-up:

Q: And so as early as [February] '02 you're saying that...because of the lack of significant changes with regards to the laboratory

data, Dr. Roane would have been second guessing the diagnosis; is that what you're saying?

A: Not second guessing. Should be looking at what potentially is going on here...At that point you go back to the drawing board and you re-workup this patient totally. Totally. You don't sit back and just say, hey, I've done it two years ago. This is 2002. I've been treating her for what I think she has, and the abnormalities are still there, they're not classical for what I am treating and so I better look at what other potential things are going on. (Zizic Dep. 75:2 – 23, Sept. 16, 2013, attached hereto as Exhibit A-1) (emphasis added)

Q: Are you – and so you believe part of your expert opinion is that as far as that February 2002 that Dr. Roane breached the standard of care by not doing a re-workup of the patient?

A: Yes. A reconsideration of where she was in the treatment of the patient...a workup should have been done. (Zizic Dep. 77:25 – 78:5, attached hereto as Exhibit A-2) (emphasis added)

Dr. Zizic continued by asserting that Dr. Roane breached the standard of care again in August of 2003, as it was his expert opinion that a workup would have discovered Plaintiff's cancer:

Q: But you, I presume, based on what you told me from February 2002, if a reworkup were done in August of '03, you believe it would have discovered—it would have led you to discovering the true underlying illness, the lymphoma?

A: Yeah.

Q: And you believe that was a breach of the standard of care, that failure to re-workup in August of '03?

A: I do. (Zizic Dep. 78:25 – 79:10, attached hereto as Exhibit A-3)

As stated, *supra*, the statute of repose for medical malpractice actions begins to run at the time of the first alleged act of negligence. *Shadwell v. Craigie*, 361 S.C. 492, 499, 605 S.E.2d 567, 570 (2004) (“We need only determine the time of the “occurrence” in order to determine if the statute of repose barred [this medical malpractice] cause of action.”). Based on this

testimony, the statute of repose was triggered in 2002 and extinguished all claims against this in 2008 thereby rendering Plaintiffs' Complaint untimely by nearly three years.

South Carolina's appellate courts have previously examined the date of occurrence in a medical malpractice claim on a multitude of occasions. All of this case law supports a grant of summary judgment in this matter. In *O'Tuel*, parents claimed the mother's OB/GYN acted negligently in failing to perform a cesarean delivery, which caused the child to suffer physical and mental disabilities. *Id.* at 26-7. These disabilities were not discovered by the parents until the child entered school. *Id.* at 27. Nine years after delivery, the parents sued the OB/GYN. *Id.* The court found that the date of "occurrence" was the date of the child's delivery, as that was when the negligent act occurred. *Id.* (citing *Johnson v. Phifer*, 309 S.C. 505, 424 S.E.2d 532 (Ct.App. 1992) (while cause of action accrued in 1987 when negligence was discovered, action filed in 1990 was barred by the medical malpractice statute of repose when negligence occurred in 1974-1977)). Accordingly, the medical malpractice claim was dismissed. *Id.* The same situation is present here, as Plaintiffs' only liability expert as to this Defendant stated that the first negligent act occurred in 2002. (Zizic Dep. 75:2 – 23; 77:25 – 78:5; 78:25 – 79:10, attached hereto as Exhibits A-1, A-2, and A-3 respectively).

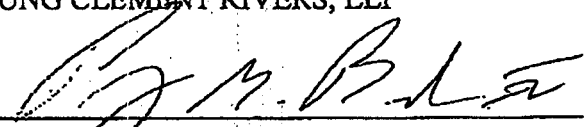
This very Court has also recently reached the same conclusion in a remarkably similar factual scenario to the instant case. In *Claire Craver Johnson v. John Roberts, M.D.*, C/A No. 2012-CP-10-2867, Judge Markley Dennis granted summary judgment to a physician defendant who treated the plaintiff over a ten year period. Similar to the instant matter, the plaintiff's liability expert assigned wrongdoing to the defendant as far back as eight years prior to the commencement of the action. The Court found such testimony established an act of negligence and render the plaintiff's Complaint as time-barred under the statute of repose. (See Judge

Dennis Order Granting Summary Judgment, attached hereto as Exhibit B) Furthermore, the Court found the continuous treatment and continuous tort rule to be inapplicable to the plaintiff's claims.

CONCLUSION

Plaintiffs' Complaint alleges that the first negligent act occurred on or about April 29, 2005, but Plaintiffs have not set forth or pointed to a single specific fact in support of that allegation. Plaintiffs' only liability expert as to this Defendant testified that Dr. Roane breached the standard of care in February of 2002 and again in August of 2003. Thus, the statute of repose expired in August of 2009 *at the latest*—meaning the Plaintiffs filed their Complaint nearly three years late. Summary judgment is therefore appropriate.

YOUNG CLEMENT RIVERS, LLP

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Attorneys for the Defendants Georgia Roane, M.D.
and Rheumatology Associates, P.A.

Charleston, South Carolina

Dated: 2/28/14

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to all counsel of record in this proceeding this 28th day of February, 2014.

Lydia H. O.

EXHIBIT B

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA,

DEFENDANT.

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT
CASE NO. 2012-CP-10-2867

FILED
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CLERK OF COURT
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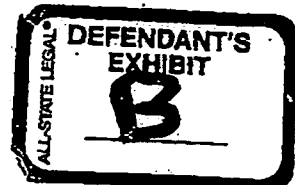
IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-8318

ORDER GRANTING SUMMARY
JUDGMENT IN FAVOR OF
DEFENDANTS

This matter is before the Court on the motions of Defendants John Roberts, M.D. ("Dr. Roberts") and Medical University of South Carolina ("MUSC") for an order granting summary judgment pursuant to Rule 56 of the South Carolina Rules of Civil Procedure as to Plaintiff's Complaint. Defendants' motions call into question the six-year statute of repose governing medical malpractice actions and the tolling of claims due to insanity under the disability statute contained in section 15-3-40 of the South Carolina Code. Specifically, because the instant action was not filed until nearly nine years after the first alleged negligent act of Dr. Roberts and nearly

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eight years after the commencement of treatment giving rise to Plaintiff's claim, Defendants maintain that Plaintiff's medical malpractice claims are barred pursuant to the six-year repose provision for medical malpractice actions provided by section 15-3-545 of the South Carolina Code. Plaintiff has attempted to toll the limitations period by asserting she lacked the mental capacity to comprehend the extent of her injuries until June of 2010. However, as set forth herein, the only tolling provided for medical malpractice actions is that contained in § 15-3-545(D) and applicable only to minors. Moreover, even assuming § 15-3-40 were to apply, this action, having been commenced more than one year after the Plaintiff's disability ceased, is still time-barred. Accordingly, for the reasons set forth below, the Court finds Plaintiff's medical malpractice claims are barred pursuant to the applicable statute of repose.

FACTS AND PROCEDURAL HISTORY

Plaintiff initiated this medical malpractice action against MUSC on November 16, 2011, asserting claims of cognitive impairment and memory loss as a result of electroconvulsive therapy ("ECT") administered sporadically from 2003 until 2008 for the treatment of severe depression and mania. (See Complaint attached hereto as Exhibit "A"). On May 16, 2012, Plaintiff filed a separate action against Dr. Roberts associated with his prescription of certain medication which caused Plaintiff's need for ECT treatment as well as the ECT treatment itself. That action was commenced by "Notice of Intent to File Suit" filed on November 4, 2011. Both cases have been consolidated. The events giving rise to these matters are as follows.

Since the mid-1980s Plaintiff has been suffering from bi-polar disorder and depression. She was formally diagnosed with borderline bi-polar disorder while attending Winthrop University in the mid-1980s. According to Plaintiff's father, her mania peaked from 1984—1986, after which she dropped out of college and fell into a deep depression. Thereafter, for a

period of about six years, Plaintiff was relatively stable and led a normal life. In 1997, her mania spiked once again, requiring hospitalization. Dr. Roberts, a licensed psychiatrist in private practice, began treatment of Plaintiff at this time. Over the next few years, Plaintiff required several hospitalizations in Rock Hill, Columbia and Charleston, during which she was treated with several different psychiatric medications, which Plaintiff alleges accelerated her manic episodes, cognitive impairment and ultimately caused the symptoms that led to the ECT.

During one of these numerous hospitalizations, Plaintiff was transferred from Piedmont Medical Center in Rock Hill to MUSC for an episode of psychotic mania. After she was discharged on a medication regimen, she was re-admitted to MUSC on November 26, 2003, with another episode of acute psychotic mania. On December 10, 2003, Plaintiff began ECT treatments. Plaintiff had numerous ECT treatments intermittently over the next several years in an attempt to either stabilize her acute mania into remission or to prevent a relapse. Plaintiff's last ECT treatment was on June 26, 2008.

Although the ECT treatment ended in June of 2008, Plaintiff and her expert maintain she did not "regain the mental capacity to understand and appreciate the harm she suffered as a result" of ECT until June of 2010. (See Affidavit of Harold J. Burstzajn, M.D.). Plaintiff subsequently initiated the instant actions against Dr. Roberts and MUSC on November 4, 2011, and November 16, 2011—nearly eight years after Plaintiff's commencement of ECT and nearly nine years after the first alleged act of negligence as to Dr. Roberts in prescribing certain medication. Consequently, due to the significant delay in commencing these actions, Defendants Dr. Roberts and MUSC filed the instant motions for summary judgment contending Plaintiff's claims are barred by the statute of repose and statute of limitations applicable to medical malpractice actions.

STANDARD OF REVIEW

Pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, summary judgment may be granted if there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law. Rule 56, SCRPC; Town of Summerville v. City of N. Charleston, 378 S.C. 107, 109-10, 662 S.E.2d 40, 41 (2008). The statute of limitations or statute of repose defense may be raised in a summary judgment motion. See McDonnell v. Consolidated School Dist. of Aiken, 315 S.C. 487, 445 S.E.2d 638 (1994). The proper interpretation of a statute is a question of law for the court. Town of Summerville, 378 S.C. at 110, 662 S.E.2d at 41 (citing Catawba Indian Tribe v. State, 372 S.C. 519, 524, 642 S.E.2d 751, 753 (2007)).

LAW/ANALYSIS

I. PLAINTIFF'S CLAIMS ARE BARRED BY THE SIX-YEAR STATUTE OF REPOSE FOR MEDICAL MALPRACTICE ACTIONS.

Medical malpractice claims are subject to a three-year statute of limitations and a six-year statute of repose. S.C. Code Ann. § 15-3-545(A). Specifically, section 15-3-545 of the South Carolina Code provides:

[T]o recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation by any licensed health care provider . . . acting within the scope of his profession must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date of discovery or when it reasonably ought to have been discovered, not to exceed six years from date of occurrence, or as tolled by this section.

S.C. Code Ann. § 15-3-545 (emphasis added).

A statute of limitations is a "procedural device that operates as a defense to limit the remedy from an existing cause of action" while the statute of repose actually "creates a substantive right in those protected to be free from liability after a legislatively determined

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period of time." Langley v. Pierce, 313 S.C. 401, 404, 438 S.E.2d 242, 243 (1993). The stated legislative purpose of the medical malpractice repose provision is to foster the delivery of quality health care services by reducing liability exposure. Hoffman v. Powell, 298 S.C. 338, 339-40, 380 S.E.2d 821, 821 (1989).

Notwithstanding the date of discovery of any claim, the six-year statute of repose begins to run upon an "occurrence" of medical negligence. See O'Tuel v. Villani, 318 S.C. 24, 27, 455 S.E.2d 698, 700 (Ct. App. 1995) (finding medical malpractice claim arising out of alleged negligence in the failure to perform a caesarean delivery of the minor plaintiff barred because it was instituted more than six years from the date of occurrence, i.e. the date of birth) overruled on other grounds by I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 526 S.E.2d 716 (2000); see also Johnson v. Phifer, 309 S.C. 505, 424 S.E.2d 532 (Ct. App. 1992) (finding while cause of action accrued in 1987 when negligence was discovered, action filed in 1990 was barred by the medical malpractice statute of repose when negligence occurred in 1974-1977). By focusing on the occurrence of negligence underlying the claim, the statute of repose ignores the discovery, knowledge and even the existence of an injury in barring claims. Hoffman v. Powell, 298 S.C. 338, 339-40, 380 S.E.2d 821, 821 (1989). Furthermore, the expiration of a statute of repose extinguishes all causes of action, including those that may later accrue and those that have already accrued. Capco of Summerville, Inc. v. J.H. Gayle Constr. Co., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006); see e.g. Columbia/CSA-HS Greater Columbia Healthcare Sys. v. S. Carolina Med. Malpractice Liab. Joint Underwriting Ass'n, 394 S.C. 68, 74-75, 713 S.E.2d 639, 642 (Ct. App. 2011) (finding equitable indemnification claim brought ten years after event giving rise to medical malpractice action barred by six-year statute of repose). Indeed, as an absolute time limit beyond which liability no longer exists, a statute of repose "is not tolled for

any reason because to do so would upset the economic balance struck by the legislative body." Langley, 313 S.C. at 404, 438 S.E.2d at 243 (citation omitted).

a. Plaintiff's Complaint against MUSC

The six-year repose provision of § 15-3-545 applies to public hospitals, such as MUSC, under the Tort Claims Act. See Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 149, 678 S.E.2d 809, 811 (2009) (finding the six year repose provision of § 15-3-545 applies to government hospitals under the Tort Claims Act). Applying § 15-3-545 to the instant case, Plaintiff has alleged acts of negligence against MUSC for performing ECT treatment on Plaintiff beginning as early as 2003. (MUSC Complaint at ¶ 2, 3 & 4).

The Complaint specifically alleges that "Plaintiff, while in the care of [MUSC] was involuntarily, repeatedly and improperly given ECT treatment" and that "[t]he ECT treatment by the defendant's employees took place between 2003 to 2008." (MUSC Complaint at ¶ 2 & 3). Plaintiff's medical records indicate the ECT was commenced on December 10, 2003. For purposes of the statute of repose, such allegations constitute an occurrence beginning as early as the commencement of treatment in 2003. See O'Tuel, 318 S.C. at 27, 455 S.E.2d at 700 (medical malpractice claim arising out of alleged negligence in the delivery of minor plaintiff barred where it was instituted more than six years from the date of occurrence, i.e. the date of birth); Johnson, 309 S.C. 505, 424 S.E.2d 532 (action barred by the medical malpractice statute of repose even though negligence was not discovered until three years prior). Thus, Plaintiff was required to bring the instant action against MUSC no later than December 10, 2009, six years from the date of the onset of treatment. Plaintiff's untimely Complaint filed on November 16, 2011, is therefore barred as a matter of law pursuant to § 15-3-545.

b. Plaintiff's Complaint against Dr. Roberts

As to Dr. Roberts, Plaintiff alleges acts of negligence beginning in 2003 and earlier. See Roberts Complaint at ¶ 2 & 7). In particular, the Complaint alleges that "on or about 2003, [Dr. Roberts] began treating plaintiff with [ECT]" and that "Plaintiff, while in the care of the defendant Roberts, was involuntarily, repeatedly and improperly given ECT treatment at the request of the defendant Roberts . . ." (Roberts Complaint at ¶ 7). As with Plaintiff's claims against MUSC, the initiation of ECT in 2003 is the occurrence from which the statute of repose is set to run. However, Deposition testimony of Plaintiff's expert identifies alleged acts of negligence as to Dr. Roberts beginning even earlier with the prescription of Wellbutrin in 2002. (Deposition of Dr. Breggin, p. 101, l. 24—p. 102, l. 6). According to Plaintiff and her expert, Dr. Breggin, the prescription of Wellbutrin and Concerta accelerated her manic episodes, cognitive impairment and ultimately caused the symptoms that led to the ECT. When asked to identify a starting point for this alleged occurrence of negligence, Dr. Breggin offered the following:

Q: Here's my concern, you have said repeatedly in this deposition, not only was there negligence, there was gross negligence in the fact he was prescribing Wellbutrin while she was in a manic phase. I just wanted you to get specific and point out to me in the medical records.

A: 2/13/02 is a start.

(Deposition of Dr. Peter Breggin, p. 101, l. 24—p. 102, l. 6). Consequently, Plaintiff's claims against Dr. Roberts, having arisen out of ECT initiated in 2003 and the prescription of Wellbutrin in 2002, are untimely under the six-year statute of repose.

II. NEITHER THE DISABILITY STATUTE NOR THE CONTINUOUS TREATMENT RULE APPLY TO TOLL PLAINTIFF'S CLAIMS.

To defeat the statute of repose and limitations bar, Plaintiff has attempted to toll the limitations period by offering expert testimony indicating that prior to June of 2010 "her capacity

to comprehend what was going on in her life" was diminished by her ECT and underlying mental illness. The legislature has codified a means by which to toll the statute of limitations for individuals deemed "insane" in § 15-3-40. However, as explained in Langley v. Pierce, this statute is inapplicable to medical malpractice actions under the plain and unambiguous language of § 15-3-545(D). See Langley, 313 S.C. at 403, 438 S.E.2d at 243. In Langley, the South Carolina Supreme Court interpreted the interplay between the medical malpractice statute and the disability statute, observing that the "[i]nclusion of the phrase "or as tolled by this section" in subsection (A) clearly indicates that the only tolling of § 15-3-545(A) intended by the legislature is that contained in subsection (D)," which "provides a limited tolling provision, applicable only to minors." Id. (emphasis in original).

Similarly, in O'Tuel, the Court of Appeals interpreted subsection (D) of the current medical malpractice statute as operating "to limit the period of tolling which would otherwise be applicable, and demonstrates that, while the legislature was concerned with increased exposure to claims created by the tolling statute, the legislature was not willing to completely abandon the protection given minors by the tolling statute." Id. 318 S.C. at 32-33, 455 S.E.2d at 703 (overruled on other grounds by Ion, L.L.C., 338 S.C. 406, 526 S.E.2d 716). Thus, as noted in Langley and O'Tuel, the plain language of § 15-3-545 limits tolling only to minors as provided in 15-3-545(D). Tolling for insanity otherwise provided by § 15-3-40 is, therefore, inapplicable in medical malpractice actions.

Consistent with this finding, South Carolina has likewise rejected such tolling mechanisms as the continuous treatment rule or the continuous tort doctrine as a means of tolling the statute of limitations in medical malpractice cases. The rationale for doing so was explained by the South Carolina Supreme Court in Harrison v. Bevilacqua, stating that adoption of the

continuous treatment/continuous tort doctrine "would run afoul of the absolute limitations policy the Legislature has clearly set" through statute, including the six year repose provision of § 15-3-545. 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003). Thus, because the only tolling provided by § 15-3-545 is contained in Subsection (D) and applicable only to minors, application of the discovery rule or tolling provided by the disability statute will not revive a claim that is filed outside the statute of repose. Consequently, Plaintiff's claims, having been brought nearly eight years from the onset of treatment and nearly nine years after the first alleged negligent act of Dr. Roberts, are barred by the absolute six-year statute of repose within § 15-3-545.

III. EVEN ASSUMING PLAINTIFF LACKED THE MENTAL CAPACITY TO COMPREHEND HER INJURIES, PLAINTIFF'S CLAIMS ARE BARRED FOR FAILURE TO BRING THE ACTION WITHIN ONE YEAR AFTER THE DISABILITY CEASED.

Assuming, arguendo, that the disability statute applied, and taking as true Plaintiff's assertion that her mental impairment prevented her from comprehending her injuries, this action is barred by the limitations period established under § 15-3-40. Pursuant to the disability statute, an action may be tolled for the period within which the Plaintiff may be disabled due to "insanity" but the time for commencement of the action must not be extended "more than five years by any such disability" nor "in any case longer than one year after the disability ceases."

S.C. Code Ann. § 15-3-40. Specifically, § 15-3-40 provides:

If a person entitled to bring an action ... under Chapter 78 of this title ... is at the time the cause of action accrued either:

- (1) within the age of eighteen years; or
- (2) insane;

the time of the disability is not a part of the time limited for the commencement of the action, except that the period within which the action must be brought cannot be extended:

- (a) more than five years by any such disability, except infancy; nor
- (b) in any case longer than one year after the disability ceases.

§ 15-3-40 (emphasis added). The general rule as to the standard for insanity under tolling statutes is as follows:

Insanity or mental incompetency that tolls the statute of limitations consists of a mental condition which precludes understanding the nature or effects of one's acts, an incapacity to manage one's affairs, an inability to understand or protect one's rights, because of an over-all inability to function in society, or the mental condition is such as to require care in a hospital.

Wiggins v. Edwards, 314 S.C. 126, 129, 442 S.E.2d 169, 170 (1994) (quoting 54 C.J.S. *Limitations of Actions* § 117 at 159-169 (internal footnotes omitted)).

Here, Plaintiff and her expert assert Plaintiff "did not regain the mental capacity to understand and appreciate the harm . . ." allegedly caused by ECT until June of 2010. Therefore, construing the facts in the light most favorable to Plaintiff, the disability statute required Plaintiff to file the instant action no later than June of 2011. Accordingly, the instant action filed against Dr. Roberts on November 4, 2011 and MUSC on November 16, 2011—more than one year after the disability ceased—is untimely as a matter of law.

Furthermore, the express language of § 15-3-40 acknowledges that disability does not affect the date of accrual. By allowing individuals who are disabled "at the time the cause of action accrued" to have the statute of limitations extended, accrual is implied to take place while the individual is under a disability. S.C. Code Ann. § 15-3-40. Substantial evidence in the instant case, including admissions in Plaintiff's deposition, statements to her treating physicians, and evidence in her divorce proceedings indicate Plaintiff's claim accrued much earlier than June of 2010. Specifically, she testified in her deposition that, between 2006 and 2008, she was upset and aware of alleged memory loss and not being able to take care of herself as a result of ECT. (See Deposition of Plaintiff, p. 68, l. 9 – p. 69, l. 25). She later acknowledged that she lost the ability to take care of herself prior to her last ECT treatment in June of 2008 and that she

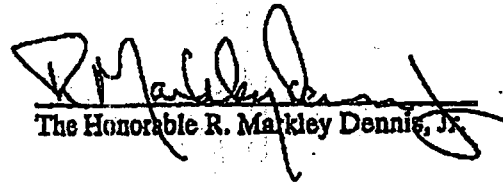
attributed that *at the time* to ECT. (See Deposition of Plaintiff, p. 81, l. 20 – p. 82, l. 21). She reiterated later in her deposition that it was during her maintenance ECT (2005-2008) that she first started believing that she was suffering from memory problems as a result of ECT. (See Deposition of Plaintiff, p. 124, l. 12-19). She also stated to Dr. Roberts, and reiterated in her deposition, that on January 6, 2009, she was upset at the effect that ECT had on her at the time. (See January 6, 2009 Notes of Dr. Roberts; Deposition of Plaintiff, p. 125, l. 19 - 126, l. 9). Similarly, there are also references to Plaintiff's memory loss from ECT dating back to Plaintiff's divorce proceedings in 2007. For instance, Plaintiff's Life Care Plan, dated January 30, 2007, notes "[Plaintiff] has been having increasing problems with her memory." (See Life Care Plan for Clair Johnson, p. 4). Plaintiff's Life Care Plan further notes that Plaintiff "has reportedly developed increasing problems with directionality and memory" and that Plaintiff admitted being "afraid to drive due to increased problems with memory. . ." (See Deposition of Plaintiff, pp. 5 & 13).

Therefore, Plaintiff's recognition of her injuries in 2007 and earlier indicates the claim accrued while Plaintiff was under disability. Consequently, even if the disability statute were applicable, Plaintiff's claims, having been filed more than one year after her disability ceased, are still untimely as a matter of law.

CONCLUSION

In sum, Plaintiff's claims against Dr. Roberts and MUSC, having been commenced well over six years after the alleged occurrence of medical negligence, are barred by the medical malpractice statute of repose. Accordingly, based upon the foregoing, summary judgment in favor of Defendants John Roberts M.D. and Medical University of South Carolina is proper. Defendants' motion for summary judgment is, therefore, **GRANTED**.

AND IT IS SO ORDERED.


The Honorable R. Markley Dennis, Jr.

January 23, 2014
Charleston, South Carolina

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STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W. Marshall,

Plaintiffs,

Versus

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC,

Defendants.

IN THE COURT OF COMMON PLEAS

C/A No. 2011-CP-10-934

**MEMORANDUM IN SUPPORT OF
DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT**

2014 MAR -5 PM 2:51
BY JULIE J. HARRIS
CLERK OF COURT

The Defendants, Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC (hereinafter "the Defendants") pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, submit this Memorandum in Support of their Motion for Summary Judgment and in response to Plaintiff's March 4, 2014 letter to the Court opposing said Motion (attached as "Exhibit A").

STATEMENT OF FACTS

In 2010, Plaintiff Virginia L. Marshall was diagnosed with lymphoplasmacytic lymphoma. On February 7, 2011, Ms. Marshall and her husband Todd W. Marshall (hereinafter "the Plaintiffs") brought a suit for medical malpractice against the Defendants alleging that they were negligent for, *inter alia*, failing to diagnose Ms. Marshall with signs of cancer.

Defendant Dr. Kenneth Dodds was an employee with Defendant Charleston Nephrology Associates, LLC. The Plaintiffs allege that on February 7, 2005, Ms. Marshall visited the Defendants and Dr. Dodd ordered a 24-hour urine test to be conducted which indicated elevated levels of protein in her urine. Exhibit B, Pls.' Am. Compl. 2. Because of this, Ms. Marshall was treated for proteinuria on February 9, 2005. Am. Compl. 2. The Plaintiffs claim that additional testing, such as a urine protein electrophoresis ("UPEP") test and/or a serum protein

electrophoresis ("SPEP") test, could have been performed and possibly shown signs of cancer. Am. Compl. 2. However, these tests were not performed. Additionally, at her follow-up visit on September 15, 2005, the Plaintiffs allege that Ms. Marshall's protein levels were again elevated, but Defendants failed to do any of the additional tests. The Plaintiffs claim that this alleged misdiagnosis and mistreatment of Ms. Marshall's condition constitute medical malpractice and now seek actual and punitive damages from the Defendants. However, the Defendants first allegedly misdiagnosed Ms. Marshall on September 15, 2004—outside of the applicable statute of repose—and as later visits where a plaintiff continued to be misdiagnosed cannot serve as the trigger of the statute of repose, Plaintiffs' claims should be dismissed.

LEGAL STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Rule 56(c), S.C.R.C.P. The moving party has the initial responsibility of demonstrating the absence of a genuine issue of material fact. Baughman v. American Tel. and Tel. Co., 306 S.C. 101, 115, 410 S.E.2d 537 (1991). However, the moving party may demonstrate this "with or without supporting affidavits," and may point out that there is a lack of evidence to support the nonmoving party's case. Rule 56(b), S.C.R.C.P.; see Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986).

Once the party moving for summary judgment meets the initial burden of showing an absence of evidentiary support for the opponent's case, the nonmoving party "may not rest upon the mere allegations or denials of his pleading." Rule 56(e), S.C.R.C.P. Instead, the nonmoving party "must set forth specific facts showing that there is a genuine issue for trial." *Id.* In order to preclude a grant of summary judgment, "the court must determine that a genuine issue of material fact exists for each essential element of the plaintiff's claim." Hansson v. Scalise Builders of S.C., 374 S.C. 352, 358, 650 S.E.2d 68, 71 (2007).

DISCUSSION

"A statute of repose creates a substantive right in those protected to be free from liability after a legislatively-determined period of time." Langley v. Pierce, 313 S.C. 401, 404, 438 S.E.2d 242, 243 (1993) (quoting First United Methodist Church v. U.S. Gypsum Co., 882 F.2d 862, 865-66 (4th Cir. 1989)). The statute of repose governing medical malpractice actions provides:

In any action . . . to recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation by any licensed health care provider . . . acting within the scope of his profession must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from date of discovery or when it reasonably ought to have been discovered, *not to exceed six years from date of occurrence*

S.C. Code Ann. § 15-3-545(A) (1976) (emphasis added). This six-year statute of repose "constitutes an outer limit beyond which a medical malpractice claim is barred, regardless of whether it has or should have been discovered." Hoffman v. Powell, 298 S.C. 338, 339-40, 380 S.E.2d 821 (1989).

As the statute of repose is an absolute limit on the right to file a medical malpractice action, the South Carolina Supreme Court does not allow the time limit to be extended and has refused to recognize the "continuous treatment rule" in medical malpractice cases. Harrison v. Bevilacqua, 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003); Kaminer, 653 S.E.2d at 832. The "continuous treatment rule" states:

[I]f the treatment by the doctor is a continuing course and the patient's illness, injury or condition is of such a nature as to impose on the doctor a duty of continuing treatment and care, the statute does not commence running until treatment by the doctor for the particular disease or condition involved has terminated—unless during treatment the patient learns or should learn of negligence, in which case the statute runs from the time of discovery, actual or constructive.

Preer v. Mims, 323 S.C. 516, 519, 476 S.E.2d 472, 474 (1996) (quoting 1 David W. Louisell & Harold Williams, Medical Malpractice, § 13.02[3] (1996)). The South Carolina Supreme Court declined to adopt this doctrine because "judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set' through statute, including the statute of repose." Shadwell v. Craigie, 361 S.C. 492, 499, 605 S.E.2d 567, 570 (Ct. App. 2004) (quoting Harrison, 354 S.C. at 138, 580 S.E.2d at 114).¹

As an absolute boundary for medical practice actions, the six-year statute of repose begins to run from the *first* negligent act or omission. See O'Tuel v. Villani, 318 S.C. 24, 27, 455 S.E.2d 698, 700 (Ct. App. 1995) overruled in part and on other grounds by I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 526 S.E.2d 716

¹ Plaintiffs take issue with the above citations to cases regarding the Supreme Court's refusal to adopt the "continuous treatment rule." See Exhibit A. They claim that they are not seeking to toll the statute of limitations or statute of repose as the plaintiff was in Harrison. The Defendants do not contend that Plaintiffs are attempting to toll the statute of repose, and merely mention the "continuous treatment rule" to illustrate the strict interpretation South Carolina courts have placed on the six-year statute of repose and that when confronted with the situation, the South Carolina Supreme Court declined to adopt the rule.

(2000) (finding that the statute of repose began to run from the date of a child's birth even though his injuries were not discovered until he began school). Therefore, in a medical malpractice case involving a misdiagnosis or mistreatment the statute of repose begins to run on the date of the *initial* misdiagnosis and mistreatment. Kaminer v. Canas, 653 S.E.2d 691, 697 (Ga. 2007); see Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009) (finding that the statute of repose began to run from the date of a physician's misdiagnosis of a plaintiff). In other words, "although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition." Howell v. Zottoli, 691 S.E.2d 564, 566 (Ga. Ct. App. 2010) (citing Kaminer, 653 S.E.2d at 697-98). Allowing plaintiffs to reallege a claim for medical malpractice at each subsequent visit to their physician after an initial misdiagnosis, would be contrary to the legislative intent of the statute of repose to be an "absolute outer limit" in medical malpractice cases. Kerr, 383 S.C. at 148, 678 S.E.2d at 810.

Plaintiffs contend that in Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 678 S.E.2d 809 (2009), where the Court found that a plaintiff's claims against a hospital for misdiagnosing a cancerous mole as benign were barred by the statute of repose, only involved one misdiagnosis. See Exhibit A. While it may be true that the only alleged negligent act in Kerr was the initial misdiagnosis, this fact does not lend any support to Plaintiffs' argument that a subsequent misdiagnosis would constitute a new negligent act and thus a new "occurrence" under the statute of repose. Patients often see a physician on numerous occasions. If failing to make a

diagnosis is the alleged deviation from the standard of care, then the statute of repose has to run from the first alleged negligent act. If litigants were allowed to choose a date where a physician merely continued to misdiagnose them for purposes of the statute of repose, the six-year statute of repose would be rendered useless and would no longer serve as an absolute limit on medical malpractice cases. Kerr, 383 S.C. at 148, 678 S.E.2d at 810.

While Plaintiffs claim that the Defendants alleged misdiagnosis of Ms. Marshall on February 9, 2005 was a separate and independent act of negligence for purposes of the statute of repose, it was simply the continuation of the Defendants initial misdiagnosis of Ms. Marshall on September 15, 2004 and cannot serve as the trigger of the statute of repose. The only deviation from the standard of care alleged by the Plaintiffs is that the Defendants failed to properly diagnose Ms. Marshall's cancer after seeing elevated protein levels in Ms. Marshall's 24-hour urine test and not ordering additional testing, such as a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test, that would have revealed the cancer. Pls.' Am. Compl. 3. At Ms. Marshall's February 9, 2005 visit, a 24-hour urine test indicated that Ms. Marshall had elevated protein levels in her urine at 3.1 g/day, and Plaintiffs claim that the Defendants were negligent for not ordering additional testing and properly diagnosing and treating Ms. Marshall's cancer at this time. Pls.' Am. Compl. 2. On September 15, 2005, Ms. Marshall's 24-hour urine test indicated that the protein levels in Ms. Marshall's urine had increased to 4.2 g/day, and Plaintiffs again claim the Defendants were negligent for not properly diagnosing Ms. Marshall. Pls.' Am. Compl. 2.

However, at Ms. Marshall's initial visit with the Defendants on September 15, 2004 a 24-hour urine test conducted on August 6, 2004 revealed that Ms. Marshall's protein levels in her urine were at 3.5 g/day—a higher level of protein than the 3.1 g/day found on February 9, 2005. The Defendants also did not perform a UPEP test or an SPEP test at the September 15, 2004 visit and did not diagnose Ms. Marshall with cancer.

Barry L. Singer, M.D., Plaintiffs' expert and a specialist in oncology, testified that based on this evidence it was more likely than not that Ms. Marshall had cancer in September of 2004 when she saw Dr. Dodds. Exhibit C, Singer Dep. 68:17–68:23. As such, Dr. Singer claims that the Defendants initially failed to properly diagnose and treat Ms. Marshall on September 15, 2004:

Q: We established earlier that you're aware that Mrs. Marshall saw Doctor Dodds in September of 2004?

A: Yes, sir.

Q: And it would be your testimony that she had cancerous protein in her urine at that time as well?

A: I believe she did.

Q: And it would be your opinion that Doctor Dodds failed to diagnose the cancerous protein at that time as well?

A: Yes, sir.

Singer Dep. 61:20–62:6. Plaintiff's other expert, Dr. Robert Luke, also agrees that cancer was present and not diagnosed by the Defendants at Ms. Marshall's first visit on September 15, 2004. See Exhibit D, Luke Dep. 25:7–12.

At the hearing on March 3, 2004, Plaintiffs tried to assert that the 3.5 g/day protein level in Ms. Marshall's urine examined by the Defendants on September 15, 2004, was merely a "spike" in her protein levels and would not have warranted the additional testing by the Defendants at that time. They claimed that it was not until the February 9, 2005 visit that such additional testing should have been ordered. Yet, this argument is in contradiction to Plaintiff's own experts who

testified that the elevated protein levels on September 15, 2004 should have indicated to the Defendants to do additional testing at that time. Dr. Singer testified:

Q: All right. And you said it's more likely than not that she had Waldenstrom's in September of '04.

A: Sure. She had been on the Cellcept and the Imuran then I believe for a period, and now I believe the disease was more active.

Q: What forms the basis of that opinion?

A: Because she had the real high proteins. When you do a 24-hour urine for protein and you only have -- I think Doctor Luke explained it in his deposition better than I can. He's a nephrologist -- there's a disparity between the protein test and the dip stick, and what actually you collect in 24 hours, you're obviously looking for some abnormal protein in the urine, and I believe if that had been done, an SPEP then or UPEP, she would have been diagnosed with her disease.

Singer Dep. 68:17-69:12 (emphasis added). In fact, Ms. Marshall had elevated protein levels at all times she saw the Defendants, and Dr. Singer could think of no reason to not include the September 15, 2004 visit in his affidavit which alleged a deviation from the standard of care by the Defendants for failure to diagnose. Id at 62: 7-25.

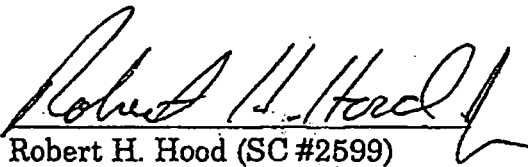
Thus, the alleged misdiagnosis and mistreatment of Plaintiff Virginia Marshall's cancer by the Defendants initially occurred on September 15, 2004 rather than February 9, 2005 as claimed by the Plaintiffs. While Ms. Marshall did subsequently visit the Defendants for treatment on February 9, 2005 and was not diagnosed with cancer, this later alleged misdiagnosis cannot serve as the starting point for the statute of repose and is not a "separate and independent act" of negligence as claimed by Plaintiffs.

As such, the six-year statute of repose period ran from September 15, 2004 until September 15, 2010. Because the Plaintiffs did not file their Complaint until February 7, 2011, this action falls outside of the applicable statute of repose, and the Defendants are entitled to summary judgment on all claims.

CONCLUSION

For the foregoing reasons, the Defendants Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC respectfully request that this Court grant them summary judgment on the Plaintiffs' claims and dismiss the Complaint with prejudice.

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Attorneys for the Defendants
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Nephrology Associates, LLC

315, 2014
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☐ mailing, ☒ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 5 day of March, 2014.



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH CIRCUIT

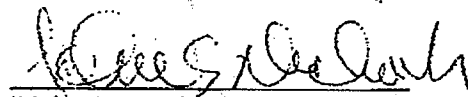
CASE NO. 2011-CP-10-0934

NOTICE OF APPEARANCE

The undersigned respectfully requests that the Court note their appearance as additional
counsel in this case for the Plaintiffs, Virginia L. Marshall and Todd W. Marshall.

May 19, 2014

Respectfully submitted,



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STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH CIRCUIT

CASE NO. 2011-CP-10-0934

MOTION TO ALTER OR AMEND
AND FOR RECONSIDERATION

TO: THE ATTORNEYS FOR ALL DEFENDANTS

This motion is made pursuant to Rules 52 and 59 of the South Carolina Rules of Civil Procedure. See also *Elam v. S.C. Dep't of Transp.*, 361 S.C. 9, 21-22, 602 S.E.2d 772, 778-79 (2004) ("it is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also as a vehicle to seek 'reconsideration' of issues and arguments.").

The plaintiffs received written notice of the entry of the court's judgments on May 8, 2014.

The plaintiffs respectfully submit that the court may have overlooked or misapprehended the following points in reaching its decisions:

This case involves what appears to be a novel issue in South Carolina. As of the writing of this motion, counsel for the plaintiffs has not been able to discover any precedent in South Carolina that addresses the question of how the statute repose is properly applied to a medical malpractice case that involves a physician's repeated misdiagnosis of an illness. Although there are at least four (4) published decisions that involve serial misdiagnosis cases, none of these decisions provides a definitive answer to the question of how the statute of repose — which begins to run when an act

of negligence “occurs” — will apply when a physician (or when multiple physicians) commits repeated instances of negligence over a period of time.¹

This Court’s decisions are largely based on Georgia law. Georgia law provides that in a misdiagnosis case, the repose period will begin to run at the first instance of a physician’s negligence, even though the physician has technically committed multiple acts of negligence over a period that may extend over several years. The Court’s decisions cite *Howell v. Zottoli*, 691 S.E.2d 564 (Ga. Ct. App. 2010) for this rule, but the principle case that adopts this rule and articulates its reasoning is *Kaminer v. Canas*, 653 S.E.2d 691 (Ga. 2007).

This rule is not without controversy. *Kaminer* was a 4-3 decision, with the three dissenters observing that it is inaccurate to say that there is a single and indivisible injury that flows from serial misdiagnoses of the same condition. Just as the initial misdiagnosis causes a patient to experience pain and to suffer unnecessary expenses, so too does a subsequent misdiagnosis cause continued pain and additional expenses. See 653 S.E.2d at 699.

This rule is also not absolute. Georgia has recognized a “new injury” component to its misdiagnosis cases that applies when a misdiagnosis allows a condition that is treatable to transform into something that is *untreatable* and that spreads. *Cleveland v. Gannon*, 667 S.E.2d 366 (Ga. 2008). Even *this* exception has caused controversy. See *id.* at 383 (suggesting that the circumstances in *Cleveland* were not materially different from the circumstances in *Kaminer*). One member of the Court of Appeals of Georgia has observed that these principles are “not easy to apply”

¹These cases are *Kerr v. Richland Memorial Hospital*, *Shadwell v. Craigie*, *Dunbar v. Carlson*, and *Johnson v. Phifer*. See *Kerr*, 383 S.C. 146, 678 S.E.2d 809 (2009); *Shadwell*, 361 S.C. 492, 605 S.E.2d 567 (Ct. App. 2004); *Dunbar*, 341 S.C. 261, 533 S.E.2d 913 (Ct. App. 2000); and *Johnson*, 309 S.C. 505, 424 S.E.2d 532 (Ct. App. 1992).

and used the word "confusion" to describe the process of sorting them. That observation appears in the concurring decision in *Howell* — the same case this Court is using as a basis of its summary judgment decisions. See 691 S.E.2d at 568.

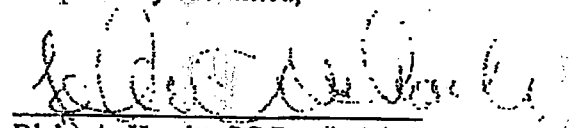
Although summary judgment is not rendered inappropriate just because a case involves a novel issue, summary *may* be inappropriate when further development of the facts is desirable to clarify the application of the law. See *Linòg v. Yampolsky*, 376 S.C. 182, 185-86, 656 S.E.2d 355, 357 (2008) and *Schmidt v. Courtney*, 357 S.C. 310, 319, 592 S.E.2d 326, 331 (Ct. App. 2003) (stating these principles).

To provide a proper record for both this Court and (potentially) an appellate court to decide how South Carolina is going to answer the question of how the statute of repose applies to a serial misdiagnosis case, it would be important for the record to contain evidence about the pain and expense the plaintiff suffered as a result of each misdiagnosis, medical evidence that might qualify the case under the "new injury" component of Georgia law, and other evidence that a court may deem to be important in hindsight. That sort of evidence is not in the present record. The specter of Georgia law did not even appear in this case until *after* the summary judgment hearing.

Rather than decide summary judgment on the current filings, the Court should either conduct an evidentiary hearing and allow the parties to present testimony that would inform the question presented, or the Court should defer the summary judgment ruling until the conclusion of the plaintiff's case at trial. The present record was not constructed in a way that would provide a meaningful context for answering this question. At the this time, and in the this context, summary judgment is premature.

May 19, 2014

Respectfully submitted,



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Attorneys for Plaintiffs

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	
Virginia L. Marshall and Todd W. Marshall,	)	C/A No. 2011-CP-10-934
	)	(consolidated)
	)	
Plaintiffs,	)	DEFENDANTS KENNETH A.
	)	DODDS, M.D. AND CHARLESTON
Versus	)	NEPHROLOGY ASSOCIATES, LLC'S
	)	MEMORANDUM IN OPPOSITION
Kenneth A. Dodds, M.D., Charleston	)	TO THE PLAINTIFFS' MOTION FOR
Nephrology Associates, LLC, Georgia	)	RECONSIDERATION
Roane, M.D. and Rheumatology	)	
Associates, P.A.,	)	
	)	
Defendants.	)	

By order filed May 2, 2014, the Trial Court granted summary judgment to the Defendants Kenneth A. Dodds, M.D. ("Dr. Dodds"), and Charleston Nephrology Associates, LLC ("Charleston Nephrology") (collectively "the Defendants") based on the statute of repose. The law firm of Bluestein, Nichols, Thompson & Delgado filed a Notice of Appearance for the Plaintiffs along with a Motion to Alter or Amend contending that the Trial Court has overlooked or misapprehended certain points of law. The Defendants maintain that the Trial Court thoroughly considered all points and arguments raised and correctly applied the applicable and relevant law, and they respectfully request that this Court deny the motion for the reasons discussed below.

1. The Trial Court correctly applied controlling precedent from South Carolina appellate courts.

To briefly summarize the pertinent facts, the Plaintiff, Virginia Marshall, a patient at Charleston Nephrology, was seen by Dr. Dodds on September 15, 2004,

November 11, 2004, February 9, 2005, and September 15, 2005. Thereafter, she was diagnosed with cancer (lymphoplasmatic lymphoma) in February 2010 by another physician/oncologist. She (and her husband) filed a complaint on February 7, 2011, alleging that Dr. Dodds was negligent in failing to diagnose her cancer. Under the statute of repose, any claim negligence is barred if it occurred more than 6 years from the date of occurrence, regardless of whether an injury has or should have been discovered. S.C. Code Ann. § 15-3-545(A); Hoffman v. Powell, 298 S.C. 338, 380 S.E.2d 821 (1989).

In an attempt to avoid the absolute bar of the statute of repose, the Plaintiffs pled a claim for negligence based on the February 7, 2005 results of Mrs. Marshall's 24-hour urine test which indicated elevated levels of protein in her urine. Dr. Dodds evaluated Mrs. Marshall on February 9, 2005, and the results from her 24-hour urine test, and did not order additional testing regarding the elevated levels of protein in her urine. The Plaintiffs claim Dr. Dodds was negligent for failing to order testing to determine the types of protein present in the urine. More specifically, they allege that Mrs. Marshall had cancerous proteins in her urine in February, 2005 that went undetected and untreated.

The Defendants deny any negligence in the treatment of Mrs. Marshall in February, 2005 or during any other visit with Dr. Dodds. However, the Defendants assert that Mrs. Marshall was in the same condition in September, 2004 and November, 2004 that she was in February, 2005. Dr. Dodds did not order additional testing in September, 2004 or November, 2004. Under the Plaintiffs' theory, Dr. Dodds was negligent during both 2004 visits. The Plaintiffs' own

experts even testified that Mrs. Marshall had the cancer at the time of the September 15, 2004 visit. The same Plaintiffs' experts testified it was a breach of the standard of care to not order additional testing in 2004 to evaluate the presence of the proteins.

The Trial Court found that the record shows that the alleged misdiagnosis and mistreatment of her cancer initially occurred on September 15, 2004, and correctly held that is when the statute of repose began to run. Accordingly, the Trial Court properly granted summary judgment because this action was filed after the statute of repose expired on September 15, 2010.

The Plaintiffs argue in their motion for reconsideration that this is a novel issue because there is no precedent directly on point that addressed application of the statute of repose in a case of alleged repeated misdiagnosis of an illness. However, the Trial Court's ruling is firmly founded on the opinions wherein our Appellate Courts have consistently applied the statute of repose as an absolute limit on the right to file a medical malpractice action. See Harrison v. Bevilacqua, 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003) (Consistent with this strict application of the statute of repose, the South Carolina Supreme Court has refused to recognize the "continuous treatment rule" in medical malpractice cases.); Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009); Shadwell v. Craigie, 361 S.C. 492, 499, 605 S.E.2d 567, 570 (Ct. App. 2004).

2. The Trial Court properly relied on Georgia authority as persuasive.

In the motion for reconsideration, the Plaintiffs argue that that the Trial Court's decision is largely based on Georgia law, and attempts to challenge the

efficacy of those decisions with discussion of dissenting opinions. First, the Trial Court does cite to appellate decisions from Georgia as *persuasive*: Kaminer v. Canas, 653 S.E.2d 691 (Ga. 2007), and Howell v. Zottoli, 691 S.E.2d 564 (Ga. App. 2010). However, the Plaintiffs submitted two letters/memoranda to the Trial Court following the hearing which addressed these two cases. Now on reconsideration, the Plaintiffs are presenting additional arguments attempting to undermine the Georgia authority. See C.A.H. v. L.H., 315 S.C. 389, 392, 434 S.E.2d 268, 270 (1993), and Hickman v. Hickman, 301 S.C. 455, 392 S.E.2d 481 (1990) (a party cannot use Rule 59(e) to present to the court an issue the party could have raised prior to judgment, but did not). But any challenge to those decisions – only relied upon as persuasive – does not detract from the authority of the South Carolina precedent on the statute of repose.

In addition, the Plaintiffs discussion of the decision in Cleaveland v. Gannon, 667 S.E.2d 366, 367 (Ga. 2008), does not support the Plaintiffs arguments. In that case, the Georgia appellate court discusses “the ‘subsequent’ or ‘new injury’ exception to the general rule that, when the patient’s medical malpractice claim is based upon negligent misdiagnosis, the statutes of limitations and repose commence to run immediately.” *Id.* Plaintiffs argue in their motion for reconsideration that this “new injury” exception may apply. However, as the Plaintiffs themselves note, this exception was applied where there was a treatable condition that was misdiagnosed and then an untreatable, cancer developed. This case, like *Kaminer*, is a situation where the patient continued to suffer from the

same condition. As the *Cleveland* court stated: "There is a significant distinction between a patient's development of an entirely new medical condition, and his experiencing the proximate symptomatic consequences of the original misdiagnosis." *Id.* at 369.

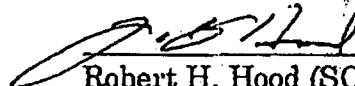
3. The Plaintiff did not oppose the summary judgment motion on the ground that further evidentiary development was necessary or request any continuance to pursue additional discovery.

The Plaintiffs, in their motion for reconsideration, argue that summary judgment is premature because they need to develop evidence about "the pain and expense the plaintiff suffered as a result of each misdiagnosis." As discussed above, the Plaintiffs argument is not consistent with the *Cleveland* opinion, as the evidence – from the Plaintiffs' own experts – establishes that the cancer was present at the time of the September 15, 2004 visit. Moreover, the Plaintiffs have not, until the motion for reconsideration, argued that more discovery was necessary. Discovery has already been completed in this case and at the time of the hearing the case was set for trial on a date certain. The Plaintiffs only request that the trial be continued was to avoid the expense of preparing for a trial if summary judgment was granted. See Motion for Continuance, filed April 8, 2014. *Bayle v. S. Carolina Dep't of Transp.*, 344 S.C. 115, 128, 542 S.E.2d 736, 742-43 (Ct. App. 2001) (issue not preserved for review where plaintiff did not present argument regarding the necessity for additional discovery until after the motion for summary judgment had been granted).

Conclusion

For the foregoing reasons, in addition to the issues and arguments raised previously at the hearing and in the memoranda, the Defendants Kenneth A. Dodds, M.D. and Charleston Nephrology Associates, LLC respectfully request that this Court deny the motion for reconsideration.

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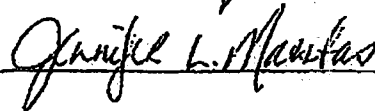
Attorneys for the Defendants
Kenneth A. Dodds, M.D. and Charleston
Nephrology Associates, LLC

6 / 4, 2014
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 6th day of June, 2014.



STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

KENNETH A. DODDS, MD,
CHARLESTON NEPHROLOGY
ASSOCIATES, LLC,

Defendants.

VIRGINIA L. MARSHALL AND TODD
W. MARSHALL,

Plaintiffs,

vs.

GEORGIA ROANE, M.D. AND
RHEUMATOLOGY ASSOCIATES,
P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-934

DEFENDANTS GEORGIA ROANE,
M.D. AND RHEUMATOLOGY
ASSOCIATES, P.A.'S RESPONSE IN
OPPOSITION TO PLAINTIFFS'
MOTION TO ALTER, OR AMEND AND
FOR RECONSIDERATION

TO: BLAKE A. HEWITT, JOHN S. NICHOLS, J. EDWARD BELL, III, AND C. CARTER
ELLIOTT, JR., ATTORNEYS FOR THE PLAINTIFFS:

The Defendants, Georgia Roane, M.D. and Rheumatology Associates, P.A. (hereinafter referred to as "Dr. Roane" and "Rheumatology" or collectively referred to as "these Defendants"), by and through their undersigned counsel, hereby submit this Response in Opposition to Plaintiffs' Motion to Alter or Amend and for Reconsideration which was filed with this Honorable Court on May 21, 2014. For the reasons set forth more fully below, the Defendants would respectfully submit that this Honorable Court's Order Granting Defendant's

Motion for Summary Judgment was well reasoned and proper and that Plaintiffs' Motion should be denied accordingly.

ARGUMENT

This is a cancer misdiagnosis case. Plaintiffs' sole liability expert with regard to these Defendants has testified that Dr. Roane failed to properly treat the Plaintiff's condition and in fact misdiagnosed the Plaintiff's cancer in 2002. More specifically, Plaintiffs' expert, Dr. Zizic, stated that had Dr. Roane ordered proper testing to be conducted in February of 2002, Plaintiff's condition would have been discovered. Plaintiffs failed to commence this action until 2011, over nine years later. The statute of repose, as set forth in S.C. Code Ann § 15-3-545(A), required the Plaintiffs to file an action within six years from the date of the first occurrence of a negligent act. Ignoring the plain, unambiguous language of the statute of repose, Plaintiffs have attempted to create a distinction in this case (and continue to do so) which does not exist so as to avoid summary judgment.

At the hearing on this matter, Plaintiffs first argued to this Court that subsequent treatment of the Plaintiff by these Defendants, specifically in April of 2005, constituted an independent, distinct act of negligence thereby removing the statute of repose as an absolute bar to Plaintiffs' claims. Conveniently, the 2005 visit referenced is the oldest treatment date among dozens throughout a nearly 8 year treatment period that still fits within the six year statute of repose period and renders the Plaintiffs' 2011 filing timely. The Court's Order carefully examined that issue and properly granted these Defendants' Motion for Summary Judgment. The Court's Order relied on Dr. Zizic's own testimony regarding the subsequent treatment in 2005, particularly his opinions on any distinction that might have distinguished it from the 2002 treatment. Without question, Dr.

Zizic simply failed to articulate any discernible difference in Dr. Roane's treatment from 2002 to 2007 which supported Plaintiffs' arguments to this Court.

At the hearing, Plaintiffs did not advance any argument that the statute of repose's six year time period would "reset" or be revived at each alleged act of repeated negligence. Quite conversely, Plaintiffs' argument that the 2005 treatment should be deemed an independent act of negligence was recognition that the first act or occurrence of negligence does in fact trigger the running of the statute of repose for allegedly repeated acts of negligence. Otherwise, there would be no need to make a distinction between the nature of treatment from 2002 to 2005.

Seemingly abandoning their prior arguments, Plaintiffs now contend, regardless of the similarities or alleged distinctions in subsequent treatment, that any allegations of repeated misdiagnosis should "re-start" the six year time period under the statute of repose if a "new injury" can be established. Further, for the very first time, Plaintiffs now suggest to this Court that Defendants have raised a novel issue under South Carolina law and request that this Court conduct an evidentiary hearing and/or further discovery in this matter so as to examine whether Plaintiffs suffered subsequent "new injuries" apart from the 2002 treatment which might would render the statute of repose inapplicable.

Notwithstanding the lack of any merit to these new arguments, it is well-established law that a party may not raise an issue for the first time by way of a motion for reconsideration. See, e.g., Johnson v. Sonoco Prods. Co., 381 S.C. 172, 177, 672 S.E.2d 567, 570 (2009) ("An issue may not be raised for the first time in a motion to reconsider."); Dixon v. Dixon, 362 S.C. 388, 399, 608 S.E.2d 849, 854 (2005) (finding issue raised for first time in Rule 59, SCRC, motion is not preserved for review). The instant Motion is therefore improper and should be given no

credence by this Court. All issues which were properly raised have been fully briefed, argued, and considered by this Court.¹

Subject to and without waiving these Defendants' objection to the Plaintiffs' improper raising of these issues for the first time in a motion to reconsider, their newfound position is unavailing for a variety of reasons.

I. SOUTH CAROLINA'S JUDICIAL REJECTION OF THE CONTINUOUS TREATMENT RULE AND THE CONTINUOUS TORT RULE FORECLOSES PLAINTIFFS' ARGUMENTS FOR RECONSIDERATION

Plaintiffs' newly raised argument amounts to nothing more than urging this Court to adopt the continuous tort/continuous treatment rule so that every alleged act of negligence serves as a new "occurrence." While Plaintiffs suggest this issue is novel in this state, South Carolina's judicial rejection of both the continuous tort and the continuous treatment rule is black letter law and dispositive on this issue. Quite certainly, the refusal by our courts to adopt the continuous tort doctrine specifically prevents a Plaintiff from arguing that the Statute of Repose's six year time period "restarts" at every occurrence of a repeated negligent act as Plaintiffs now insists. South Carolina jurisprudence has continually recognized that to adopt either the continuous treatment or continuous tort rule would directly contravene the adopted legislative policy of our General Assembly in establishing a statute of repose for medical negligence actions. Harrison v. Bevilacqua, 354 S.C. 129, 580 S.E.2d 109 (2003); Dunbar v. Carlson, 341 S.C. 261 533 S.E. 919

¹ Plaintiffs argue that these Defendants did not raise the Georgia Court of Appeals holding in Howell v. Zottoli, 691 S.E.2d 564 (Ga. Ct. App. 2010) until after the Summary Judgment hearing. However, the timing of these arguments was dictated solely by Plaintiffs failure to submit any memorandum or brief opposing Defendants Motion prior to the hearing. Indeed, until the hearing commenced, Plaintiffs had not offered any suggestion that they intended to offer the "independent act" arguments. After Plaintiffs' counsel did raise this argument and then provided further correspondence to the Court after the hearing, but before a ruling, Defendants did raise the Howell case. However, unlike the arguments which Plaintiffs now advance, this persuasive Georgia law was presented to the Court before any ruling on Defendants' motion.

(2000); Shadwell v. Craigie, 361 S.C. 492, 605 S.E.2d 567 (2004). The Court's Order Granting Summary Judgment as to these Defendants properly relied upon this well-established law.

Plaintiffs appear to contend that the rejection of these doctrines relates only to the statute of limitations and not the statute of repose.² However, a careful examination of both Shadwell v. Craigie, 361 S.C. 492, 605 S.E.2d 567 (2004) and Harrison v. Bevilacqua, 354 S.C. 129, 580 S.E.2d 109 (2003) demonstrates that Plaintiffs are mistaken. See, Shadwell 361 S.C. 492 at 498, 605 S.E.2d 567 at 570 ("Thus, the statute of repose in the present case was not tolled by the time period between Shadwell's February 1996 and March 1996 appointments, presumably a period of time she was under the care of Dr. Craigie."); Id. ("[In Harrison], [t]he court declined to adopt the continuous treatment/continuous tort doctrine, stating that 'judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set' through statute, including the statute of repose.") (citing Harrison, 354 S.C. at 138, 580 S.E.2d at 114).

It is undebatable that the primary purpose for refusing to adopt these doctrines derives from the importance of the substantive rights created by the statute of repose set forth in S.C. Code Ann. § 15-3-545(A). Plaintiffs' argument simply cannot be reconciled with the clear, controlling precedent in this state rejecting the continuous tort and continuous treatment rules. Stated differently, given that our Courts have expressly refused to recognize that allegations of continuous negligent acts should delay the accrual of cause of action because of the policy underlying the statute of repose, it would be nonsensical to suggest that our courts would permit allegations of repeated negligent acts to serve as new distinct occurrences under the statute of

² See Plaintiffs' Reply to Defendant Dodds Memorandum in Opposition to Motion for Reconsideration at pg 1-2.

repose itself. As a result, the rejection of the continuous tort rule and the continuous treatment rule is of equal application to the statute of repose under South Carolina law.³

Furthermore, Plaintiff's proposal to carve out an exception to the statute of repose where allegations of repeated negligent acts exist would render the substantive rights afforded by S.C. Code Ann. § 15-3545(A) meaningless and demean the very legislative intent in enacting the statute. As the South Carolina Supreme Court stated in Langley v. Pierce, 313 S.C. 401 at 404, 438 S.E.2d 242, 243 (1993): "[a] statute of repose creates a substantive right in those protected to be free from liability after a legislatively-determined period of time." The Court in Langley further added, in pertinent part:

"Statutes of repose are based upon considerations of the economic best interests of the public as a whole and are substantive grants of immunity based upon a legislative balance of the respective rights of potential plaintiffs and defendants struck by determining a time limit beyond which liability no longer exists.

Society benefits when claims and causes are laid to rest after having been viable for reasonable time. When causes of action are extinguished after such time, society generally may continue its business and personal relationships in peace, without worry that some cause of action may arise to haunt it because of some long-forgotten act or omission. This is not only for the convenience of society but also due to necessity. At that point, society is secure and stable."

Id. at 404-05, 438 S.E.2d at 244 (quoting Kissel v. Rosenbaum, 579 N.E.2d 1322, 1328 (Ind.Ct.App.1991)). Plaintiffs' argument that this Court should entertain evidence of a "new injury" thwarts and undermines the chief purpose of the statute of repose. Further, the existence of a subsequent or existing injury is of no consequence to the application of the statute of repose under South Carolina law. To be sure, the statute of repose ignores the discovery, knowledge, and even the existence of any injury in barring claims; instead, its focus centers squarely on that first act of negligence underlying the claim. Hoffman v. Powell, 298 S.C. 338, 339-40, 380

³ See also, Dunbar v. Carlson, 341 S.C. 261 at 269, 533 S.E.2d 913 at 917-918 fn 1 (discussing the application of the continuous treatment rule to statute of repose).

S.E.2d 821 (1989) (the medical malpractice statute of repose bars claims "regardless of whether [the claim] has or should have been discovered" or "whether [the claimant's] injuries are latent or readily apparent."). Plaintiffs' "new injury" arguments ignore this precedent and the language of the § 15-3-545(A) itself.

Plaintiffs' argument is particularly unavailing when considered in the context of misdiagnosis case such as the instant matter. In a very practical sense, the exception which the Plaintiffs ask this Court to adopt would swallow the entire rule established by the statute of repose as set forth in S.C. Code Ann. § 15-3-545(A). A misdiagnosis, by its nature, is an act of nonfeasance which generally occurs by failing to conduct or perform a certain function or act in accordance with the standard of care. As such, the "occurrence" under Plaintiffs' view would conceivably take place at every treatment date if not every single day after treatment that the Plaintiffs' condition is not realized. In other words, the failure to realize or correct any diagnosis must qualify as an "occurrence" under Plaintiffs' view, and the "occurrence" would be a never-ending, recurring event. If it were not, how could any subsequent treatment in this case be considered any different? The statute of repose for a medical misdiagnosis case would be *de facto* abolished if such were the law in this state.

On this topic, Dr. Zizic's testimony is particularly instructive:

- Q: Were there any other points along the time line of events that you have particular concerns? You've identified a couple, 2002, 2003. Were there any other points in time along that spectrum that you believe you're going to be particularly critical of?
- A: Well, I think just like we take care of our patients with annual exams, physicals, and we're more appropriately doing that than their internists in patients with systemic rheumatic diseases such as an undifferentiated connective tissue disease. And so most rheumatologists will yearly do a more complete evaluation with laboratory studies, particularly when there's some features that are atypical and may not be fitting with our normal patients have. So I would say from 2004, 2005, 2006, 2007 *she should have had yearly exams looking at the laboratory studies we've been talking about.....* (emphasis added)

(See Deposition Excerpt of Dr. Zizic, Page 125, Lines 8-25, attached hereto as Exhibit A).

Plaintiffs only suggestion of any subsequent, alleged negligent act is the failure to do something that had not been previously done for the exact same condition. This alleged failure is no different from any treatment that took place in 2002. As the Court's order properly concluded, such evidence does not "revive" the Plaintiffs' claims under the statute of repose and does not constitute an "occurrence" for purposes of determining the timeliness of this action. If it did, the statute of repose could never be applied to a misdiagnosis case.

II. THE COURT PROPERLY RELIED ON GEORGIA LAW AS PERSUASIVE AUTHORITY

Plaintiffs take issue with the Court's ruling by arguing that it is "largely based" on Georgia law. First and foremost, the Court's decision is well-reasoned and proper based on the application of South Carolina law alone. As set forth above, Defendants would respectfully submit that the Georgia Court of Appeals' holding in Howell, while pertinent and persuasive, is not necessary to the Court's granting of summary judgment on this matter. Notwithstanding this fact, the Court's holding in Howell does pertain to remarkably similar set of facts and Georgia, like South Carolina, has rejected the continuous tort rule in the context of medical malpractice claims. See, Harrison, 354 S.C. 129 at 139, 580 S.B.2d 109 at 114. The Court's ruling properly relied on this persuasive authority.

Interestingly, while Plaintiffs take issue with this persuasive authority, they themselves ask this Court to create new law relying on Cleaveland v. Gannon, 667 S.B.2d 366 (Ga. 2008). This case does not support Plaintiffs' arguments. In Cleaveland, the Court recognized only an exception to the immediate running of the statute of repose in a misdiagnosis case where a treatable condition was misdiagnosed and an untreatable cancer subsequently developed. These

facts are clearly distinguishable from the instant facts in that Plaintiff continued to suffer from the same condition throughout the course of these Defendants' treatment. Additionally, the Howell opinion, which addresses a more similar set of facts, came after the opinion in Cleaveland, and the court noted this same distinction. The Howell court explained:

"although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition."

Howell, 302 Ga. App. at 479.

III. NO FURTHER DISCOVERY IS NEEDED IN THIS MATTER

In their eleventh hour effort to negate an unfavorable ruling, Plaintiffs also request that the Court conduct an evidentiary hearing to further inquire into whether Plaintiffs might fall under the "new injury exception" carved out in the Cleaveland case. Plaintiffs represent that such evidence would assist in establishing a record for appeal and that Plaintiffs did not appreciate the need for such testimony until the Court's Order Granting Summary Judgment was entered.

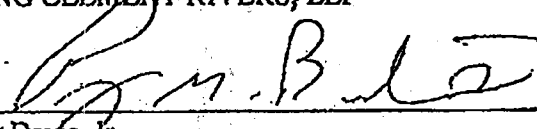
To the extent such evidence is lacking from the record in this case, the Plaintiffs are the architect of their own dilemma. After over three years of litigation and extensive discovery, the time for Plaintiffs to develop a new theory of the case has run. To be sure, these Defendants raised the statute of repose as an affirmative defense at the outset of the case in their initial responsive pleading. If Plaintiffs sought to combat this defense and demonstrate that the claim was timely filed based on the evidence at hand, it is incumbent upon Plaintiffs to do so before the Court has issued a dispositive ruling. Now, after summary judgment has been entered, Plaintiffs seek to introduce new evidence to circumvent the Court's ruling.

Like the arguments discussed above, Plaintiffs' request for an evidentiary hearing was not made prior to the summary judgment hearing or even after these Defendants raised the case law which Plaintiffs contend sparked their need for such a hearing.

CONCLUSION

For the reasons set forth above, Defendants respectfully request that Plaintiffs' Motion to Alter or Amend and for Reconsideration be DENIED.

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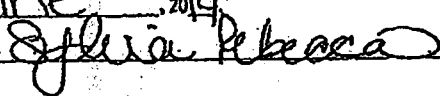
Charleston, South Carolina

Dated: 6/19/14

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to all counsel of record in this proceeding this 19 day of

June, 2014



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

Plaintiffs,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH CIRCUIT

CASE NO. 2011-CP-10-0934

REPLY IN SUPPORT OF
PLAINTIFFS' RULE 52 & 59 MOTIONS

The plaintiffs offer the following as a brief reply in support of their post-judgment motion.

1. There is no South Carolina precedent that "controls" this case.

Dr. Dodds and his practice contend that the court has correctly applied "controlling" precedent from South Carolina. Respectfully, this is incorrect.

Hoffman v. Powell was a constitutional challenge. 298 S.C. 338, 380 S.E.2d 821 (1989).

It does not appear to have any relevance to the question presented, which is whether a serial misdiagnosis involves one "occurrence" of negligence or whether it involves multiple "occurrences."

Harrison v. Bevilacqua involved the "continuous treatment rule." 354 S.C. 129, 580 S.E.2d 109 (2003). This rule relates to the statute of limitations — not the statute of repose. The Marshalls are not asking to extend the limitations period. They are asking whether several instances of a misdiagnosis constitutes one occurrence of negligence or multiple occurrences. See *Kaminer v. Canas*, 653 S.E.2d 691, 698-99 (Ga. 2007) (distinguishing the continuous treatment rule, in dissent).

Kerr v. Richland Memorial Hospital held that the statute of repose applies to suits under the South Carolina Tort Claims Act. 383 S.C. 146, 678 S.E.2d 809 (2009). *Shadwell v. Craigie*

involved only one occurrence of a misdiagnosis which happened over six years prior to the plaintiff filing suit. 361 S.C. 492, 605 S.E.2d 567 (Ct. App. 2004). None of these cases discuss the question presented, yet the defendants cite all of them in their argument that this case treads no new ground.

The reality is that as of the date of this reply, no South Carolina appellate case has considered the question of how the statute of repose applies to a serial misdiagnosis case. In this State, this question *is* novel.

2. Georgia's rule is controversial, and it is not the better view.

The first part of the previous statement should not be fairly debatable. Georgia follows a specific approach to misdiagnosis cases, but this approach has produced considerable disagreement. The principal Georgia case was decided by a 4-3 vote, and it has been criticized by subsequent precedent as difficult to apply. These are facts. This is not a proposition that is arguable.

What *is* arguable is whether the Georgia rule is the better view. Under the Georgia rule, the court confines itself to the view that the "injury" in a misdiagnosis case is the underlying disease. That view equates Mrs. Marshall's "injury" with the earliest point she had cancer.

But Mrs. Marshall's injury is not *just* her illness. Each failure to reach a correct diagnosis resulted in a *continued* disease, *additional* pain, *additional* suffering, and *additional* expenses. Consider an extreme example: imagine a case that involved a defendant who spent several years physically assaulting a hypothetical plaintiff by punching him in the ribs. Each assault bruises the plaintiff's ribs, and though the injuries never get worse, they also never heal. Is this only one "occurrence" of battery? Surely not. It seems obvious that each instance is actionable.

Suppose a statute of repose barred a claim for the oldest attack. It is difficult to imagine someone arguing that the repose period for *all* attacks was tied to the original instance. Yet, that is

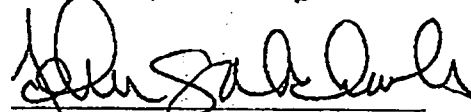
precisely the rule that is being advanced here. This is *not* the better view. The proposed rule encourages a physician to stick to a misdiagnosis rather than re-evaluate it — to keep committing additional negligent acts rather than provide care that is competent. A defendant's refusal to correct course will be rewarded. By sticking to his guns, he can insulate not just one occurrence, but a chain of occurrences, from liability. This is reading the statute of repose expansively, not strictly. The court should decline the invitation to take this view of the law.

CONCLUSION

The plaintiffs intend to appeal this order if the court does not modify it, and it is respectfully submitted that the court would benefit from deferring a decision on this issue until after the record has been more fully developed. This is a question of first impression, and this argument based on Georgia law did not appear in this case until after the court conducted a hearing. The court should hear the plaintiffs' motion, and at the conclusion of such hearing, the court should deny summary judgment with leave to renew that motion when the plaintiffs conclude their case at trial.

June 11, 2014

Respectfully submitted,



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STATE OF SOUTH CAROLINA) COURT OF COMMON PLEAS
COUNTY OF CHARLESTON) NINTH JUDICIAL CIRCUIT

VIRGINIA L. MARSHALL) TRANSCRIPT OF RECORD
AND TODD W. MARSHALL,) 2011-CP-10-934

PLAINTIFF,)

V.)

KENNETH A. DODDS, MD,)

ET AL.,)

DEFENDANT.)

MARCH 3, 2014

CHARLESTON, SOUTH CAROLINA

B E F O R E:

THE HONORABLE J. C. NICHOLSON, JR., JUDGE

SHARON L. VIZER

CIRCUIT COURT REPORTER

A P P E A R A N C E S:

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CIRCUIT COURT REPORTER

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****NO EXHIBITS WERE INTRODUCED****

1 Monday, March 3, 2014

2 THE COURT: If everybody will identify themselves
3 for the court reporter, please.

4 MR. ELLIOT: Judge, Carter Elliot and Ed Bell for
5 the plaintiff.

6 MR. BELL: Morning, Your Honor.

7 MR. HOOD: Jamie Hood on behalf of Ken A. Dodds, MD
8 and Charleston Nephrology Associates, LLC.

9 MR. BUCKNER: Barry Buckner on behalf of Dr. Roane
10 and Rheumatology Associates.

11 MR. BRADSHAW: I'm Drew Bradshaw here with Jamie
12 Hood on behalf of Dr. Dodds and Charleston Nephrology.

13 THE COURT: Mr. Hood, let me see copy of the
14 pleadings so I can see the names. I just want to get the
15 caption with all the names.

16 All right. Mr. Hood, you represent who now?

17 MR. HOOD: Your Honor, I represent Dr. Dodds.

18 THE COURT: Dr. Dodds. Okay.

19 MR. HOOD: His practice, which is Charleston
20 Nephrology.

21 THE COURT: Now, who else represents -- run through
22 it again.

23 MR. BUCKNER: Your Honor, I represent Dr. Roane and
24 Rheumatology Associates.

25 THE COURT: Dr. Roane?

1 MR. BUCKNER: Yes, sir.

2 THE COURT: And Rheumatology. All right.

3 MR. BUCKNER: Correct.

4 THE COURT: All right.

5 MR. BRADSHAW: My name is Drew Bradshaw. I'm here
6 with Mr. Hood.

7 THE COURT: Okay. All right. I've got a summary
8 judgment motion of Dr. Roane and Rheumatology.
9 Mr. Hood --

10 MR. HOOD: I think they are the same motion --

11 THE COURT: The same motion?

12 MR. HOOD: They are, just a little bit different
13 facts that apply to his doctor versus mine.

14 THE COURT: Who wants to go first then?

15 MR. HOOD: Your Honor, I'll jump off, if it's okay
16 with you. I've got a copy of my filed motion to speed
17 things up.

18 THE COURT: Okay. Thank you, sir.

19 MR. HOOD: Yes, sir.

20 THE COURT: I'll be glad to hear you, Mr. Hood.

21 MR. HOOD: Thank you, Your Honor. This is a
22 medical malpractice case and I represent Dr. Dodds and
23 his practice. He's a nephrologist. We are before you
24 today on a Rule 56 requesting the Court grant summary
25 judgment on all the claims by the plaintiff against

1 Dr. Dodds and his practice based upon the application of
2 the Statute of Repose, Your Honor.

3 The timeline that's pertinent to this case -- well,
4 let me back up. This is a misdiagnosis case and the
5 claim is that Dr. Dodds failed to recognize elevated
6 protein levels in the plaintiff's urine which in the
7 plaintiff's expert's opinion should have prompted him to
8 conduct further tests, and had those tests been performed
9 they would have diagnosed the plaintiff with cancer which
10 she was ultimately diagnosed with, I think in 2011.

11 The pertinent timeline, Your Honor, starts with the
12 filing of the lawsuit which was filed on February the
13 7th, 2011. The plaintiffs actually filed both the
14 lawsuit -- straight lawsuit and then a notice of intent
15 simultaneously, and presumably that's because the
16 allegations began before the effective date of the Tort
17 Reform Statute, which is July 1st, 2005, and then the
18 treatment by Dr. Dodds continued thereafter.

19 According to the plaintiff's complaint they alleged
20 that Dr. Dodds on February 9th of 2011 failed to
21 recognize elevated protein levels that should have
22 resulted in additional testing and ultimately resulting
23 in the diagnosis of this cancer. That date is within the
24 six year Statute of Repose and if that date were the
25 operative trigger for the running of the Statute of

1 Repose we would not be here.

2 The basis of their claim, as I mentioned, is that
3 there were abnormal levels of protein in the urine which
4 warranted further workup. Those were reflected in the
5 doctor's chart as of February the 9th, 2011. But those
6 abnormalities were also found within Dr. Dodds' chart and
7 from his initial consultation dating back to September
8 15th of 2004.

9 THE COURT: Well, did the patient know about it on
10 September 15th, 2004, or is it just in his charts?

11 MR. HOOD: Well, Your Honor --

12 THE COURT: Was the patient informed, back in
13 September 15th, '04?

14 MR. HOOD: About the abnormalities?

15 THE COURT: Yeah.

16 MR. HOOD: She was. She was being treated for
17 abnormal protein in her urine.

18 THE COURT: So she knew about it?

19 MR. HOOD: She did but as it relates to the Statute
20 of Repose, Your Honor, knowledge is not an issue. There
21 is no discovery rule applied to the Statute of Repose.
22 Under the South Carolina jurisprudence the first act of
23 negligence for the alleged malpractice begins the running
24 of the Statute of Repose six years from that date
25 regardless of knowledge or discovery.

1 THE COURT: So you are saying if the doctor finds
2 abnormality, doesn't tell the patient about it, doesn't
3 treat the patient and that continues through six years
4 then the repose is applicable?

5 MR. HOOD: Yes, sir.

6 THE COURT: Okay.

7 MR. HOOD: I think that there would be
8 circumstances where there were fraud and there would be
9 equitable tolling of the Statute of Limitations in some
10 circumstances, none of which are applicable here, but as
11 harsh as that may sound I think that when you look at the
12 Statute of Repose under the Kerr vs. Richland Memorial
13 Hospital case, which is 383 S.C. 146, it establishes that
14 harden fast rule as the absolute outer limit in any
15 medical malpractice case, Your Honor.

16 And in a case of failure to diagnose or
17 misdiagnose, which are similar to the cases here, you
18 have to determine, you know, the earliest act by the
19 physician that would ultimately give rise to their
20 theory. In this case, if the theory is that failing to
21 order additional studies and evaluation because of
22 abnormal protein --

23 THE COURT: What were the facts in the Richland
24 Memorial case? Was there one particular incidence or
25 failure to diagnose, because apparently in this case

1 there's been a continuation of failure to diagnose.

2 MR. HOOD: Sure, and that's a good point because I
3 think that is ultimately the threshold issue that the
4 Court has to determine. And I'll hand you a redacted
5 version of the 2015 visit so you can see what I'm
6 referring to.

7 THE COURT: Okay. Was the Richland County Memorial
8 -- Richland County -- did you say Richland County
9 Hospital or Richland Memorial Hospital case, was that a
10 failure to diagnose or was that --

11 MR. HOOD: It was a failure to diagnose, Your
12 Honor, and it did not specifically address the continuous
13 following up issue which is present here because
14 Dr. Dodds did continue to see the patient for a number of
15 occasions, including the February the 9th, 2005 date that
16 I've already eluded to that would be within the Statute
17 of Repose but when the South Carolina -- our Court
18 specifically has addressed this issue and our Court in
19 Harrison vs. -- I don't know how you pronounce it,
20 Bebilacqua. That's just a terrible pronunciation but the
21 case --

22 THE COURT REPORTER: May I get a spelling, Your
23 Honor?

24 MR. HOOD: Sure. It's B-e-b-i-l-a-c-q-u-a, which
25 is 354 S.C. 129. Our Court examined this continuous

1 treatment rule to determine whether that would be
2 applicable for misdiagnosis and medical malpractice cases
3 where there was a continuation of treatment, and the
4 South Carolina Supreme Court specifically declined to
5 adopt that doctrine because to do so would run afoul of
6 the absolute limitations, the policy --

7 THE COURT: Run afoul of what? I'm sorry.

8 MR. HOOD: The absolute limitations.

9 THE COURT: The Statute of Repose?

10 MR. HOOD: Yes, sir. And that case has been cited
11 as recently as 2004 by the Court of Appeals.

12 So the initial reaction is the trigger date is
13 outside the Statute of Repose but he continued to treat
14 her and under South Carolina law, Your Honor, we submit
15 that the issue is not a continuous issue. You go to the
16 initial date, which is September of 2004, add up six
17 years, and any claims brought thereafter fall outside the
18 Statute of Repose.

19 And I do recognize that the plaintiff's complaint,
20 Your Honor, does specify that the allegation of
21 negligence commenced on September 9th of 2005 but when we
22 deposed their expert oncologist, whose name is Barry
23 Singer, S-i-n-g-e-r, he established in his testimony that
24 it would be -- the question was asked, And would it be
25 your testimony that she had cancerous protein in her

1 urine at that time as well, referring to September of
2 '04?

3 I believe she did.

4 And the next question is: And would it be your
5 opinion that Dr. Dodds failed to diagnose the cancerous
6 protein at that time as well?

7 Yes.

8 And I'll hand up to you pages 61 through 68 of
9 Barry Singer, just the excerpted portion of Barry Singer,
10 so you can have that.

11 THE COURT: Thank you.

12 MR. HOOD: So, Your Honor, we feel that the
13 characterization of the allegation in the complaint is
14 not sufficient to avoid the application of the Statute of
15 Repose and in a case like this where their experts
16 identified that the failure to diagnose the cancer dates
17 back to 2004 there's no genuine issue of material fact.

18 THE COURT: Well, what did they say about the
19 cancer? When did the cancer come on the scene, so to
20 speak?

21 MR. HOOD: Well, he said that it existed as of 2000
22 -- sometime before -- in 2004. And so the issue is the
23 marker for the cancer according to their expert.

24 THE COURT: Was the protein?

25 MR. HOOD: Correct, and that when you saw these

1 elevated proteins bells and whistles should have gone off
2 and if you had done the further workup that they suggest
3 should have been done that that would have resulted in
4 diagnosis of these cancerous cells and a diagnosis for
5 cancer resulting in earlier treatment, etcetera. And as
6 Dr. Singer notes, you know, that date began some point
7 before 2004.

8 THE COURT: Anything else?

9 MR. HOOD: It's really quite simple, Your Honor. I
10 don't want to try to overcomplicate it but those are the
11 operable dates, and I'll be happy to respond to anything
12 Mr. Bell or Mr. Elliot have to say.

13 THE COURT: Okay. Anything you want to add?

14 MR. BUCKNER: Yes, Your Honor. I'll try not to
15 overlap of what Mr. Hood explained. The issues are
16 similar although the facts are a little different because
17 we have a different doctor and different practice. Our
18 client is actually a rheumatologist who treated the
19 plaintiff as far as back as 2000 for these issues.

20 And like Mr. Hood's argument, our motion for
21 summary judgment here today consists entirely of the
22 Statute of Repose set forth in, I think 15-3-545(a). And
23 again, we think the sole inquiry under that statute --
24 and I think there's a lot of case law --

25 THE COURT: What's your dates?

1 MR. BUCKNER: My dates -- the dates of treatment
2 for my client begin actually in 2000 and go all the way
3 to 2007. We think the operative date for purposes of a
4 motion at issue before the Court are 2002.

5 THE COURT: When in 2002?

6 MR. BUCKNER: Well, it actually doesn't specify.
7 February 2002 would be the month according to treatment
8 notes, and that comes from their expert. They retained
9 one expert to testify against my client. The other two
10 experts said in their deposition we are not here to
11 qualify the experts --

12 THE COURT: Well, what's the allegations against
13 your client?

14 MR. BUCKNER: They are actually the same.

15 THE COURT: The same?

16 MR. BUCKNER: Well, the same in terms of there
17 should have been flags raised in the course of treatment
18 that should have alerted you to this. They were working
19 off a diagnosis -- my diagnosis was working off a
20 diagnosis of mixed connective tissue disorder and
21 ultimately was discovered later that she had
22 Waldenstrom's of a rare type of Non-Hodgkin Lymphoma.

23 THE COURT: Okay.

24 MR. BUCKNER: But in terms of -- they actually
25 selected a date in their complaint like they did against

1 Dr. Dodds that was April of 2005.

2 THE COURT: April 2005?

3 MR. BUCKNER: That's what's in their complaint, but
4 their expert testified that our client breached the
5 standard of care in February of 2002 regarding this same
6 exact treatment and same exact injury, which obviously
7 would require them to file by 2008 or 2009, and they did
8 not file until April of 2011.

9 And, you know, Mr. Hood touched on this a little
10 bit but under the Statute of Repose the discovery, the
11 knowledge or even the existence of an injury the case law
12 says is absolutely irrelevant and the sole focus is on
13 the occurrence of negligence which in South Carolina can
14 only come through a qualified expert.

15 The plaintiff's pleadings and her own testimony are
16 really irrelevant for the purposes of this motion. And
17 Dr. Zicik (phonetic), the sole liability expert against my
18 client, said she breached the standard of care in 2002,
19 and that's uncontradicted. And we think they had to file
20 by 2008 or 2009 but he also made reference to a 2003
21 incident.

22 And one other thing I'd like to touch on that was
23 addressed in our brief was that South Carolina has
24 rejected the continuous treatment and continuous tort, so
25 any sort of recurring allegations of negligence aren't

1 sufficient to revive a time-barred claim, and the same
2 just because she was treating her. And the courts have
3 recognized in some occasions the plaintiffs might say,
4 Well, this is unfair and inequitable, but it still
5 violates the Statute of Repose.

6 And we had almost an identical issue, I think it
7 was last month, and attached the order to the brief in
8 front of Judge Dennis, and the same thing; eight years of
9 treatment, the issue is not discovered until sometime
10 down the line.

11 The liability expert said, Well, they breached the
12 standard of care in 2003 and they didn't file within six
13 years, and he granted the motion. We think this is this
14 exact same issue here.

15 THE COURT: Okay.

16 MR. BUCKNER: Thank you.

17 THE COURT: Thank you very much.

18 Mr. Bell or whoever.

19 MR. ELLIOT: Thank you, Judge. I'll begin. I'm
20 Carter Elliot, and Ed may have some things to had. What
21 I'll first hand up, if you don't mind, Judge, we used the
22 same causation expert in both cases.

23 As they pointed out, we have a case against
24 Dr. Roane, who is the rheumatologist, and also Dr. Dodds,
25 who is the nephrologist in the case, but we have to same

1 causation expert. And I will hand that up. It's just
2 the same affidavit we got as Dr. Singer's affidavit.

3 (WHEREUPON, a document was handed to the Court.)

4 MR. ELLIOT: Those are the same affidavits, Judge,
5 that I'll be showing you today that we filed initially
6 and that were marked in all the experts' depositions in
7 the case. As you can see on page three of that
8 affidavit, I mean, they asked over and over and over to
9 all three experts, When do you think there would have
10 been cancers -- proteins?

11 And then later -- it's a protein test, Judge, that
12 you do that would lead you to do other tests such as a
13 bone biopsy and other things that would show lymphoma,
14 which she ended up having.

15 And what Dr. Singer said in this deposition and
16 what he said in that affidavit, and I think what the
17 other -- our other experts said is that it's unclear when
18 it may have started. It may have started before 2005,
19 but as you can see from his affidavit he said that by
20 February of '05 and then September of '05 that that is
21 most likely the time periods when --

22 THE COURT: They come up with these figures of
23 February and September '05 because the Statute of Repose
24 would have then come up with it for medical reasons.

25 MR. ELLIOT: Well, they base it on medical reasons

1 in the deposition. They said, you know, if it had been
2 there staring in 2002 or 3 who knows if it would have
3 shown up on some of those tests. But as of 2005 -- and
4 let me explain, Judge, if I can.

5 Both Dr. Luke -- well, Dr. Luke, especially, who is
6 the nephrologist in this case, testified that by the time
7 you started seeing this difference in a 24-hour urine
8 test and the basic --

9 THE COURT: But didn't they see that same thing in
10 '04?

11 MR. ELLIOT: No, sir. Sir?

12 THE COURT: Same thing in '04?

13 MR. ELLIOT: No, sir. The difference that they saw
14 and as it began in '05 is that these differences in some
15 of the testing they were doing was something that they
16 should -- that our experts said they should have
17 recognized --

18 THE COURT: The excess proteins show up first in
19 September '04, right?

20 MR. ELLIOT: The first time.

21 THE COURT: The first time.

22 MR. ELLIOT: But just one time, but a continuous
23 excess protein, Judge. And then the difference in the
24 protein results in a 24-hour and a basic test is what our
25 expert, Dr. Dodds said. By the time you start getting

1 into '05 then you got to start recognizing that that
2 amount of protein, this difference in the two different
3 kind of tests means you might have these kinds of
4 proteins that may lead you to cancer, and that's why both
5 of them -- and I'll pass up these other two affidavits,
6 Judge. These are Dr. Zicik and Dr. Luke. These are our
7 two expert affidavits.

8 Both of them, as you can see, Dr. Zicik and
9 Dr. Luke talk about the fact that she had treatment
10 beginning prior to some certain dates, but they focus on
11 the care and treatment that started in either February or
12 April, as these guys pointed out.

13 They don't shy away from the fact that she had some
14 problems before and that maybe even some of these guys
15 might have done something wrong prior to 2005.

16 THE COURT: Hold on just a second.

17 (PAUSE.)

18 THE COURT: Go ahead.

19 MR. ELLIOT: But that when the cancer most likely
20 would have been there and the focus of their attention in
21 terms of the negligence as you can see in those
22 affidavits were during the time periods as pointed out by
23 defense counsel.

24 Dr. Luke pointed out that it focussed on treatment
25 that began by Dr. Dodds in February of 2005. Not just

1 misdiagnosis in this case. It's not only misdiagnosis
2 but a failure to treat, a failure to properly prescribe
3 the correct medications.

4 And Dr. Luke's affidavit starts four of five at the
5 bottom. It goes onto page five, but you can see, he
6 talks about it, that they got treatment --

7 THE COURT: Looking at his deposition, Dr. Singer,
8 on page 61 line 24, the question, And it would be your
9 testimony that she had cancer protein in her urine at
10 that time as well? And that's referring to September of
11 '04. I believe she did was the answer.

12 On line 3 page 62 it says, And it would be your
13 opinion that Dr. Dodds failed to diagnose the cancer or
14 protein at that time as well.

15 His answer: Yes, sir.

16 Next question, line 7: Okay. Is there a reason
17 why you didn't include September '04 in your affidavit?

18 Answer: No sir.

19 MR. ELLIOT: Well, Judge, he definitely testified
20 that it could have been there in September but as of
21 February when our other experts talk about the negligence
22 and malpractice he's also saying that it would have been
23 there. So I don't know, I mean, how that changes things,
24 Judge. I mean, okay. She might have had cancer in maybe
25 February of '04 as well. Who knows. But at the time

1 where both of our experts testify --

2 THE COURT: Well, isn't your argument basically a
3 continuation of with malpractice starting in '04, you
4 just happened to pick '05?

5 MR. ELLIOT: Not really, Judge, and Ed can expound
6 on that.

7 THE COURT: I mean, why not?

8 MR. BELL: Judge, you've heard -- excuse me, Your
9 Honor. Ed Bell for the plaintiffs. You've heard many
10 cases where doctors will say, well, I had this thing
11 happen or this blood test going on but it wasn't until
12 sometime later when you were able to correlate a history
13 and it going on for a period of time where we really had
14 the real reason to know that we should do something.

15 After the '04 incident they started looking at
16 these proteins and actually one doctor was doing a
17 24-hour, one was doing just a regular -- a blood stick or
18 a dipstick, and it was the failure after '05 to compare
19 the immediate plus the 24-hour that really is where the
20 negligence occurred.

21 THE COURT: I mean, your expert doesn't say it
22 should have started in '04, same process in '04?

23 MR. BELL: Judge, I believe, I personally believe
24 and I think our experts -- Dr. Singer is a cancer doctor
25 and the other expert is the rheumatologist and the

1 nephrologist say that the negligence occurred after '05.
2 And so while you may have Dr. Singer saying way back they
3 should have looked at it the fact is if all we had was
4 that one time in '04 -- and forget the Statute of
5 Limitations or anything like that, just for illustrative
6 purposes. If all they had was that one incidence of
7 protein elevation and that's all it was and she never
8 went back to the doctor and later she got cancer and sued
9 on that most every doctor we know, and especially in this
10 case, would say one instance of elevated protein doesn't
11 give you any kind of -- you could have that from drinking
12 wrong or doing something bad or some kind of dietary
13 problem. It's that history that all of a sudden you have
14 now and now you've got the 24-hour protein and the single
15 protein and all of that occurred, all of that occurred
16 afterwards. We don't think this is a continuation
17 treatment issue. We do not think that. We think it's an
18 independent act of negligence or negligence from '05
19 forward because they had more information, they had it
20 then.

21 Now, if all we had was a misdiagnosis of a broken
22 bone and an x-ray clearly showed it in '04 and they just
23 kept misdiagnosing and misdiagnosing that's a different
24 case. The longer this thing went on the more evidence
25 they had, and now instead of just looking at it on a

1 single snap shot at '04 they have more information in
2 '05, more information in '06, more in '07.

3 THE COURT: I haven't read the Richland County
4 Memorial Hospital case fact wise. I assume you have.

5 MR. BELL: Well, I was hoping I'd get a copy. I
6 have read it in the past but I don't --

7 THE COURT: Well, from your memory, I hope it's
8 better than mine, how were the facts different in that
9 case versus this case?

10 MR. BELL: I think it was a one-time incident where
11 there was a misdiagnosis and it was the same information.
12 They just kept relying upon it as it went down the road.
13 This is different here. We have that one time where
14 protein elevation.

15 Judge, you and I can go get a prostate exam today
16 and have an elevated number, go back three months from
17 now and it's down, and that doesn't meant that you have
18 cancer. If you go in and get an elevated today and it's
19 elevated next week and all of a sudden you have a spike
20 that's really where you should be looking, not that first
21 false negative that can happen or false positive or even
22 if it's positive. It takes some time to realize what's
23 going on.

24 We believe that the critical time period is that
25 '05 time period where they referred out to another

1 doctor, let's figure out what's going on. This thing has
2 now gone on for a little more of awhile. Let's look at.

3 So all of a sudden they go in '05 and they have the
4 single sticks and the 24-hour sticks and they are not
5 correlating. And in addition to that now you are getting
6 into a treatment issue verus a misdiagnosis issue which
7 is not even available in '04. We are not even alleging
8 that it could even be treated in '04. So now you get to
9 where it's getting worse and worse and worse and the
10 failure to treat is a separate act of negligence not even
11 related to the '04 incident.

12 We clearly are within the six years of the Statute
13 of Repose. We are not alleging negligence. While the
14 doctor may have said, you know, in hindsight they should
15 have looked at, but you don't look at things in
16 hindsight. We think we are within that Statute of
17 Repose.

18 THE COURT: Okay.

19 MR. BELL: At least the facts support that, Judge.
20 It's not an issue for summary judgment.

21 MR. ELLIOT: And one additional thing that they
22 pointed out. In September of '05 not only was the
23 protein levels for the 24-hour increasing in fact the
24 last time our client saw Dr. Dodds, I think in September
25 of '05, it was as high as it had ever been. It had gone

1 from 3 or 3.5 to 4.2.

2 So it wasn't just the same the whole time. It
3 wasn't just the same facts, the same medical history. It
4 was in fact getting worse. The medicines were continuing
5 not to work. They put -- Dr. Dodds put her on another
6 medicine, it did not work. One of the things that our
7 doctor alleged --

8 THE COURT: Who put her on the medicine? Was she
9 put on any medicine in '05?

10 MR. ELLIOT: He started on the medicine at the end
11 of '04 but it wasn't until '05 that our doctor said he
12 should have known that it wasn't working.

13 THE COURT: Okay. All right.

14 MR. BELL: So they started some treatment. But,
15 Judge, we have some really intricate chart to show all
16 this but we didn't think we really needed it this
17 morning, but if you need us to send you --

18 THE COURT: Why not?

19 MR. BELL: Quite frankly, Judge, we didn't think it
20 would be a hard motion to win.

21 THE COURT: Oh, okay.

22 MR. BELL: I'm sorry about that but I should
23 have --

24 THE COURT: You shouldn't have taken that for
25 granted.

1 MR. BELL: No, sir. We have a smart judge. We
2 knew --

3 THE COURT: I don't know about that but go ahead.
4 Anything else?

5 MR. BELL: No.

6 THE COURT: All right. Mr. Hood or whoever?
7 Mr. Davis?

8 MR. HOOD: Your Honor, counsel's characterization
9 of what they think the evidence shows is interesting but
10 that's not the record before you. They provided expert
11 affidavits that were provided at the beginning of the
12 trial -- or beginning of the case. Those expert
13 affidavits have not been updated after their depositions.
14 They have not been updated to reflect the motion that we
15 filed on the Statute of Repose issue.

16 Dr. Singer's testimony can be no clearer that it
17 was a deviation from of standard of care not to diagnose
18 this patient with cancer back in '04, and that's outside
19 the Statute of Repose.

20 And in this case Dr. Singer was asked that specific
21 question and he was asked as you have seen from his
22 testimony to address whether there was any reason not to
23 include it, and he said, No. We haven't seen anything
24 else.

25 So, Your Honor, as far as the trigger date I don't

1 believe that there is any distinction between what I said
2 earlier and what the plaintiffs have just articulated.
3 They've said that this is not just a misdiagnosis case
4 but it's a failure to treat. Well, you can't treat
5 something unless you diagnose it and it's part and parcel
6 of the diagnosis claim. And what they articulated
7 without saying it is precisely the continuous treatment
8 theory that's discussed in our jurisprudence.

9 So, Your Honor, we remain as convinced as we were
10 when we filed this motion that the reading of the Statute
11 of Repose as strict as it may be and as hard as that rule
12 may be has been determined to serve some benefit, and
13 then when you apply it to the facts of this case it just
14 doesn't support any other explanation.

15 Now, I did not get into their other -- one of their
16 other experts, Dr. Luke, because this subject matter of
17 protein in the urine in nephrology can be incredibly
18 confusing even for all of us who have lived with the case
19 for a number of years.

20 But their expert, Dr. Luke, who was just referenced
21 a moment ago and whose affidavits you have, he was
22 deposed and his testimony dealt with specific changes,
23 and he said that back in 1999 she had a disease process
24 and then something changed. And he says that the reason
25 that you know something changed, that she has this new

1 disease, which is cancer, is because there are light
2 chains, c-h-a-i-n-s, that are noted. And what he
3 describes -- and I'll hand you the excerpt from the
4 deposition. We are on page 25 of his testimony and he's
5 talking about some of the tests that were administered.

6 He says, So it's likely that the disease was not
7 there at least until early 2000 but certainly from 2003
8 on I believe that there was -- there were light chains in
9 the urine that were not tested thereafter.

10 And what he's saying is that the marker was present
11 in 2003 and the doctors who treated it failed to check
12 the marker, and that's what the essence of this case is.
13 And I'll hand you that excerpt. And what I'll be happy
14 to do, if you'd prefer, some judges prefer, some don't, I
15 can e-mail to your law clerk the full depositions if
16 you'd refer.

17 THE COURT: No, don't do that.

18 Mr. Buckner?

19 MR. BUCKNER: Yes, sir. Just a few more things.
20 One thing I want to make clear that was sort of confused
21 when the plaintiffs were making the argument is
22 Dr. Singer and, I think, I believe it's Dr. Luke have
23 nothing to do with our argument. Neither one of them are
24 designated as experts against my client. It's just
25 Dr. Zicik, and he's the only one who's qualified to have

1 an opinion against mine. Both of their other experts
2 said as much. They are not offering any opinions against
3 Dr. Roane in her practice. So it's just literally what
4 he says and, you know, that's exactly what Dr. Zicik
5 testified was as far as back as 2002 Dr. Roane violated
6 standard of care.

7 Now, the plaintiffs have sort of said, well, that's
8 not significant, but there's nothing in his own opinion
9 that says that. He very much thinks it's significant.
10 And if you were able to create an issue of fact just by
11 contradicting your own expert then every time they are at
12 deposition they could just go out, get an affidavit and
13 say, well, this is really what we think is significant.
14 His testimony is in 2002 she should have done this
15 differently and it was a violation of the standard of
16 care.

17 THE COURT: Well, I mean, I think what the
18 plaintiff is saying is just that one spike in protein in,
19 I believe September of '04 -- was September of '04?

20 MR. ELLIOT: That's right. That's the first time
21 they had done a 24-hour.

22 THE COURT: That alone in itself wasn't a failure
23 to diagnose in that they had to do some follow up, and
24 they followed up the following year and at that time were
25 two spikes in a row, so to speak, that that was the

1 negligence. I believe in a nutshell that's their
2 argument. You want to address that. I know you keep
3 hammering on September '04 and I heard that --

4 MR. BUCKNER: I am not hammering on it. September
5 2004 is not really part of our argument.

6 THE COURT: Well, whatever your date is.

7 MR. BUCKNER: It's February of '02.

8 THE COURT: February of '02. You are even further
9 back than that. Okay.

10 MR. BUCKNER: Yes, sir, because the act of
11 negligence is the inquiry on the Statute of Repose
12 argument and their expert says, Your client committed
13 malpractice in 2002, and there were elevated things that
14 should have --

15 THE COURT: Did you say committed malpractice or
16 that the cancer was there?

17 MR. BUCKNER: He does not say the cancer was there
18 but the existence of the injury is irrelevant in the
19 Statute of Repose. It's just the act or occurrence of
20 negligence, and in 2002 he says she should have done this
21 and done a workup and she would have realized what was
22 there. He doesn't distinguish with what happened in '05.

23 THE COURT: His affidavit says it occurred in '05.
24 Primarily his affidavit says it occurred in '05.

25 MR. BUCKNER: Dr. Singer?

1 THE COURT: Yeah. I think.

2 MR. ELLIOT: Dr. Zicik -- the expert against his --

3 MR. BUCKNER: But again, I don't think you can
4 create an issue of fact by contradicting yourself. It's
5 in his deposition testimony he said '02 they violated the
6 standard of care.

7 THE COURT: I think people contradict themselves
8 all the time in depositions and in the courtroom. Now,
9 what's contradiction have to do with it?

10 MR. BUCKNER: Well, just that there is no, I don't
11 think, credibility evidence.

12 THE COURT: All right. I appreciate it. Thank you
13 all very much. Let me read what you gave to me plus your
14 memos and I'll give you my opinion when I'm ready. Thank
15 you very much.

16 (WHEREUPON, the hearing was concluded.)

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STATE OF SOUTH CAROLINA) COURT OF GENERAL SESSIONS
) NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON) CASE NO.: 2011-CP-10-00934

VIRGINIA L. MARSHALL and
TODD W. MARSHALL,

PLAINTIFFS,

VS.

KENNETH A. DODDS, M.D., CHARLESTON
NEPHROLOGY ASSOCIATES, LLC, GEORGIA
ROANE, M.D., and RHEUMATOLOGY
ASSOCIATES, P.A.,

DEFENDANTS.

MOTIONS HEARING

held before the Honorable J.C. Nicholson, Jr.
Mia Perron, Circuit Court Reporter, 9th Judicial Circuit
in the Charleston County Courthouse
Charleston, South Carolina
on Wednesday, July 16, 2014, Commencing at 3:11 a.m.

SUSAN "MIA" PERRON, CVR-CM-M
Circuit Court Reporter - 9th Judicial Circuit
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CERTIFICATE OF COURT REPORTER

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EXHIBITS

[None]

PROCEEDINGS

1
2 THE COURT: We've got a motion to reconsider.
3 We've got this motion for a restraining order and a
4 preliminary injunction.

5 Who wants to go first? Why don't we do the
6 motion to reconsider first and then we'll get into
7 the injunctive relief.

8 MR. HEWITT: Thank you, Your Honor. May it
9 please the Court. Blake Hewitt, John Nichols, and
10 Carter Elliott for the plaintiffs.

11 May I approach? I've got some copies of our
12 filings, Your Honor.

13 THE COURT: You've got some copies of what?

14 MR. HEWITT: Of our filings of our motion to
15 reconsider and my reply.

16 THE COURT: We've got the motion to alter and
17 we've got the reply. What else have you got?

18 MR. HEWITT: That's it. I just wanted to make
19 sure you had the filings.

20 THE COURT: Okay. Mr. Hewitt?

21 MR. HEWITT: Thank you, Your Honor. If it
22 please the Court. This is a motion to reconsider.
23 I'll do my best to be very circumspect and just focus
24 on a couple of points. Be happy to answer any
25 specific questions you have.

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1 The general umbrella of this motion is this.
2 The statute of repose focuses on one thing and that's
3 an occurrence of negligence. Not whether there's a
4 new occurrence of new negligence, not whether this
5 negligence fits into a stream of earlier negligence:
6 whether there is an occurrence of negligence. And in
7 this state, negligence is tied not to a new injury,
8 negligence is tied to your damages. I'm going to use
9 that as a springboard to make two points. The first
10 is this notion -- and it appears in both the summary
11 judgment orders -- that the statute of repose begins
12 to run at the first negligence occurrence.

13 Judge, no case in South Carolina has held that.
14 The defendants have cited four cases to you: the
15 O'Toole case, the Kerr case, the Hoffman case, and the
16 fourth one escapes me. But none of those cases have
17 held that the statute of repose begins to run at the
18 first occurrence of a negligent act. And the reason
19 why is that there has not been a case like this case
20 where there are several negligent occurrences, some of
21 which fall within the repose period, others of which
22 fall outside of the repose period. This is a novel
23 question. You're a smart guy. Your law clerk is a
24 smart guy. Y'all can read these cases. That
25 statement is not in there. This is not -- no South

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1 Carolina appellate court has articulated this
2 principle of law.

3 That leads to the second point that appears in
4 those orders, which is that the negligence that
5 occurred in 2005 is the same type of negligence that
6 occurred in 2004. There's a factual problem with
7 that, Your Honor. We're going to use two instances
8 of negligence as to each of the defendants. For
9 Dr. Dodds, your expert is Dr. Luke. And Dr. Luke says
10 that when Dr. Dodds prescribes a medication that
11 starts with the letter D, as in Delta, that's designed
12 to lower my client's protein level, that medication is
13 supposed to act immediately.

14 It's severe medication. It has a tremendous
15 impact on her immune system. As a nephrologist, you
16 have the duty when you prescribe that sort of
17 medication, which he does in 2004, to continuously
18 monitor the patient because if it doesn't work, if it
19 doesn't immediately slash her protein level, then you
20 know you've got a problem. Well, if that is an
21 incident of negligence -- and because we're here on
22 summary judgment and so we get all the benefit of the
23 doubt and they don't get any benefit of the doubt, we
24 have to assume that that is an act of negligence.
25 When did that occur? It didn't occur in 2004 when he

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1 first prescribed the medication. It occurred every
2 single time she went back to him. And he didn't
3 change course.

4 If that's too nebulous, I'll use another
5 example. Again, Dr. Luke says to Dr. Dodds, as a
6 nephrologist, when you have inconsistent protein test
7 results -- my client goes to see Dr. Dodds in
8 September of 2005. One test, the twenty-four-hour
9 urine test, shows protein way through the roof. So
10 not only has this dangerous drug or this severe drug
11 supposed to slash her protein level in half not
12 worked, it's gotten worse. Then she does another test
13 the same day that shows no protein problem. Dr. Luke
14 says, you had the duty at that point to say, look, we
15 should not be getting inconsistent tests, we need to
16 do further investigation. If that act is an
17 occurrence of negligence, and it is, when did it
18 occur? It occurred when you got the inconsistent test
19 result.

20 As to Dr. Roane, Dr. Zizzic [phonetic] is your
21 expert. Dr. Zizzic says, as a rheumatologist, when
22 you have a patient that has been released from a
23 nephrologist with a high protein count, you have a
24 duty at that point, at the point of release, to
25 investigate further into the renal failure, to

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1 investigate further into the high protein levels.

2 THE COURT: What was the date on Dr. Roane?

3 MR. HEWITT: That is September of 2005 -- excuse
4 me -- that is correct. She's released from Dr. Dodds
5 in September of 2005 and Dr. Zizzic's [phonetic]
6 testimony is that when she's no longer under the care
7 of the nephrologist, that's when that duty occurs,
8 when it springs into play.

9 Second act of negligence as to Dr. Roane in
10 2005: Dr. Zizzic [phonetic] says when you have lymph
11 nodes that get enlarged, 2005 is when that happens,
12 you have a duty as a rheumatologist to investigate why
13 those lymph nodes are enlarged and perform tests.
14 That occurred, again, not in 2004, not in 2003, not in
15 2002.

16 Although there are similar incidents of
17 negligence back then, that is a negligence occurrence
18 that occurs in 2005. It's just like if my wife gets
19 mad at me this weekend and beats me up and then she
20 beats me up again next weekend because I do the same
21 thing, those are both unlawful acts.

22 [Off the record momentarily]

23 THE COURT: Go ahead.

24 MR. HEWITT: Just as both of those unlawful acts
25 are similar in character, they are separate unlawful

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1 acts. And the driving language I think, and the
2 principle, that should illuminate resolution in this
3 case is that our statute of frauds is tied to an
4 occurrence of negligence, not the first occurrence of
5 negligence, not the first occurrence of negligence in
6 a new chain.

7 THE COURT: Well, when was the last time she saw
8 Dr. Dodds? What's the date on that?

9 MR. HEWITT: September of 2005. I think that's
10 correct, but don't hold me to that.

11 [Whereupon, counsel confer]

12 MR. HEWITT: Okay. The end of 2005.

13 THE COURT: What's the time frame on that one?

14 MR. HEWITT: I believe it's in September. And,
15 of course, this lawsuit was initiated early in 2011,
16 which is, you know, just within the repose period.
17 But that's okay. You know, we're honoring the purpose
18 of the repose period, which I have always viewed as a
19 rule of closure.

20 You know, the tail on a malpractice claim can be
21 slow and long. You can have a physician that provides
22 either negligent care, care that's not performed in
23 the duty of care, so many years ago and it cannot
24 manifest for many, many years, as was the case in the
25 O'Toole case. The allegation there was that the

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1 fellow's learning disability was the result of the
2 failure to do a C-section and it didn't manifest until
3 he went to school many, many years later.

4 The statute of repose the legislature passed to
5 say, physicians, we're not going to let you -- or make
6 you have to look over your shoulder the entire time
7 you practice, so when you treat somebody you've got to
8 wait six years and after six years you can say, you
9 know, there's no more -- there's no lawsuit coming, I
10 know -- and no physician thinks this way -- I know I'm
11 in the clear, but it provides peace of mind and
12 encourages people to keep practicing medicine, I want
13 you to apply that rule. Every time somebody provides
14 that, that starts a repose period. It's a straight-
15 word application of the statute of repose. Which is
16 not what they're asking. They're asking for a
17 physician to have the ability to make a negligent --

18 THE COURT: I thought your expert testified that
19 it occurred years before.

20 MR. HEWITT: Well, there was certainly
21 negligence that occurred years before. That's exactly
22 right.

23 THE COURT: Isn't that when he said it occurred,
24 all the breaches of standard of care occurred early
25 on --

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1. MR. HEWITT: There were --

2. THE COURT: -- and he never corrected that?

3. MR. HEWITT: That's true.

4. But there were subsequent breaches of the
5. standard of care, which --

6. THE COURT: Well, did your expert testify to
7. that?

8. MR. HEWITT: Absolutely, Your Honor.

9. And specifically Dr. Zizzic [phonetic] as to Dr.
10. Roane. He said when she -- when my client is released
11. from a nephrologist, which is in September, at that
12. point the rheumatologist, Dr. Roane, has a duty to
13. keep investigating and reevaluate and she didn't do
14. it. When the lymph nodes show up in -- yeah, she --
15. she missed every stoplight she had to make a correct
16. decision. But that means that the subsequent stop
17. lights, you know, are tied to the original violation.

18. And the same is true as to Dr. Dodds. He's
19. supposed to be reevaluating how the significant
20. medication that's supposed to slash protein levels
21. worked and he didn't do it. And that occurs every
22. time she has a visit.

23. I want to share with you some language from the
24. Shadwell case. This is a case where there were
25. multiple occurrences of negligence. But the latest --

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1 even the latest one, the most recent one, was still
2 outside the six-year period. The Supreme Court -- and
3 it's sort of similar in that there are several visits
4 to a doctor's office. The language that the Court of
5 Appeals used is this: the occurrence in this case is
6 no later than the date of her last appointment. But
7 that's still outside the repose period.

8 This is not a controversial point. They know
9 that there are multiple occurrences of negligence.
10 That's why they're proposing to you that the clock
11 starts at the first occurrence. Otherwise, they
12 wouldn't use the word first.

13 We talk about Georgia law in the order. And I'm
14 going to share with you some language from the Kaminer
15 case that's the seminal Georgia case on this point.
16 The Georgia Supreme Court wrote: subsequent failures
17 to correct an additional -- additional increased
18 symptoms that were indicative of Aids -- that was an
19 HIV case -- may well constitute new and separate
20 instances of professional negligence.

21 But under Georgia law, the statute of
22 limitations isn't tied to the occurrence of a
23 negligent act. It's tied to the date of the injury.
24 That's not South Carolina law.

25 There are four elements of negligence in South

1 Carolina law: the duty owed from the defendant to the
2 plaintiff, breach of that duty that results in damages
3 -- not injury, damages -- and a proximate causal
4 relation between the damages and the breach. That's
5 exactly what my client has. In September of 2005, all
6 throughout that -- she has to continue to pay for
7 treatment for a disease that she doesn't even have.
8 She has to have her immune system destroyed by drugs
9 that she doesn't need to be taking. All the while the
10 cancer that she has continues to be undiagnosed and
11 untreated.

12 Judge, I'll be happy to entertain any questions
13 you have, but that's our argument.

14 THE COURT: Thank you very much.

15 Who wants to go first?

16 MR. BUCKNER: Your Honor, Perry Buckner for
17 Dr. Roane and Rheumatology Associates.

18 First and foremost, I want to dispute counsel's
19 representations about a negligent act under the
20 statute of repose being, you know, related to damages
21 or an injury. I think that South Carolina law is very
22 clear on that point. And when we talk about
23 occurrences under 15-3-545, we are talking about a
24 negligent act, not a cause of action for negligence.

25 And I think that that point has really struck

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1 home in Hoffman vs. Powell, which is one of the cases
2 he disputes that doesn't support our argument. But on
3 this point, it actually is very strong. And it says
4 the statute of repose ignores the discovery,
5 knowledge, and even the existence of an injury in
6 barring claims and instead focuses squarely on the
7 first act of negligence.

8 So we're not talking about a cause of action for
9 negligence, because this isn't a statute of
10 limitations type of argument. Repose is talking about
11 a negligent act by a physician, a breach of a duty of
12 the -- or care.

13 Now, as you noted earlier and he acknowledged
14 about Dr. Zizzic [phonetic], their first allegation of
15 a negligent act comes from February of 2002 when the
16 proper tests were not performed and they -- as Dr.
17 Zizzic [phonetic] has said, would have led to the
18 discovery to the plaintiff's cancer.

19 And at the hearing on this matter, we didn't
20 hear anything from them about this being a novel issue
21 of law. We didn't hear anything about this being a
22 serial misdiagnosis case back in March when we were
23 before you previously. What we heard from them was,
24 actually, Your Honor, 2005, in April, when the protein
25 levels were elevated, this was a different and

1 distinct act of negligence.

2 And what's important about that procedurally, I
3 don't think these issues that are now being argued
4 were properly preserved, is that when you argue 2005
5 is a separate and distinct act of negligence, that is
6 a recognition that the first occurrence of negligence
7 starts the clock on the statute of repose. Otherwise,
8 there would be no reason to make a distinction before
9 the Court. And now they've come in and said, well, we
10 recognize there were occurrences of negligence that
11 were a part of this lawsuit back in 2002 but every
12 time there's another one, the clock re-starts. That
13 is an entirely different argument that was advanced at
14 the summary judgment hearing back in March, and I
15 don't think that's properly been preserved, first and
16 foremost.

17 Secondly -- and this is why I think South
18 Carolina law is directly on point and why Your Honor's
19 order didn't need to even cite Georgia law, although
20 it is very persuasive. And that is that the
21 continuous tort and the continuous treatment rule have
22 continually been judicially rejected by our courts on
23 at least five or six instances. Now, a lot of times
24 the Courts do talk about them in conjunction with one
25 another because they are very similar. But they're

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1 both very important for this case. And they simply
2 say that a plaintiff's claim will not re-accrue in the
3 statute of limitation's context or start over in the
4 statute of repose context just because there are
5 multiple acts of negligence. And every time our Court
6 has spoken about those, what they've said is the
7 reason we're not going to allow the continuous tort or
8 continuous treatment rule in the state is because of
9 the public policy behind the statute of repose.

10 And I think what plaintiff's have advanced here
11 today is that, well, the continuous treatment rule and
12 the continuous tort rule, to the extent they have been
13 barred in this state, it only relates to the statute
14 of limitations. That's not true.

15 They've -- the same thing in the Shadwell case
16 with the statute of repose and said while he's under
17 the treatment of this physician, we're not going to
18 toll the statute of repose, it continues to run. I
19 think that is black-letter law that applies to this
20 case.

21 The first act of negligence is what starts the
22 clock. And to the extent it would re-accrue, we would
23 have to acknowledge the continuous tort or the
24 continuous treatment rule in the state, which we do
25 not.

1 And lastly, Your Honor, I think --

2 THE COURT: Let me ask you this. You've read
3 some continuous treatment rule cases; right?

4 MR. BUCKNER: I have.

5 THE COURT: What were the facts of those cases?

6 MR. BUCKNER: Well, they obviously vary a lot.

7 And I'll concede, Your Honor, that plaintiff's
8 counsel is absolutely correct that we haven't had this
9 precise factual scenario --

10 THE COURT: Well, tell me what some of the fact
11 scenario was on the continuing treatment cases that
12 you've read.

13 MR. BUCKNER: Well, in one of the cases,
14 specifically in Shadwell, like he said, was we had a
15 misdiagnosis and an allegation of negligence by a
16 physician during the course of treatment and several
17 subsequent visits where the same condition was not
18 properly diagnosed, which is similar here. And it
19 would have been perfect for this issue. But as the
20 plaintiff's counsel properly represented to the Court,
21 even the last act of negligence was older than six
22 years.

23 So he's correct to say that this precise factual
24 scenario hasn't been teed up for the Court to say
25 that. But I think the rejection of the continuous

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1 tort and the continuous treatment rule, including in
2 the statute of repose context, tells us everything we
3 need to know about this legal issue. I mean, we've
4 got an allegation of negligence in --

5 THE COURT: I understand you keep arguing that,
6 but you still haven't answered my question,
7 Mr. Buckner, and I'll ask it again.

8 On the cases outside the state that recognize
9 the continuous treatment rule, what are the facts in
10 those cases?

11 MR. BUCKNER: Outside of the state?

12 THE COURT: Yeah. What are the facts in those
13 cases? That's what I want to know.

14 MR. BUCKNER: I thought you wanted South
15 Carolina law, Judge.

16 THE COURT: No. I'm sorry. I'm sorry. It was
17 a poor question. I hope -- do you understand what I'm
18 asking you?

19 MR. BUCKNER: Absolutely.

20 I think probably one of the most important was
21 the Howell vs. Zottoli case from Georgia where I think
22 it was a congenitive heart failure case and it was a
23 misdiagnosis case. And it was the same thing here
24 where there were -- they came in, wasn't properly
25 diagnosed, there was subsequent treatment where it

1 still wasn't properly diagnosed, and it continued over
2 a course of period of time. And in Georgia it's
3 actually five years and not six years. And then
4 outside of -- the last visit I think occurred in
5 2003 --

6 THE COURT: Was the patient attending the doctor
7 for the same reason each visit?

8 MR. BUCKNER: Yes, sir. Yes, Your Honor.
9 Absolutely.

10 And then he actually died of congenitive heart
11 failure a number of years later and there was an
12 allegation that it was never properly diagnosed during
13 that entire period of time. And the Georgia Court
14 said -- and this is what they are correct about, is
15 that the Georgia cases are stronger because of that
16 specific factual scenario. They said where you have
17 an active negligence that occurs a repeated number of
18 times but as long as it's in the same course and
19 condition of the treatment, there's nothing that
20 varies or distinguishes it, then the first act
21 properly serves as a start of the running of the
22 statute of repose for that six-year period. And even
23 if you have, you know, a repeated act, as long as it
24 doesn't create, you know, some sort of -- you know, a
25 completely different entirely misdiagnosis or they've

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1 come up with a new course of treatment plan, then that
2 first act is what matters.

3 And that's what we're arguing here is that
4 there's no -- nothing that was different. I mean,
5 Dr. Zizzic [phonetic]'s testimony is the basis for our
6 motion here before Your Honor because he says in
7 February of 2002, this should have been discovered by
8 doing this and follow up should have been the same in
9 '03, the same in '04 and the same in '05.

10 THE COURT: Okay. Thank you.

11 MR. BUCKNER: Thank you.

12 THE COURT: Thank you, Mr. Buckner.

13 Mr. Hood?

14 MR. HOOD: Thank you, Your Honor. Jamie Hood,
15 on behalf of Dr. Dodds and his practice.

16 Without repeating what Mr. Buckner just
17 concluded, I would adopt his argument. I think he
18 succinctly described it.

19 One of the questions that you just asked was
20 what were some of the facts about some of the Georgia
21 cases. And in the Howell case, --

22 THE COURT: Well, not necessarily Georgia.
23 Wherever you've read about where the Court's have
24 adopted the continuous treatment rule. What I'm
25 interested in is how those facts vary from this case

1 or don't vary from this case.

2 MR. HOOD: Well, you know, to be candid, Your
3 Honor, I haven't looked at the factual scenarios in
4 states where they have adopted the continuous
5 treatment rule, because in South Carolina they have
6 repeatedly rejected it. And the reason that they have
7 is our courts have said we've identified in our
8 statute -- we talked --

9 Let me back up. We talk about a statute of
10 limitations and the statute of repose as if they're
11 two separate statutes. They're contained in the same
12 statute. The repose portion is an outer limit of six
13 years from the date of the occurrence. And that's
14 contained within it. So these are not two different
15 statutes. It's two different time frames that provide
16 the framework in which a malpractice case can be
17 brought.

18 It also acknowledges that malpractice cases are
19 different than intentional torts like your wife
20 fussing at you and hitting you in the head. And
21 whether we're being funny or cute about it, in all
22 candor, our legislature has decided in our Supreme
23 Court, and Court of Appeals have concluded, that there
24 is a legitimate legislative intent behind the statute
25 of repose and it is harsh. It is harsh. It's harsh

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1 because it's based on an occurrence. Has nothing to
2 do with a date of injury, knowledge, or any of those
3 normal components. And that's what we get to here.
4 And it's just the application of a relatively harsh
5 rule. And that's the reason why the continuous
6 trigger has not been adopted by our court.

7 So what we look at is purely an occurrence
8 analysis. And we have to say in this instance, in
9 this lawsuit, what is the occurrence and then from
10 that point we then measure the time period. And the
11 occurrence, as it relates to Dr. Dodds, is when he
12 failed to recognize the abnormalities of these
13 proteins which -- according to the plaintiff, which
14 would have triggered him to do additional testing that
15 would have led to the diagnosis and subsequent
16 treatment of the condition.

17 And that was the question that was posed to
18 their expert, Dr. Luke, who said that these conditions
19 that warranted additional testing were present as of
20 September of 2004, were present again later in 2004,
21 and again in February 7th of 2005.

22 And so the analysis, the reason we get to the
23 continuous trigger or continuous treatment or the
24 continuous tort analysis is that the plaintiffs have
25 articulated that each separate time the patient is

1 seen and that patient's condition is not diagnosed,
2 that represents an independent act of negligence.
3 That is the quintessential definition of the
4 continuous negligence or continuous treatment
5 doctrine, or whatever you want to refer to it as. So
6 you have to look at what are the circumstances
7 surrounding --

8 THE COURT: Well, that's why I was asking you
9 the facts of these cases. In this particular case,
10 the doctor kept treating her the same way. Okay?

11 MR. HOOD: Right.

12 THE COURT: And my question -- and what it is I
13 want to know about the facts and the continuous
14 treatment cases in the states, was it the same
15 treatment each time or was it different occurrences,
16 different things happening, in relation to that
17 patient.

18 MR. HOOD: Well, Your Honor --

19 THE COURT: I don't know if that would make any
20 difference, but I was just asking the question.

21 MR. BUCKNER: Your Honor, I'm happy to read the
22 sort of -- from my brief about the Howell case, which
23 is the case from the Georgia Court of Appeals which
24 deals, like South Carolina state where --

25 THE COURT: Well, you said the -- well, standard

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1 in Georgia is different. It's the date of injury, not
2 occurrence. So, I mean, the Howell case would really
3 be immaterial, wouldn't it?

4 MR. BUCKNER: No, Your Honor.

5 I think Georgia, like South Carolina, deals with
6 occurrences and --

7 THE COURT: Occurrence, not injury? All right.

8 MR. BUCKNER: And in Howell, Howell, the
9 plaintiff, was treated over a five-year span by the
10 defendant physician but was never properly diagnosed
11 with coronary artery disease. After five years of
12 treatment --

13 THE COURT: Well, I mean, so why wasn't it
14 diagnosed? They just didn't pick up on it?

15 MR. BUCKNER: They just didn't pick up on it.
16 Yes, sir, Your Honor.

17 For purposes of today, that would be the same
18 argument.

19 THE COURT: Well, not necessary. In this
20 particular case, from what I remember, and you correct
21 me if I'm wrong because it's been a couple of months
22 since we had the last oral arguments, she would go to
23 the doctor, the protein would spike. And then
24 according to her expert, they needed to do additional
25 tests because that protein spiked. That occurred each

1 time.

2 So I know you're calling it a failure to
3 diagnose. I guess that's the proper legal
4 terminology. But that's a little bit different than
5 just saying, hey, the man had heart problems that was
6 never found. They knew there was a protein spike in
7 this case, if I remember correctly --

8 MR. HOOD: And it wasn't --

9 THE COURT: -- each time she visited. Is that
10 correct?

11 MR. BUCKNER: Well, the protein levels were
12 different on different visits.

13 THE COURT: But there was a spike each time she
14 visited; right?

15 MR. BUCKNER: Not necessarily, Your Honor.

16 THE COURT: Not necessarily?

17 MR. BUCKNER: It depended on the treatment date,
18 I guess, because there were several.

19 But that's where we think Dr. Zizzic's
20 [phonetic] testimony is particularly illustrative on
21 that point was that, you know, when we -- when
22 Dr. Zizzic was asked in his deposition to distinguish
23 what should have been done based on these different
24 levels, it was the same failure to do follow-up tests
25 based on those. It was the same failure in 2002 that

1 it was in 2004 that it was in 2005.

2 THE COURT: Okay.

3 MR. BUCKNER: And that's what I believe brings
4 it within that, because that's exactly what the
5 Georgia Court of Appeals said with the -- after five
6 years of treatment, the plaintiff died of that
7 condition. And the Court said although the focus on
8 the statute of repose is generally the date of the
9 alleged negligent act, a later negligent act cannot
10 serve as the new starting point of the statute of
11 repose where the negligent act is merely the repeated
12 failure to diagnose and treat a continuing, though
13 worsening, condition.

14 I think that though worsening condition really
15 speaks to the what they allege were elevated protein
16 levels in '05.

17 THE COURT: All right. Now, I don't know if I
18 asked you this or we even talked about it at the last
19 hearing, but I'll ask you the question. There's some
20 cases out there that say on novel issues such as this,
21 you shouldn't grant a summary judgment motion, you
22 need to develop the facts a little more fully. Now,
23 what's your position on that?

24 MR. BUCKNER: Well, even the plaintiffs concede
25 in their brief -- but I don't know if it was in their

1 reply to their motion to reconsider --

2 THE COURT: I haven't read the current brief,
3 okay? Go ahead.

4 MR. BUCKNER: -- that there is nothing improper
5 about granting summary judgment on what is a novel
6 issue of law. The only thing they think is that the
7 record needs to be more developed. Not necessarily by
8 trial. They didn't even really argue that. They
9 argued at an evidentiary hearing.

10 But because all the facts are construed in the
11 light most favorable to plaintiff, it would make a
12 whole lot more sense to me, and our position would be,
13 that before we had a trial and everybody spends fifty,
14 sixty, \$70,000 on experts, let's have the appellate
15 courts address what is I think a pure legal issue --

16 THE COURT: Well, my problem --

17 MR. BUCKNER: -- whether the statute of repose
18 and misconduct --

19 THE COURT: My problem with it is if I remember
20 correctly, the plaintiff's attorney that attended the
21 deposition of their expert asked no questions. Y'all
22 zeroed in on the statute of repose. That was never
23 developed by the plaintiff's attorney.

24 MR. BUCKNER: Well, Your Honor, in that case --

25 THE COURT: And I'm not saying he did wrong or

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1 didn't do wrong. I'm not trying to insinuate that.
2 The deposition was one-sided.

3 So my question I guess, really, shouldn't those
4 facts from that expert be more fully developed because
5 this Court basically grants summary judgment motion --

6 MR. BUCKNER: Well, Your Honor, I certainly --

7 THE COURT: -- and possibly even your expert's
8 deposition be taken?

9 MR. BUCKNER: Well, I certainly don't -- you
10 know, don't want to comment on the propriety of what
11 was or wasn't asked by the plaintiff's counsel but --

12 THE COURT: And I'm not trying to insinuate they
13 did anything wrong. Okay? Don't get me wrong. I'm
14 just saying that's what happened.

15 MR. BUCKNER: Yes, Your Honor.

16 And what I would say is that to the extent he
17 didn't ask those questions, he's the architect of his
18 own dilemma. I mean, we pled the statute of repose at
19 the very beginning of this case --

20 THE COURT: Well, I understand that. But why
21 should the client suffer as a result of that?

22 MR. BUCKNER: Well, I'm not arguing that their
23 client should suffer because of that. What I'm saying
24 is that this issue has been litigated from the very
25 outset of the case. If they wanted to develop that at

1 the deposition, they had every chance to do it just
2 like we had every chance to develop --

3 THE COURT: Have they taken your expert's
4 deposition? Have they taken your expert's --

5 MR. BUCKNER: They have, Your Honor.

6 THE COURT: They have. Okay.

7 All right. Thank you. I appreciate your
8 comments --

9 MR. BUCKNER: And that's a good example of how
10 they could have developed counter-testimony through
11 that. And they still haven't. I --

12 THE COURT: I appreciate your comments on that.

13 Mr. Hood, what do you want to add

14 MR. HOOD: A couple of points. Number one is on
15 the novel issue, Your Honor. I would just point you
16 to the Linoq case, which is 376 S.C. 182, which says
17 that, you know, although summary judgment is not
18 rendered inappropriate because it involves novel
19 issues, it may be inappropriate when further
20 development is desired.

21 I mean, that's --

22 THE COURT: Well, that's all I was asking, do
23 you think further development needs to be taken.
24 That's what I -- and I'm not necessarily saying trial.
25 Okay?

1 MR. HOOD: And I want to address that point.

2 THE COURT: I'm not necessarily saying you've
3 got to go to trial before you get to that point.

4 MR. HOOD: Okay.

5 THE COURT: And to be perfectly blunt about it,
6 I'm thinking about letting y'all go take some experts'
7 deposition on this particular issue and see what comes
8 back --

9 MR. HOOD: And the reason I --

10 THE COURT: -- to fully develop it. Okay?

11 MR. HOOD: Yes, sir.

12 And I want to address that, because that's the
13 case cited by the plaintiff in their brief, for two
14 reasons. Number one, I want to cite to it because it
15 recognizes that just because it's a novel issue
16 doesn't mean summary judgment is inappropriate.

17 THE COURT: I understand. I won't even argue
18 with that.

19 MR. HOOD: And number two is on the time and
20 necessity for additional discovery. This case was
21 filed back in 2012 -- in 2011. This case --

22 THE COURT: I'm not impressed with that
23 argument. Okay?

24 MR. HOOD: But, Your Honor --

25 THE COURT: I don't care if it was filed 2008

1 for the question I've got to resolve today. Okay?

2 MR. HOOD: We were scheduled --

3 THE COURT: Don't go there. Move on.

4 MR. HOOD: We were scheduled to have a date
5 certain trial two months after the hearing. This was
6 not a case that was not developed. And there was no
7 affidavit under Rule 56 that would support the notion
8 that additional discovery was necessary. The rules of
9 civil procedure give us, as attorneys, that option.
10 If there's something out there that we need in order
11 to rebut summary judgment, then we have the ability to
12 sign an affidavit saying to the Court additional
13 discovery is necessary on this point before I can
14 fully respond. That's not in the record. If there
15 were, it would be a different argument. But it's not.

16 The issue of it needs further development is a
17 new argument that was presented for the first time in
18 a motion to reconsider, not in the initial hearing.

19 THE COURT: Well, I haven't even read the
20 motion. I'm presenting it. Okay? I don't know if
21 they presented it or not. Okay?

22 MR. HOOD: And, sir, for those reasons, one, I
23 don't think it's timely and, two, there wasn't the
24 affidavit that you see in instances, whether it's the
25 plaintiff or defendant who's seeking summary judgment,

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1 where additional discovery is necessary. And I would
2 submit to you that's because we were two months out
3 from trial. And this case was, by all intents and
4 purposes, ready to proceed in the event that the
5 motions were denied.

6 And there was a motion for continuance filed by
7 the plaintiff. And the basis for that continuance was
8 not, we need more discovery. It was, we don't want to
9 pay for the cost to ramp up a trial while this issue
10 for summary judgment is pending. Two different
11 issues. And so that's a recognition that at that
12 time, there was no additional discovery necessary.

13 And just one other point. As to Georgia law:
14 Georgia law is very similar to South Carolina law in
15 that its statute incorporates two provisions. It's
16 O.C.G. Section 9-3-71. And section A is their
17 equivalent of a statute of limitations, and that's two
18 years from the date of injury or death arising from
19 negligent act. And subsection B of that same statute,
20 Your Honor, deals with the five years after which an
21 action must be brought on which the negligent wrongful
22 omission occurred. It's an occurrence analysis. So
23 it's just like our provision.

24 And I just wanted to clarify that because I
25 think Georgia is persuasive. I don't think you need

1 to rely on it to reach the result. We think your
2 initial opinion and order was brilliant and we don't
3 think that you need to change it for any reason
4 whatsoever.

5 THE COURT: Thank you, Mr. Hood.

6 Yes, sir?

7 MR. HEWITT: Very briefly, Your Honor.

8 And I'm going to just set this up factually so
9 that we're all aware of the umbrella we're working
10 under.

11 My client had renal failure in 1999. It was
12 resolved, she was discharged, treated with steroids.
13 And the experts say there's no reason for her to have
14 elevated protein levels after that. We, of course,
15 know that over time she developed elevated protein
16 levels. Was treated for five years by Dr. Roane, for
17 -- one of those years concurrently with Dr. Dodds.
18 They don't do a hundred-dollar test, which all of our
19 experts say they should have done for various
20 different reasons during various different points of
21 her treatment. And when she goes to somebody that's
22 competent four years later, they do the hundred-dollar
23 test and find out that she has cancer, not connective-
24 tissue disorder.

25 Nobody but them understand this. Nobody but

1 them takes the position that this is not a series of
2 negligent occurrences, not Georgia law in the Kaminer
3 case -- they say this is negligent occurrences -- not
4 South Carolina law in the Shadwell case that says
5 there are a series of negligent occurrences, the last
6 of which is the last time she sees her doctor. So
7 nobody but them adopts that view.

8 Let's talk about the continuous treatment rule.
9 I appreciate the interest in the continuous treatment
10 and the continuous tort rule, but I am not advocating
11 for that. The continuous treatment rule is a matter
12 of policy. It says, we're going to give medical
13 patients the ability to trust that their physicians
14 are competent. So no negligence claim under the
15 continuous treatment rule. None. It's going to
16 accrue until they're discharged from treatment.

17 I am not arguing for that at all. In fact, it
18 is them who want you to adopt the continuous treatment
19 rule. They want you to say one occurrence of
20 negligence at the very beginning can excuse the repose
21 period, start a repose period, for a series of
22 negligent occurrences. That is not the purpose of the
23 statute of repose, which is to give a physician, after
24 six years, the peace of mind to know that no tail
25 claim for malpractice is coming in. Well, the time to

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1 start that clock here, as our experts say, is in the
2 last -- for a claim based on the last occurrence for
3 Dr. Roane, when she last makes a negligent occurrence.
4 For the last occurrence, based on Dr. Dodds, when he
5 last makes a negligent -- we know some of this stuff
6 is out of bounds. 2002 stuff, 2003 stuff, 2004 stuff,
7 that's out of bounds. But 2005 is within the repose
8 period. And when you're negligent in 2005, you can be
9 sued all the way up until 2011.

10 I want you to apply the statute of repose
11 correctly. I respectfully submit to you that they do
12 not and they know they do not. Thank you.

13 THE COURT: Okay. Thank y'all very much.
14 Appreciate your being here.

15 [HEARING CONCLUDES AT 3:45 P.M.]
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25

1 State of South Carolina)
2 County of Charleston)
3 Virginia L. Marshall and) 2011-CP-10-934
Todd W. Marshall,) 2011-CP-10-4057
4)
Plaintiffs,)
5)
vs.) Deposition
6)
Kenneth A. Dodds, MD,) of
7 Charleston Nephrology)
Associates, LLC,) Kenneth A. Dodds, MD
8)
Defendants.)
9)
Virginia L. Marshall and)
10 Todd W. Marshall,) 2011-CP-10-2587
2011-CP-10-5897
11 Plaintiffs,)
12 vs.)
13 George Roane, MD and)
Rheumatology Assosciates,)
14 PA,)
15 Defendants.)
16)

17 Deposition of Kenneth A. Dodds, MD, taken before
Kathleen R. Tackett, CVR, a notary public in and for the
18 State of South Carolina, commencing at the hour of 9:37
a.m., Tuesday, June 19, 2012, at the office of Hood Law
19 Firm, 172 Meeting Street, Charleston, South Carolina.

20
21 Reported by
Kathleen R. Tackett, CVR
22
23
24
25

1 Q So the -- let me write this down. So the -- one of
2 the -- the first things you look for with someone
3 with proteinuria is you think about and want to
4 rule out the abnormal proteins.

5 A Sure.

6 Q Okay. And that's what happened in 1999 and 2000
7 when she had that surgery.

8 A No, sir. She didn't have --

9 Q Oh, the biopsy. I'm sorry.

10 A -- surgery. As a matter of fact, you remember she
11 had a history of having had proteinuria for several
12 years prior to 1999.

13 Q Right. She had the biopsy done.

14 A Well, in 1999, she had the biopsy done.

15 Q That's what I --

16 A But she had had a history of proteinuria for
17 several years before that.

18 Q Yes, sir.

19 A And then, while she was in the hospital, part of
20 her evaluation included looking for abnormal
21 proteins which -- if -- if -- if you don't mind,

22 why don't we be a little bit more specific?

23 Q Okay.

24 A And let's call them -- let's refer to it as a
25 "monoclonal gammopathy."

1 Q Okay. I may have to refer to it as "abnormal
2 proteins."

3 A Okay.

4 Q But you can certainly --

5 A But I'll -- might refer to it as monoclonal
6 gammopathy.

7 Q Okay.

8 A But, no, that would be the first thing you would
9 do.

10 Q Right.

11 A And so that's why that was the first thing that was
12 done. And then she continued to have proteinuria
13 continuously from that time on.

14 Q Can I ask you: In 1999, based on your review of
15 the records, they did a biopsy. Did they also do
16 that SPE -- the UPEP and the SPEP tests?

17 A They did both a serum protein electrophoresis and a
18 urine protein electrophoresis. That would've been
19 just standard workup in the beginning. And Dr.
20 Roane repeated the serum protein electrophoresis in
21 2000.

22 Q Uh-huh.

23 A And all that showed was chronic nonspecific
24 inflammation, no monoclonal gammopathy.

25 Q Okay. The SPEP is the blood test and the UPEP is

1 the urine test.

2 A That's correct.

3 Q That are looking for these abnormal proteins?

4 A Monoclonal gammopathy. Yes, sir.

5 Q Okay. All right. And both those tests and the
6 biopsy were negative for any problems like lymphoma
7 in 1999 and 2000?

8 A The -- both the serum protein electrophoreses
9 showed no indication at all of monoclonal
10 gammopathy. There were no signs of abnormal
11 proteins or immune complexes on the renal biopsy.
12 And, although there were many, many cells in -- in
13 the kidney that indicated inflammation, there was
14 nothing suggestive of a malignant cell.

15 Q Based on the biopsy that was done?

16 A On the biopsy there was no abnormal, cancerous cell
17 seen.

18 Q Right. Okay. And I understand that was done in
19 1999 and 2000. But if you continue to have
20 proteinuria, at what point in time are you supposed
21 to be thinking about abnormal proteins in someone
22 that continues to have proteinuria for years after
23 that?

24 A You don't unless there is a substantial change in
25 their clinical condition.

1 Q Didn't she have a -- a substantial change in her
2 condition?

3 A No, sir.

4 Q She didn't?

5 A No, sir.

6 Q So just the fact that she continued to have
7 nephrotic range proteinuria for five years/ten
8 years after that, you don't -- you don't have to --

9 A I don't turn around and do a workup every year on
10 somebody that's got a stable condition. That's
11 silly.

12 Q I'm not asking about every year. I'm asking about
13 how about every two years?

14 A No.

15 Q Three years?

16 A No.

17 Q Four?

18 A No.

19 Q Five?

20 A Not unless there is a substantial change in their
21 condition.

22 Q So you never have to think about it again if all
23 they had was just high proteinuria?

24 A And they --

25 MR. SCOTT: Object to form.

1 testimony is she had a lymph node biopsy which
2 showed that she didn't have any --

3 A It was benign.

4 Q All right. So I take it, then, that -- do you
5 believe had -- had you done that -- those two tests
6 that we've talked about today, that -- I never can
7 say it right -- EP --

8 A UPEP.

9 Q -- UPEP and the other one in 2005, do you think
10 they would've shown the abnormal proteins at that
11 time?

12 A No.

13 Q Why is that?

14 A Because the amount of proteinuria she had, had not
15 changed because there had not been any substantial
16 change in her overall condition. There hadn't been
17 any change in any of her other labs that made me
18 suspect that something new was going on. Actually,
19 it appeared that things were improving, looking at
20 the sed rates.

21 Q Whenever Dr. Pride ordered the -- the lymph node
22 biopsy in 2010, where was that biopsy done?

23 A Dr. Pride didn't order a lymph node biopsy.

24 Q He ordered the two tests, and then she ultimately
25 had the biopsy done?

1 A No.

2 Q She didn't?

3 A No.

4 Q Did you hear her testify that that's why she sent
5 her to you?

6 A I don't know whether she testified that or not, but
7 I never got that message. And it's written in my
8 initial note that she was referred for attempts to
9 decrease the amount of protein in her urine, and
10 Ginny was in agreement with that.

11 Q So you were not asked to look for nor did you try
12 to determine what the cause of the underlying
13 problems with the kidneys were.

14 A That's correct.

15 Q Did you, since you've looked at all these records
16 now and done research and everything else you've
17 done, determine what you think was the cause of her
18 kidney problems?

19 A I still think at the time I saw her that she had
20 some form of connective tissue disease that was
21 causing her to have abnormal amounts of protein in
22 her urine.

23 Q What do you think now? I know that's the time you
24 saw her; have you changed your opinion since then?

25 A I just said I still think --

1 STATE OF SOUTH CAROLINA

2 COUNTY OF CHARLESTON

3 * * *

4 VIRGINIA L. MARSHALL and

5 TODD W. MARSHALL,

6 Plaintiffs,

7 vs.

CASE NOS. 2011-CP-10-934
2011-CP-10-4057

8 KENNETH A. DODDS, M.D.,

9 et al.,

10 Defendants.

11 * * *

12 Deposition of ROBERT G. LUKE, M.D.,

13 Witness herein, called by the Defendants for

14 cross-examination pursuant to the Rules of Civil

15 Procedure, taken before me, Mindy R. Huffman, a

16 Notary Public in and for the State of Ohio, at the

17 offices of Mike Mobley Reporting, 1600 Scripps

18 Center, 312 Walnut Street, Cincinnati, Ohio, on

19 Friday, April 5, 2013, at 11:19 a.m.

20 * * *

1 proteinuria disappeared and -- well, that's my
2 opinion, that she had acute interstitial
3 nephritis.

4 Another very important finding was
5 the renal biopsy which showed no glomerular
6 disease, no immune complexes, no deposition of any
7 immunological proteins, essentially were normally;
8 whereas, the tubulointerstitial changes were quite
9 substantial. And the response to steroids was
10 very, very clear, and that is well described in
11 using steroids in tubulointerstitial acute renal
12 failure. So I'm confident, more likely than
13 not -- which is the phrase you like us to use --
14 that this was acute renal failure not due to
15 glomerular disease, due to drugs, and that it
16 cleared up. And in 2000, 2001 and 2002, urine
17 analysis by stick tests continued to show very
18 little proteinuria. So there's a clean-cut
19 disease there, and then she developed something
20 else later.

21 Q. And you realize you're the only
22 physician to reach that remarkable conclusion
23 in this case?

24 A. I disagree with that statement.

25 Q. Who else has reached that

1 remarkable conclusion?

--2-- A. I think Dr. Dodds made the remark
3 too that it was acute renal failure due to
4 tubulointerstitial disease, Dr. Roane remarked
5 that too, and I can't remember if there was
6 anyone else.

7 Q. Well, how is it then, Doctor, that
8 you're able to say, more likely than not, that
9 the disease that Ms. Marshall had in 1999 is
10 not related to what we see in 2004 and 2005?

11 A. Dr. Roane, in 2000 and 2001 and
12 2002, did just what we call routine urinalysis,
13 and those showed trace proteinuria, which is a
14 few hundred milligrams. The first time she did
15 measure proteinuria on a 24-hour basis by
16 chemical test for proteinuria, it was about
17 three point five grams. So I don't know --
18 since part of this case relates to the
19 discrepancy between stick tests and 24-hour
20 urine protein tests, I don't know what happened
21 in 2000, 2001 and 2002 because there were no
22 24-hour measurements. And clearly, Dr. Roane
23 thought that the acute renal failure had
24 resolved and was testing only with sticks. The
25 first quantitative number I saw was in 2003.

1 So I can't say that there wasn't development of
2 light chains in the urine between 2000 and 2003
3 until that was measured. And I am aware that
4 there were negative IEPAs,
5 immunoelectrophoreses, I think twice, once in
6 the hospital and once in early 2000, showing no
7 M spike in the serum. So it's likely that the
8 disease was not there at least until early
9 2000, but certainly from 2003 on, I believe
10 that there was a light -- there were light
11 chains in the urine that were not tested for
12 thereafter.

13 Q. Okay. We'll talk about that in
14 significant detail in just a few minutes.
15 Before we do, you used the term trace proteins.
16 Can you first define for me what you mean by
17 the term trace protein?

18 A. Well, there are various stick
19 tests. Some people call them S T I X, stix
20 tests. One of them is Albustix. It's a --
21 it's a qualitative test of protein, and it goes
22 from negative to trace up to three plus, and
23 there's a color change in the -- in the sticks
24 that you just dip in the urine. It's a very
25 useful brief screening test, and it's well

1 known, and you'll see in the UpToDate, it's
2 described in detail that the light chains do
3 not affect this and can be missed and only --

4 Q. What is -- sorry.

5 A. Go ahead.

6 Q. So what is normal then?

7 A. Well, the normal in the urine is
8 negative, or in a very concentrated urine,
9 trace. But one always interprets that test in
10 the context of what the patient's data is and
11 findings are and what the other tests are.

12 Q. When you used the term trace
13 proteins in your description earlier, the
14 evidence of trace proteins, what were you
15 specifically referring to from the medical
16 records?

17 A. The urinalysis or the dipstick
18 which was done several times by Dr. Roane and
19 was done in the hospital before she left.

20 Q. Is there a -- can you quantify
21 what trace proteins means?

22 A. It's the same -- it's really a
23 qualitative test, and it simply -- depending on
24 the circumstances, if it was a normal patient
25 with normal renal function and no cells in the

1 A. I think I've given you the main
2 ones. I mean, I can't say that I've covered
3 the waterfront totally. There might be other
4 reasons in a specific patient.

5 One question would be is the overall
6 disease causing the proteinuria, or is there
7 another disease altogether separate. People can
8 have two diseases. And that -- that's -- I've
9 already said that. That's just another way of
10 expressing the same thing.

11 Q. Was there anything in the
12 materials that you've reviewed that suggested
13 that Dr. Roane sent Ms. Marshall to Dr. Dodds
14 in an effort for her -- to assist her in making
15 a diagnosis?

16 A. I did not read those -- that
17 specific area. She clearly was a bit worried
18 about the proteinuria and felt she should send
19 it to him to see if there was anything else to
20 be done about the proteinuria from a
21 nephrologist's point of view. That's the gist
22 of what I got.

23 Q. And she had reached her own
24 diagnosis of the disease that she believed that
25 Ms. Marshall had had prior to that referral,

1 identified, as one of the bases for needing to do
2 a SPEP or UPEP as a discrepancy between the
3 dipstick and the 24-hour urine collection during
4 Dr. Dodds' treatment, right?

5 A. Yes.

6 Q. I want you to tell this jury what
7 medical records support that testimony.

8 A. Tell me the dates at which he --
9 well, did he go over her data very carefully
10 that she sent to him and all the lab tests?

11 MR. HOOD: Madame Court Reporter, can
12 you please repeat the question to the witness?

13 (Record read.)

14 BY MR. HOOD:

15 Q. Do you understand the question,
16 sir?

17 A. Yeah. I would refer you back to
18 what we went through with item six in the --
19 on -- we can go through them all again:
20 5/12/2000, 100; 7/19/2000, 100; 3/08/2001, 30;
21 11/28/2001, 30; 2/27/2002, 30; 8/12/2002, 30;
22 2/18/2003, 100; 8/12/2003, 30; 3/19/2004, 100;
23 and then 8/06/2004, which I think was the time
24 when she had started to think about referring ,
25 and that was three point five grams. I think

1 that's the time that he started -- the first
2 visit he started Diovan, I think.

3 So she consistently had, between 2001
4 and 2004, stick tests that were much lower than
5 the protein that was being recorded, plus no
6 previous cause, and a glomerulus in '09, of
7 proteinuria.

8 Q. When did Dr. Dodds begin treating
9 this patient?

10 A. In -- I think it was November '09.
11 You've asked me so many questions about dates.
12 I'm confused.

13 THE WITNESS: Let's see the date --
14 is this them (indicating)?

15 MR. ELLIOTT: His records are under
16 your summary (indicating).

17 THE WITNESS: I'm sorry?

18 MR. ELLIOTT: His records are under
19 your summary (indicating).

20 THE WITNESS: This (indicating)?
21 Okay. These are the proper records. The first
22 day I have here is 9/15/2004, then 11/11/2004.

23 I should comment also that Dr. Pride
24 was amazed when he saw the urine tests, the stick
25 tests and then saw nine grams of protein in 2010

1 the first time he saw her.

2 BY MR. HOOD:

3 Q. What's the clinical significance
4 between nine grams and three point five grams?

5 A. High significance. That's a real
6 increase because the tumor is increasing in
7 size, the tumor's mass.

8 Q. Was there ever a time during
9 Dr. Dodds' involvement where the proteinuria
10 reached a level even approaching nine grams?

11 A. No.

12 Q. In all of the 24-hour urine
13 collections, you would agree that the
14 proteinuria levels were relatively stable?

15 A. Well, despite treatment, if it was
16 a glomerular range of proteinuria, would have
17 been expected to drop. The treatment with
18 Diovan, on the average, gives a 40 percent drop
19 in proteinuria, as I've already testified. So
20 I would have been a little surprised to see no
21 response.

22 Q. How long does it take for Diovan
23 to -- for patients to see that type of
24 response?

25 A. A month or two.

1 Q. One month or two? And what
2 medical literature would I go to look up, just
3 to make sure that that's accurate?

4 A. Well, there were studies of the
5 effects of low-salt diuretics, which showed --
6 I think the tests were a couple months to show
7 the effects. I can find those for you.

8 Q. That's okay. I'll show them to
9 you the next time we see each other. Is
10 there --

11 MR. ELLIOTT: You cut out again. We
12 missed the whole question.

13 BY MR. HOOD:

14 Q. During the time of Dr. Dodds'
15 treatment, was there any evidence there was
16 improvement of the proteinuria?

17 A. No.

18 Q. How do you determine whether
19 there's significant improvement? I mean, is it
20 based on a percentage? Is it based on raw
21 numbers? How do you make that determination?

22 A. Well, again, as I said, you want
23 to look at more than two numbers. You look at
24 the trend. I think it was three point five
25 when he started, and the last one was four one

1 or something like that. I mean, you want more
2 than two numbers. You want to see a trend. 40
3 percent is only the average, roughly.

4 Q. Do you know when the Diovan was
5 started?

6 A. I think he prescribed it the first
7 time he saw her on 9/15. Let's see, yeah.
8 Today I have given her samples of Diovan to
9 begin, 80 milligrams QD. That was 9/15/2004.
10 And the last time he saw her was, I think,
11 9/15/2005. She had four point two grams of
12 protein there, so I interpret that as no
13 change.

14 Q. What about from February 9th,
15 2005?

16 A. Well, I would go to the last time
17 he saw her. I mean, that's the time of
18 treatment. I think there was one or three
19 grams.

20 Q. It was actually --

21 A. But the last one was four point
22 something, as I recollect.

23 Q. And so you had one in February of
24 '05, and the last one that was collected in
25 September of '05; is that correct?

1 A. I'm trying to find it again.

2 Well, certainly the first one was about three
3 six or something, which is around about what
4 Dr. Roane was getting. That's 11/2. 2/9/2005;
5 it was three zero four five milligrams, three
6 grams. There was another one --

7 Q. Before you --

8 A. Three grams.

9 Q. Three grams, down from three point
10 five grams, right?

11 A. Yes.

12 Q. In five months.

13 A. Yeah, but there was another one at
14 four point one. Here we are, 9/15/2005, four
15 point two grams of protein. Again, you're
16 looking at the slope. You chart the points.
17 You don't look at two points.

18 Q. Can I ask you a question about
19 February, or is that February time frame just
20 unimportant?

21 A. No. I answered it. It was three
22 grams, I think.

23 Q. Okay. What percentage change is
24 that from the three point five that he had seen
25 the first time he saw the patient?

1 A. Well, you can do the math of three
2 over three point five times 100.

3 Q. And that's after five months of
4 Diovan, right?

5 A. Yeah, I think so, but it was four
6 grams, later.

7 Q. Okay. We'll get to it. I
8 promise. I'm not going to deprive you of the
9 opportunity to talk about it.

10 A. But you look at a line. You don't
11 just take two points. You look at all the ones
12 you've got.

13 Q. All of them, right, every single
14 point?

15 A. Yes, to see whether the slope is
16 going up or down. It's the same with a serum
17 creatinine.

18 Q. So now we're looking at February,
19 and it's -- there has been a decrease from
20 three point five to three grams in the
21 proteinuria, right?

22 A. Yes.

23 Q. You then see proteinuria of four
24 point one grams --

25 A. Yes.

1 Q. -- in September of '05?

2 A. Yes.

3 Q. Was there anything different about
4 the patient in September of '05 that could --

5 A. Well, there was discussion of was
6 there a UTI or something, but I didn't see the
7 evidence for that.

8 Q. You didn't have any evidence of an
9 infection at the time of September --

10 A. Well, Dr. Dodds said -- let me
11 read what he said. He thought that it was
12 higher because of an infection. She is not in
13 any gross hematuria. I'm reading the 9/15 --
14 24-hour urine collection showed four point two
15 grams, stable proteinuria in a patient with
16 mixed connective tissue disease. In fact,
17 considering that the patient had a febrile
18 illness during this urine collection, this may
19 represent something -- less protein than
20 before.

21 Q. Did you see the history of the
22 present illness that the patient described to
23 Dr. Dodds that she recently had an upper
24 respiratory tract infection and was treated by
25 the use of Zithromax and that this was going on

1 when she did her last 24-hour urine collection?

2 A. She does report that she recently
3 had a URI and this was treated by Zithromax,
4 and this was ongoing when she did her 24-hour
5 urine collection.

6 Q. So at the time of the 24-hour
7 urine collection where her proteinuria level --

8 A. Well, I don't know the exact times
9 of her symptoms and the exact times of the
10 collection.

11 Q. Well, why don't we look to see
12 what the patient said, Doctor. The patient --

13 A. She recently had an upper
14 respiratory tract infection that was treated by
15 Zithromax.

16 Q. Please continue reading to the
17 jury.

18 A. I'm sorry. Yes, she did say when
19 her last -- when she did her last 24-hour
20 urine.

21 Q. That's right. So the patient
22 reported that the infection was ongoing when
23 she did her last 24-hour urine collection?

24 A. Yes, that's what it says.

25 Q. And that would be an explanation

1 for why her proteinuria levels were increased?

2 A. Not necessarily. She was treated
3 with -- I mean, she was being treated. And
4 also, an upper respiratory infection is much
5 less to cause protein than a urinary tract
6 infection, and I have no note what her fever
7 was. The mechanism of proteinuria with -- a
8 respiratory infection is not admissible, but a
9 bad pneumonia or something is fever, and I
10 don't know what her fever was.

11 Q. And doesn't the package insert for
12 the Siemens Multistix dipsticks caution that
13 acute illnesses with fever can cause
14 temporarily elevated results?

15 A. Fever can certainly cause
16 transient proteinuria. Running a marathon or
17 running a long race can give you proteinuria,
18 so we always look into transient proteinuria
19 and repeat it. If you really wanted to see
20 what happened, you would repeat it after the
21 infection had gone. I didn't see any record of
22 that. It's a theoretical explanation of why it
23 was higher.

24 Q. Okay. And the reasonable thing to
25 do would be to repeat that study to make a

1 determination of this outlier?

2 A. Yes.

3 Q. Okay. And you're aware in this
4 case that that was suggested and requested by
5 Dr. Dodds, but the patient elected not to
6 follow up.

7 A. Well, I don't --

8 Q. You knew that, right?

9 A. -- know exactly what happened. I
10 know he wanted to see her again in six months.
11 I don't know whether --

12 Q. She never came back to him, did
13 she?

14 A. In six months. But if you were
15 going to follow up with this, you wouldn't wait
16 six months.

17 Q. Doctor, she never followed up with
18 Dr. Dodds, did she?

19 A. That's my understanding, yes.

20 Q. Okay. And do you hold the patient
21 responsible for not following up with
22 Dr. Dodds?

23 A. Well, I don't know why she didn't
24 follow up.

25 Q. Well, don't you think that in a

1 patient like this where you see an upward
2 adjustment of their proteinuria at the same
3 time that she has an infection and is requested
4 to come back, that that patient bears some
5 responsibility for not coming back?

6 MR. ELLIOTT: Object to the form.

7 THE WITNESS: I can't comment on why
8 she didn't come back or whether she's to blame or
9 not to blame. It's beyond my knowledge. I state
10 again people with colds without a fever don't
11 necessarily get increased proteinuria.

12 BY MR. HOOD:

13 Q. Well, you can't attribute any
14 responsibility to Dr. Dodds for Ms. Marshall
15 not following up, can you?

16 A. I agree with that.

17 Q. And if she had followed up and her
18 proteinuria level after September of 2005 had
19 increased, it would further support the idea
20 that a new workup or additional workup was
21 necessary, correct?

22 A. I have testified that from the
23 time he saw her or the second visit, that -- I
24 mean, I've made it very clear it's my opinion
25 that the consult should have done the protein

1 testing for light chains, and if that was
2 negative, renal biopsy. I've written it. I've
3 said it. That's my view.

4 Q. But you haven't answered my
5 question, Doctor. My question is, if the
6 patient had come back and the proteinuria level
7 had increased, then that would then be an
8 additional reason to contemplate working up
9 from a nephrology standpoint to determine the
10 cause of the increase in the proteinuria,
11 correct?

12 A. The key word --

13 MR. ELLIOTT: Object to the form. Go
14 ahead.

15 THE WITNESS: The key word in your
16 statement was additional reason.

17 BY MR. HOOD:

18 Q. Do you agree with me or not?

19 A. I agree that it was an additional
20 reason for working her up.

21 Q. And the person responsible for
22 that not happening is the plaintiff, right?

23 A. Well, it's certainly not Dr. Dodds
24 for not following up. I don't know what the
25 reason of the lady for not following up is.

1 Q. Are you suggesting that there's
2 some other reason other than the patient
3 bearing responsibility for this?

4 A. I am not saying anything. I'm
5 saying Dr. Dodds is not responsible -- he asked
6 her to come. She didn't come. I don't know
7 why she didn't come.

8 Q. But why would she not be
9 responsible for the consequences of not
10 following the recommendation of the physician?

11 A. I don't know. She was also seeing
12 Dr. Roane still, who had already obtained an
13 opinion that Diovan was the right treatment,
14 and I think she continued it. Therefore, she's
15 maybe in a position that he's given her his
16 opinion as a consultant to Dr. Roane;
17 therefore, I can continue -- he said what he
18 thinks by proteinuria needs -- I mean, this is
19 all hypothesis. I'm just saying she may have
20 said I've seen him four times, he prescribed
21 this, he thinks it's helping me, I'll go back
22 to Dr. Roane, she's treating me. That's a
23 reasonable hypothesis as to what happened.

24 Q. You have no idea on God's green
25 earth whether that's the case or not, do you?

1 MR. ELLIOTT: Object to the form.

2 That's not what he said.

3 THE WITNESS: I said it's a

4 hypothesis. That's what that means.

5 BY MR. HOOD:

6 Q. That's a guess.

7 A. Hypothesis is a guess, yes. It's
8 more than a guess. It's supposed to be based
9 on possibilities, probabilities. We're talking
10 about semantics here.

11 Q. Did you know that the patient
12 stopped taking Diovan in 2006?

13 A. I knew at some stage, she stopped
14 taking Diovan, yes.

15 Q. That would pretty much destroy
16 your hypothesis, wouldn't it?

17 A. When did she -- when was it -- I
18 don't think it would destroy it. The
19 proteinuria, it wasn't any different with
20 Diovan or not with Diovan. It continued to be
21 the same before it went up again.

22 Q. Doctor, in the relationship
23 between a doctor and a patient, you agree that
24 that's a joint relationship with duties and
25 obligations that flow both from the doctor to

1 the patient as well as from the patient to the
2 doctor?

3 A. Yes.

4 Q. And a patient needs to be truthful
5 and forthright in providing information to the
6 doctor?

7 A. Yes.

8 Q. And the doctor needs to take
9 reasonable care to provide fair and reasonable
10 care and treatment to patients?

11 A. Yes.

12 Q. And part of the things that
13 physicians do is they provide patients with
14 instructions regarding medications, recommended
15 courses of treatment, follow-up visits, those
16 sort of things as well, correct?

17 A. Yes.

18 Q. And if a patient elects not to
19 follow the advice of a physician, do you agree
20 with me that the patient bears responsibility
21 for the consequences of not following that
22 advice?

23 MR. ELLIOTT: Object to the form.

24 THE WITNESS: Well, I -- her husband
25 loses his insurance at some point, and she can't

1 afford medicines. I can't remember when that
2 happened, so I -- if she couldn't pay for the
3 drug, then that's one thing.

4 I know that Dr. Dodds gave her some
5 samples to begin with, but I know she had to have
6 prescriptions after that. A possible reason would
7 be she couldn't pay for it.

8 But one thing she -- this is, again,
9 hypothesis. One thing she might have noticed,
10 this makes no difference to the proteinuria, since
11 I assume Dr. Dodd was telling her what the results
12 were showing, she continued with the protein.

13 Diovan is also used for hypertension,
14 and she wasn't hypertensive, so the only use of
15 the treatment was to treat the proteinuria, and
16 she might have been, a sensible lady -- have
17 thought, well, I'm paying for this, and it's not
18 doing anything to the proteinuria, but that's a
19 hypothesis.

20 BY MR. HOOD:

21 Q. Again, if the patient reaches that
22 conclusion for whatever reason the patient
23 reaches that conclusion, doesn't the patient
24 bear responsibility for the consequences of the
25 decision he or she reaches?

1 A. Well, it depends whether the
2 medicine is doing any good or not. If a
3 patient makes a decision that a medication
4 isn't doing any good and she's not any
5 different, it might be reasonable for her to
6 stop it.

7 In normal circumstances, for a drug
8 that's indicated for the treatment of a disease
9 the patient has and she stops it, then she carries
10 the responsibility.

11 Q. And likewise, when a patient is
12 instructed to follow up with a doctor in order
13 to do testing to monitor a condition and they
14 elect not to follow up for whatever reason it
15 may be, the patient bears some responsibility
16 for that decision. Do you agree with that?

17 A. Well, my hypothesis was that
18 Dr. Roane was doing the same measurements of
19 the urine protein and that she had been, as a
20 consultant to Dr. Roane, who was really
21 functioning as the primary care physician
22 almost. I think she was seeing her more often
23 than the primary care, but I'm not sure about
24 that, but she may have decided I've had what
25 Dr. Dodds had suggested for me and the protein

1 is just the same, I know it's not for my blood
2 pressure; therefore, I will stop. That is just
3 a guess.

4 Q. Do you --

5 A. If you can tell me the reason she
6 stopped, then I'll be able to comment about the
7 responsibility she had.

8 Q. Let me ask you, why is it that the
9 reason she stopped make any difference whether
10 she bears any responsibility for the act of
11 stopping?

12 A. Well, bears responsibility for has
13 the connotation that she's to blame. If she
14 can't afford it or she thinks that it's not
15 doing any good, then it's not unreasonable.

16 Q. Did you know that she called
17 Dr. Dodds' office in '06 to get a refill of
18 Diovan?

19 A. Yeah. I saw that, yeah.

20 Q. Okay. Does that suggest that she
21 had a mechanism for paying for the drugs?

22 A. Well, at some point, she lost --
23 her husband lost their insurance. I can't
24 remember when that was.

25 Q. Wasn't it much later? Wasn't it

1 approaching the time frame before she went to
2 see Dr. Pride?

3 A. It was two years, according to the
4 notes, before she saw Dr. Pride, yeah. So if
5 it was January '10, it would be January '08.
6 So yeah, in '06 --

7 Q. Yeah. So that was -- the whole
8 medical insurance thing was two years later,
9 right?

10 A. Well, as far as I know, she said
11 she stopped it when he -- the insurance -- all
12 I know is she was off it two years. I don't
13 know whether she struggled to pay for it before
14 that.

15 Q. But you don't have any evidence,
16 do you, that Ms. Marshall made a conscious
17 decision not to see Dr. Dodds for financial
18 reasons?

19 A. I have no idea why she didn't go
20 back.

21 Q. You do know that she was
22 instructed to come back in six months and
23 repeat the urinalysis, correct?

24 A. Yes.

25 Q. And you do know that she failed to

1 do that, correct?

2 A. Yes.

3 Q. And if there is a consequence for
4 her failing to come back, she bears
5 responsibility for that. Do you agree with
6 that?

7 A. Well, the consequence --

8 MR. ELLIOTT: Asked and answered.

9 THE WITNESS: -- seems to be
10 irrelevant --

11 MR. ELLIOTT: Object to the form.

12 THE WITNESS: -- since the drug
13 wasn't doing her any good because the cause was
14 not a cause that would respond to an ARB or an
15 ACE.

16 BY MR. HOOD:

17 Q. Okay. We'll get to cause in a
18 minute, but I'm talking about responsibility
19 first. You agree that they have a joint
20 responsibility, the doctor and the patient.
21 And in this case, the doctor recommended she
22 follow up in six months, and the patient
23 elected, for whatever reason, not to come back,
24 right?

25 A. I agree with that.

1 Q. Do you agree with me --

2 A. I said -- yes.

3 Q. Okay. I was just waiting for the
4 laughter to stop before I completed my
5 question. Do you agree with me that the
6 consequences of the decision of not coming back
7 as recommended are to be borne by Ms. Marshall?

8 A. The consequences are a problem
9 because the consequences were brought by the
10 diagnosis and treatment that she received for
11 the time she saw Dr. Dodds, inadequate
12 investigation of what she had.

13 Q. Well, how did Dr. Dodds -- I mean,
14 he missed the opportunity to continue
15 evaluating a trend that you think is moving
16 upward that would have moved farther upward in
17 six months --

18 A. He didn't --

19 Q. Let me finish my question -- to
20 make a greater discrepancy that would have
21 heightened the clinical suspicion for doing the
22 test that you suggested, and if that would have
23 been the case and those tests would have been
24 done, under your theory, he would have
25 identified the light chains, and he would have

1 started treatment sooner.

2 A. I totally disagree with what you
3 just said. I testified that on the basis of
4 the first two visits and the review of the
5 records by Dr. Roane, the information was there
6 to act differently. That's a very clear
7 statement he didn't need to wait until the
8 fourth visit and another six months to see what
9 happened. There was enough information that he
10 received from Dr. Roane and his knowledge of
11 the visit that he -- when he saw her in '99,
12 plus the clinical circumstances, to know that
13 further investigation was indicated.

14 Q. And if he and other physicians
15 disagree with your interpretation of the
16 evidence of this case, would you agree that
17 there was not an opportunity to continue
18 evaluating the patient's proteinuria when she
19 failed to come back to the office?

20 A. I'm so run around with all your
21 questions, I don't know how to answer anymore.

22 Q. Do you want to take a break?

23 MR. ELLIOTT: Yeah. If you don't
24 mind -- like I said, it's about 15 until. I'm
25 going to call a cab here in a minute. Is that

1 okay?

2 MR. HOOD: Well, I want to make the
3 physician to be comfortable answering the
4 questions, so yeah, let's take a break, and we'll
5 come back.

6 MR. ELLIOTT: What I'm saying is,
7 Jamie, I have to leave at 4:00.

8 THE WITNESS: Just go on. I'm all
9 right. I'm all right.

10 MR. ELLIOTT: I mean, we can finish
11 it up later. I'm just saying I think I need to
12 leave somewhere around 4:00 to get to the airport.

13 BY MR. HOOD:

14 Q. In your affidavit, sir, you
15 mention the prescription of Diovan as an ARB
16 and potential problems connected with overflow
17 proteinuria; is that right?

18 A. Diovan doesn't work on overflow
19 proteinuria of light chains.

20 Q. And that doesn't have anything to
21 do with this case because there was a cancerous
22 tumor or bone marrow, correct?

23 A. Yeah. I'm testifying that this
24 kind of proteinuria doesn't respond. The
25 action of ARBs and ACEs is on the glomerulus,

1 and the glomerulus wasn't to blame here.

2 Q. In paragraph six, sir, you state
3 there that the patient experienced acute renal
4 failure most likely caused by an allergic
5 response to antibiotics?

6 A. Yeah. When I saw all the details,
7 I thought that NSAIDS were more likely, but I
8 did testify to you that I couldn't exclude
9 antibiotics.

10 Q. So which is it?

11 A. Well, I think, based on the
12 knowledge that I have now, that it's most
13 likely the NSAIDS. But there's no question
14 what the diagnosis was. It was acute
15 interstitial nephritis with acute renal failure
16 responding briskly to steroids. In many
17 circumstances with acute interstitial
18 nephritis, unless a patient was using a single
19 drug, you can't really be sure about it. Now,
20 there were multiple drugs here, and I've
21 explained numerous times that because of the
22 syndrome and the proteinuria, that I think it
23 was most likely the NSAIDS, but I couldn't
24 exclude antibiotics.

25 Q. I understand, but when you were

1 under oath and you swore before the notary
2 public into this affidavit, you said it was a
3 response to antibiotics.

4 A. Yes, I said that then. I'm now
5 saying -- the diagnosis hasn't changed. The
6 responsible drug is more probably NSAIDS, but
7 it may have been both. I think it's highly
8 likely to have been NSAIDS.

9 Are you suggesting I was lying when I
10 said antibiotics?

11 Q. I'm suggesting that you said one
12 thing in your affidavit and you're saying
13 something different today.

14 A. Well, I disagree with that
15 statement describing what I've said totally.

16 Q. Well, tell me where in your
17 affidavit you make reference to ibuprofen.

18 A. I don't think I mentioned it. I
19 was wrong. I should have mentioned it.

20 Q. Okay. So it's fair to say that
21 you're saying something different today than
22 you did in your affidavit?

23 A. I'm not saying something
24 different. The basic diagnosis is the same. I
25 just think because I now know that there was

1 six grams of protein on careful review of the
2 chart, that that would make nonsteroidals more
3 likely.

4 The key thing in what we're talking
5 about in relation to this patient is was there
6 anything in that initial illness that would
7 explain three or four grams of protein some years
8 later, and there is not. That's the key matter of
9 this case.

10 Q. Doctor, I mean, in all fairness,
11 you had this chronology, which we have marked
12 as Exhibit No. 6, in the time that you prepared
13 the affidavit, and the chronology was prepared
14 by the lawyers who hired you, correct?

15 A. It was prepared by this lady. I
16 don't know who it is.

17 Q. Okay. But it was provided to you
18 by the lawyers, right?

19 A. Yes, yes.

20 Q. All right. And on page 5 of that,
21 it says over six grams of protein were being
22 excreted on collection completed by July 18th,
23 right?

24 A. Look, I didn't lie. I thought the
25 antibiotics initially. On reviewing my things,

1 I now think that nonsteroidals are more likely.
2 I still think it's possible it was the
3 antibiotics, but the syndrome including this, I
4 think it's more likely NSAIDS. It's a trivial
5 point.

6 Q. I don't think anything that's
7 sworn under oath is trivial, sir.

8 A. I gave my opinion then. On
9 further reflection, I think it's likely that it
10 was the NSAIDS, but in terms of whether it was
11 NSAIDS or antibiotics, the key thing is the
12 biopsy showed the glomeruli being normal.
13 That's where the kidney leaks protein.
14 Therefore, we had no reason for the proteinuria
15 later, and we had to start again. It was a
16 different disease, a different situation. And
17 that's my testimony, and that's -- that's it.

18 Q. You started the deposition by
19 explaining that you had recently reviewed and
20 were made available the 1999 medical records,
21 correct?

22 A. Yeah. They were the last ones
23 that I got, yeah.

24 Q. And you suggested that in the
25 review of that, you learned about the six grams

1 of protein, which changed your opinion from
2 antibiotics to ibuprofen.

3 A. Well, maybe I thought more about
4 it, but -- I don't know to tell me you. I may
5 have made a mistake blaming the antibiotics.
6 When I testified today, I still said the
7 antibiotics are still possible. I just thought
8 it was more likely, having thought about it,
9 for the six grams. I'm not a perfect human
10 being, as my wife tells me frequently.

11 Q. But the six grams is referenced in
12 the summary of the medical records.

13 A. I understand what you're saying.
14 What's your point?

15 Q. Is that a true statement, yes or
16 no?

17 A. Is what a true statement?

18 Q. That the reference to six grams
19 was in the summary available to you --

20 A. Yes, it's in the summary. I think
21 I've read about 1,000 pages of stuff in this,
22 and if I missed that at that time, then I
23 missed it. I can't remember, and I think
24 that -- I'll testify again that it's more
25 likely that it's nonsteroidals than the

1 antibiotics. And if I said the antibiotics
2 before, I think that the second opinion was
3 better. I say again it's irrelevant to the
4 overview of the case.

5 Q. Would it be irrelevant, the cause
6 of the proteinuria in 1999, if you're
7 evaluating whether this patient took ibuprofen
8 afterwards and did not have this event?

9 A. I know she took ibuprofen -- well,
10 she took various nonsteroidals afterwards, and
11 I -- I don't know which kinds there were, how
12 much she took or anything. There's -- nobody,
13 I think, is denying that this lady had acute
14 tubulointerstitial nephritis, biopsy proven.

15 Q. Let's see. Let me tell you the
16 page number. Looking at page 5 of your
17 affidavit, in the last bullet point on that
18 page --

19 A. If the routine urine test --

20 Q. The bullet part starts off on
21 February 9th, 2005.

22 A. Oh, you're not talking about my
23 affidavit. You're talking about --

24 Q. I'm still -- I'm on your
25 affidavit.

1 A. Oh, it is on the affidavit. Item
2 five?

3 Q. No, it's -- it's page 5 of your
4 affidavit.

5 A. Oh, I'm sorry. Right.

6 Q. It's the last bullet point. You
7 say Dr. Dodds continued to prescribe Diovan
8 even after his noting there was no significant
9 change in the plaintiff's protein from the
10 prior test in November 2004.

11 A. Yeah.

12 Q. Okay. I want to -- I'm curious to
13 know, when you say after noting that there was
14 no significant change, what are you referring
15 to?

16 A. Well, I'm talking about the four
17 grams that we just discussed in detail.

18 Q. And are you familiar with any
19 aspect of Dr. Dodds' note where -- or his
20 medical records where he states that -- or
21 notes that the Diovan was not providing any
22 significant changes?

23 A. No. I'm interpreting the lab
24 findings in such a fashion. If you're going to
25 follow up to find if this was a real increase

1 or not, I would have followed up in a month.

2 Q. Okay. But it's not accurate to
3 say that Dr. Dodds noted that there was no
4 significant change in the plaintiff's protein.

5 A. I agree -- I can't say what
6 Dr. Dodds' intentions were. I agree with that.

7 Q. All right. And then the next
8 sentence, it says that Dodds continued to
9 prescribe Diovan without properly monitoring
10 the plaintiff's response to the medication
11 constitutes negligence. Do you still stand by
12 that opinion?

13 A. Yes. Not the issue of her failing
14 to come back. I've already said to you that if
15 he thought -- well, we don't know if she had
16 fever, but if the upper respiratory tract
17 infection was the cause of it going from three
18 five to four one, you don't have to wait six
19 months for that. Again, the issue is -- I
20 can't restate it. You know what my opinion is.

21 Q. My question has nothing to do with
22 the plaintiff yet. My question has to do with
23 whether Dr. Dodds failed to monitor her
24 response to the medication.

25 A. Six months is too long. If he

1 felt that four point one was related to the
2 recent upper respiratory tract infection and he
3 was concerned that it was increasing despite
4 the treatment, I would have done it in a month.

5 And again, that's not my principal
6 complaint. It's that the first two visits were
7 enough to indicate other actions.

8 Q. Well, isn't it fair to say that
9 every time the patient came to see Dr. Dodds,
10 he had evaluated her proteinuria levels?

11 A. Yes.

12 Q. And when he's doing that, isn't he
13 monitoring the response she's having to the
14 Diovan?

15 A. Yes.

16 Q. And so every time that she is seen
17 by Dr. Dodds, he's monitoring her response to
18 the Diovan?

19 A. Yes.

20 Q. And your criticism is that because
21 he didn't order her to come back within one
22 month, he was negligent?

23 A. That is not -- I have said ten
24 times that during the first two visits, he was
25 outside the standard of care without following

1 up for the diagnosis of the proteinuria. The
2 other business about responding to Diovan is a
3 relatively minor element of the whole thing.

4 Q. It might be minor to you, but
5 you're not the defendant in this case. So with
6 all due respect, sir, I asked if you stand by
7 this opinion, and you say that you do?

8 A. Which opinion? Which opinion are
9 you talking about?

10 Q. The same sentence we've been
11 reading on page 5 of your affidavit where you
12 say that the fact that Dr. Dodds continued to
13 prescribe Diovan without properly monitoring
14 the plaintiff's response to the medication
15 constitutes negligence.

16 A. I have told you that he should
17 have done -- he should have asked her to come
18 by or else just bring in a urine specimen in a
19 month if he really thought that the reason it
20 was up was the infection.

21 Q. And you think it constitutes
22 negligence to ask her to come back in six
23 months instead of one month?

24 A. I think it -- it's not the main
25 negligence, which I've stated 100 times. It's

1 a minor component of it, but the main thing,
2 I've stated.

3 Q. Is it -- do you believe that that
4 issue has nothing to do with the ultimate issue
5 in this case?

6 A. Well, obviously when I said the
7 first two visits were enough information for
8 further studies to be done, I think that's the
9 main evidence.

10 Q. Then why did you include this in
11 your affidavit?

12 A. Well, I -- in my opinion -- in my
13 opinion, she had no response to the Diovan.
14 Now, I understand the arguments against that.
15 I'm saying the only way to refute that argument
16 is to do it again soon because if it really had
17 no other reason just than the disease to go
18 from three point five to four point one or four
19 point two, then -- then it is an increase.

20 Q. It was three point 0, wasn't it?

21 A. Oh, whatever you say. Look, I've
22 been testifying for five hours, and we've been
23 round and round and round and roundabout. I
24 don't know what you're after.

25 Q. Three point 0 was in February of

STATE OF SOUTH CAROLINA) COURT OF COMMON PLEAS
)
 COUNTY OF CHARLESTON) CASE NO.: 2011-CP-10-2587
 VIRGINIA L. MARSHALL AND)
 TODD W. MARSHALL,)
)
 Plaintiffs,)
)
 -vs-)
)
 GEORGIA ROANE, M.D. AND)
 RHEUMATOLOGY ASSOCIATES, P.A.,)
)
 Defendant.)
)
)

Monday, September 16, 2013

Oral Discovery Deposition of THOMAS M. ZIZIC, M.D., taken pursuant to notice, was held at the law office of Young Clement Rivers, LLC, 25 Calhoun Street, 4th Floor, Charleston, South Carolina, 29401, commencing at 1:00 P.M., on the above date, before Judy W. Galuppo, Professional Court Reporter and Notary Public for the State of South Carolina.

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1 present, or you're just not sure?

2 A I'm not sure.

3 Q All right. But in the context of
4 Dr. Roane's question and answer with Mr. Elliott in
5 this sequence on Page 97, the lymph nodes that are
6 being discussed are approximately described as
7 1-centimeter; correct?

8 A Right. I agree with that, yeah.

9 Q And that's small; correct?

10 A Yes.

11 Q You wouldn't necessarily biopsy a
12 1-centimeter lymph node; correct?

13 A Depends upon on all the things that --
14 not be the first thing I do anyhow, they're a lot
15 simpler tests. But I don't think persistent
16 lymphadenopathy over a period of time, which is what
17 was transpired here, in the context of proteinuria
18 cannot be disassociated. You've got to be thinking
19 that a lymphoma, Waldenstrom's kind of situation,
20 the paraproteinemia might be occurring in this
21 situation because you already know there's protein
22 in the urine. You don't have to look for protein in
23 the urine. There's protein in the urine. So find
24 out if it's Bence-Jones protein. What's so hard
25 about that? Just order the test.

1 always a lot easier. And so would I have in the
2 same position done that initially? Pretty close to
3 initially if not initially.

4 Q Let me ask it this way. In your
5 opinion, did the standard of care require a checking
6 of Waldrenstrom's or lymphoma in May of 2000 based
7 on everything that was known at that time?

8 A I want to be fair to Dr. Roane. So I
9 don't know that I can say. I'm going to give her a
10 pass on that initially because it was done in the
11 hospital. And so I don't know that it's fair to say
12 that it should have been done in the initial visit.

13 After it was clear that this was a
14 persistent problem in terms of elevated sed rate,
15 low complements and no antibodies to explain it, at
16 that point paraproteinemias have to be considered,
17 including Waldrenstrom's.

18 Q Did those findings, or lack thereof,
19 rule out an autoimmune disease? The low
20 complements, the no antibodies? The things that you
21 listed as a basis for suspicion of Waldrenstrom's,
22 are those not also consistent with an autoimmune
23 disorder?

24 A They are, except that she didn't have
25 the specific clinical manifestations nor the

1 antibodies that one would expect to see in an
2 autoimmune phenomenon. And that's classically the
3 kind of situation where, with low complements and
4 evidence of inflammation, we would expect a
5 paraproteinemia.

6 Q Isn't that --

7 A And we teach our medical students and
8 our fellows that all the time. You know, you can't
9 stay in your box of rheumatology, although it's a
10 big box and we have a lot of diseases in there.
11 When things don't fit over a period of time, you're
12 following them and they still don't fit, well, then
13 you've got to go outside your box a little bit and
14 say, hey, it may be a paraproteinemia that I'm
15 looking at because they can cause the same kind of
16 symptoms constitutionally, nonspecific and low
17 complements and inflammation and no autoantibodies
18 that you can detect.

19 Now, if you do and we find a
20 cryoglobulin, it may be with an IGM rheumatoid
21 factor or some other autoantibody as part of that
22 cryoglobulin or as part of that macroglobulin, but
23 if you don't look for it, find it, you can't tell.

24 Q But isn't that the genesis of mixed
25 connective tissue disorder or undifferentiated, is

1 that it's not neatly packaged?

2 A No. No, no, no. No, no, no. In fact
3 mixed connective tissue is a distinct specific --

4 Q All right. Undifferentiated.

5 A Undifferentiated again is -- and
6 Dr. Roane said it perfectly well on Page 52: It is
7 some of the symptoms but not classical and the
8 antibodies aren't present.

9 Okay? So some of the symptoms are ones
10 we would see in a connective tissue disease along
11 with a lot of other disease like paraproteinemias or
12 like other malignancies or some chronic infections,
13 et cetera, et cetera. So you see some of the things
14 that you would see in a connective tissue disease
15 but not enough to make a clinical diagnosis, and
16 then you're lacking laboratory corroboration of
17 that. Now the combination of that leaves a lot to
18 be desired in terms of making a diagnosis that you
19 treat from.

20 Q But it is -- undifferentiated connective
21 tissue disorder is a diagnosis in the field of
22 rheumatology?

23 A Oh, I couldn't agree more, yes.

24 Q All right. All right.

25 A But it's something that we put there to

1 make sure it's undifferentiated connective tissue
2 disease. We got to keep -- and she said it again in
3 her deposition: We follow these patients to see how
4 these things evolve over time.

5 But we got to see how they evolve not
6 just in the patient but how they evolve in the
7 laboratory. And that part of the follow-up was
8 overlooked for some reason.

9 Q And how they evolve clinically as well?

10 A Yeah, but it didn't change.

11 (At this time there is a brief break in the
12 deposition.)

13 BY MR. SCOTT

14 Q Let me clarify something. I said
15 earlier I think that the SPEP was done in '99. It
16 was actually done in 2000 right before she was --

17 A Yeah, I saw it in Dr. Roane's records.
18 I can tell you exactly when it was done. I meant to
19 put -- I didn't have a sticker. That was one of the
20 things I wanted to ask for, a sticker. But yes, I
21 did see that, and it was -- it clearly was in
22 Dr. Roane's lab studies here.

23 Q And that's fine. I mean you're welcome
24 to look for the date. But the point is, I wanted to
25 clarify that it was even closer in time to

1 Dr. Roane's initial evaluation than I represented.
2 But I think we agreed in the end of our discussion
3 that you were not testifying that the standard of
4 care required another SPEP when she was first
5 evaluated by Dr. Roane; correct?

6 A That is correct. She also had an SPEP
7 by Dr. Minnick in March of that year.

8 Q Yes. All right.

9 Now, going back to my last line of
10 questioning, you agree that part of the evaluation
11 over time is the clinical evaluation of the patient?

12 A Yes.

13 Q In other words, how are they doing, how
14 are they doing with my therapy, is it working, is it
15 not working. That's a key part of any physician,
16 whether you're a rheumatologist or a family doctor's
17 evaluation; correct?

18 A That is correct.

19 Q All right. And do you agree -- and I'm
20 going to try to do this with broad strokes, but if
21 we need to go page by page, that's fine too, it
22 doesn't matter, but...

23 A I'm not going page by page. I have
24 about 20 and we're down to the third one.

25 Q Well, I'm going to come back to that.

1 But since we're talking about this evaluation over
2 time, do you agree with me, in general, that the
3 patient reported good response to Dr. Roane's
4 therapy beginning with the initial medication
5 therapy, transitioning into the Imuran and then
6 eventually the Cellcept, but overall the patient
7 reported a good response to those medications?

8 A I don't think there's any basis to say
9 that.

10 Q All right. Well --

11 A I mean a patient feeling better is one
12 thing from nonspecific constitutional symptoms, but
13 when your sed rate remains persistently elevated,
14 the protein in the urine doesn't change and the
15 complements are still low, that's not a response, a
16 specific response to the treatment.

17 Q Right. You're talking about the lab
18 values and such. My line of questioning was really
19 about the clinical response to the therapy.

20 A You know, our diseases, and
21 paraproteinemias vary so that people from time to
22 time may feel better, may feel worse. If you're
23 asking me do I think that the treatment, we'll have
24 to go by treatment, then, and by each day, because
25 I've taken each of her visits and summarized them,

1 I'll be happy to tell you where I think it did or
2 didn't help with some of the nonspecific clinical
3 symptoms. But did it change the underlying disease
4 or did it make -- was she treating something
5 specifically, first of all, I'm not sure.

6 If she was treating undifferentiated
7 connective tissue disease, and we have nonspecific
8 clinical symptoms that would indicate treatment,
9 that would not necessitate treatment with Imuran or
10 Cellcept, then what are we treating? And the only
11 answer you could possibly give me that has any
12 creditability is that I'm trying to see if I can get
13 whatever is happening to decrease the complements,
14 to stop decreasing the complements, and therefore
15 the inflammation to be decreasing. And there's no
16 evidence that that did that.

17 So I need something more than
18 touchy-feely to tell me that this patient was
19 improving. I mean, people can feel better from day
20 to day, and part of it, we get our patients, we're
21 following them on a regular basis and, yeah, I feel
22 a little bit better today.

23 Q All right. I'm going to try my question
24 again. I think we already established that for any
25 type of physician following patients clinically that

1 an important aspect of their evaluation and
2 treatment is based on clinical response over time to
3 various therapies, we agreed with that in general;
4 correct?

5 A We do.

6 Q All right. Dr. Roane in this case was
7 treating the patient over time with various therapy,
8 medications; correct?

9 A Correct.

10 Q Part of being a good physician is to
11 follow the patient on those therapies and see how
12 the patient responds to the therapy; correct?

13 A Yes.

14 Q Part of that involves talking with the
15 patient. And I'm not suggesting it's the only thing
16 you would do, but part of the evaluation is to talk
17 with the patient and say, how are you doing, how
18 does this medication seem to be working, and get a
19 subjective report back from the patient to see how
20 they seem to think they're doing on the medication.
21 That's part of the evaluation; grant me that?

22 A I agree.

23 Q All right. And that was done based on
24 the clinical records in this case; correct?

25 A That part of it, yes.

1 Q All right. And you would agree, would
2 you not, that the records suggest that both with the
3 Imuran and the Cellcept the patient reported a good
4 response to the medication?

5 A You'll have to be more specific as what
6 parts of her complaints seem to be a good response.

7 Q Okay. Did the patient report
8 subjectively that she was not suffering any side
9 effects from either the Imuran or the Cellcept?

10 A Yes.

11 Q Did she report feeling like both -- now
12 I'm talking about -- I'm trying to lump all this
13 together. But these were different times, because
14 she was taking the Imuran at one point; right? And
15 then the Cellcept at a later time; correct?

16 A Yes.

17 Q But did she report on both, with regard
18 to both medications, that she felt like the
19 medicines were working at various times, they were
20 helping with her feelings of myalgias and
21 arthralgias?

22 A Well, at times, yes.

23 Q All right. Did Dr. Roane -- did you
24 note that the -- and I'm going to mispronounce it,
25 the rash that she had, the malar rash?

1 A Malar rash.

2 Q That cleared; correct?

3 A Yes.

4 Q And that rash, is that something that's
5 known to occur in conjunction with an autoimmune
6 disorder?

7 A It can.

8 Q All right. Did you ever find that
9 Dr. Roane recorded objective fevers in any of her
10 records that the patient was suffering?

11 A No. Subjective fevers.

12 Q Did ever note Dr. Roane reporting any
13 rigors or chills during the therapy that she was
14 providing for Ms. Marshall?

15 A Patient didn't transmit that.

16 Q All right. And for the most part over
17 time the arthralgias and fatigue resolved, for the
18 most part over time?

19 A Well, I don't know. Dr. Dodds saw her
20 in September 15th, 2004, documented that the patient
21 was having myalgias, shortness of breath, right
22 chest pain, pleurisy, right flank pain and some
23 joint pain.

24 Q Right. I'm not suggesting it went away
25 totally. And then they did adjust the medication at

1 some point. But for the most part, those complaints
2 were held at bay; correct?

3 A I think her general constitutional
4 complaints waxed and waned somewhat. And it
5 wouldn't surprise me with the anti-inflammatory
6 effect of these medications, as well as
7 immunosuppressive effect, that there may not be some
8 improvement.

9 Q And one way for a physician to assess
10 whether a medication is working is to get reports
11 back from the patient to see how they're doing on
12 the medication, that's one way.

13 A Very important.

14 Q All right. You're not testifying that
15 there was some report from the patient that
16 Dr. Roane just missed or misread -- in other words,
17 there was nothing you found in the chart to suggest
18 that the patient was causing some adverse effect or
19 was not working properly but Dr. Roane just missed
20 it?

21 A No, I'm not saying that.

22 Q All right. Are you testifying that
23 there was some new or different symptoms that
24 developed over time that should have led Dr. Roane
25 to suspect her initial diagnosis was incorrect?

1 A Well, not new, but just persistent
2 despite treatment with Imuran and Cellcept,
3 persistent elevation of sed rate, persistent
4 decrease in C3 and C4.

5 Q And those cannot be seen persistent even
6 with therapy in an autoimmune disorder?

7 A Well, now we're adding another very
8 improbable scenario. We're saying that she didn't
9 have all the manifestations of a connective tissue
10 disease, she didn't have any of the antibodies that
11 we associate with a connective tissue disease, and
12 she's not -- and these are -- and has objective
13 evidence of inflammation with a sed rate and these
14 aren't responding to the medications that we would
15 use for lupus. Or as Dr. Roane had said also in her
16 deposition, I was basically treating a lupus,
17 seronegative lupus kind of patient that I labeled as
18 an undifferentiated connective tissue disease.

19 Now, I mean, that's sort of the gestalt
20 of what I put. And I may not -- I don't want to put
21 words in her mouth. That was sort of the way I read
22 what she was saying.

23 I don't have a problem with that
24 initially. I think that's a very reasonable way to
25 think about things initially. My problem is, when

1 you continue to see that over a period of years,
2 then it's not new symptoms. It's the persistent
3 despite -- I'm treating what I think I'm treating
4 and it's not responding the way I think, and it's
5 not classical in the first place. I'm sorry. I
6 have a problem with that.

7 Q Let me ask you about that. One of the
8 issues you have is the sedimentation rate not
9 responding as well as you think it should to the
10 medications. That's one of the concerns you have;
11 correct?

12 A Correct. She's on full dose of Imuran,
13 150-milligrams for a prolonged period.

14 Q There was some response to the sed rate,
15 would you concede that point? Maybe not an ideal
16 response, but there was some response?

17 A I don't know that you can say that.
18 Because sed rates can vary because of other things
19 in addition to what's causing them to be elevated.
20 And yeah, I mean, it wasn't the same but it was
21 always elevated.

22 Q All right.

23 A It never, even with treatment, got back.
24 And as I showed you even in 2004 or '5 it was 102
25 again. It mean it's in a very high range that makes

1 you say, wait a minute.

2 Q But that 102, that was a bit of an
3 outlie; right? I mean, she had bronchitis going on,
4 was on antibiotics at that point.

5 A I grant you that.

6 Q All right.

7 A Okay. But there was a lot of 60's and
8 70's around that, and a couple ones that were a
9 little lower. But in general they were above 50,
10 which is a cutoff most of us use for that's a very
11 high sed rate.

12 Q Okay. All I'm asking is when you're
13 treating someone, a complicated patient, you've got
14 a working diagnosis of a connective tissue order, is
15 it your testimony that an elevated sed rate, in
16 spite of medication therapy, is grounds to throw out
17 your diagnosis or to second guess the diagnosis? In
18 other words, can you not see a chronically elevated
19 sed rate in spite of therapy in an autoimmune
20 disease or connective tissue disease?

21 A Well, it's not that simple again.
22 Because if you put in conjunction with that the
23 continuation of a low C3 and C4, then that, in
24 conjunction causing or associated with the elevated
25 sediment rate, elevated sedimentation rate, without

1 the antibodies that the immune complex with
2 autoantibodies that would activate the complement
3 system makes you think of a paraproteinemia.

4 And I'm not criticizing that it wasn't
5 Waldrenstrom's. I mean, you'd be looking for
6 cryoglobulins. You're looking for other
7 macroglobulins. But you need to verify do these
8 other autoantibodies, have they developed or
9 emerged? Is that why it's still and it's just a
10 refractory disease? That's a possibility. But when
11 the antibodies aren't present, the complements still
12 low and the sedimentation rate is still high,
13 despite treating my working diagnosis, then I've got
14 to reconsider my working diagnosis and look a little
15 further and be a little more aggressive in terms of
16 my diagnostic approach.

17 Q All right. Let me try to get back on
18 track. I was asking you about criticisms that you
19 plan on offering. Do you have any other criticisms
20 of Dr. Roane that you plan on testifying about at
21 trial?

22 A Yes. 120, Page 120.

23 Q Okay.

24 A Just my statements here on Line 14 and
25 down. She is aware that in addition she has a

1 persistently elevated sed rate and low complement
2 level. So it wasn't like it was -- she had been
3 thinking about this.

4 Q But that's not in and of itself
5 diagnostic of lymphoma.

6 A No, no. It's not diagnostic of
7 lymphoma. But in the absence of autoantibodies it
8 makes you think that it's -- I've got to think about
9 whether something else other than autoimmune disease
10 is going on here, like an undifferentiated
11 connective tissue disease.

12 Q Well, doesn't -- isn't part of this when
13 you're doing that, isn't part of your evaluation
14 looking back on the fact that this patient had just
15 been worked up extensively in a recent history for
16 cancer, and however you want to put it, but the
17 tests that were run could not find any cancer?
18 Isn't that part of her analysis, is thinking back,
19 okay, well, the patient was worked up extensively in
20 '99, 2000, and basically filtered down to me by
21 process of exclusion, so I already know that in the
22 back of my mind that these tests have been run and
23 it's not there so I'm starting to work with that
24 knowledge to figure out what's going on, isn't
25 that -- shouldn't that give her some level of

1 comfort when she's evaluating this patient over
2 time?

3 A Well, and that's why I'm giving her a
4 pass, basically, at least no criticism on my part of
5 the very early on treatment because she has recently
6 had an extensive workup. So I don't criticize her
7 from day one not making this diagnosis of a
8 relatively rare disorder. And by the way, I mean
9 relatively rare because it's not just
10 Waldrenstrom's, it's the other things, the
11 cryoglobulins that are part of the paraproteinemia
12 thing.

13 But when you go on, continue to treat
14 the patient, and no other specific clinical symptoms
15 lead you to a specific connective tissue diagnosis,
16 and when no autoantibodies emerge over time, then
17 you've also got to consider that other things can
18 emerge. That we got to follow patients for all of
19 those things, for everything we should be following
20 that is in our broader view. We looked at that in
21 the past, she didn't have evidence of that back in
22 '99 and 2000, I grant you that, okay? But she
23 didn't have evidence of a specific connective tissue
24 disease or didn't have specific autoantibodies
25 either.

1 So as we follow the patient we got to
2 follow for all three things: Is there evidence of
3 connective tissue disease developing? Is there
4 evidence of autoantibodies developing? Or is there
5 evidence of other manifestations from another
6 disease, laboratory or otherwise?

7 Q Well, let me -- at the risk of repeating
8 everything we've talked about the last hour and a
9 half, I think we agreed early on that at the time
10 she hit the door with Dr. Roane, it was reasonable
11 at that time to Dr. Roane to suspect a connective
12 tissue disorder; fair?

13 A As her working diagnosis.

14 Q Right. All right. And she did that
15 with the knowledge that the patient had a history of
16 proteinuria and an elevated sedimentation rate;
17 correct?

18 A And low complements.

19 Q All right. Are you testifying that
20 something changed to where that was an unreasonable
21 working diagnosis? Or what is it that changed from
22 being reasonable at point A to unreasonable at point
23 B?

24 A Well, clearly what changed is that over
25 a period of a number of years no other evidence in

1 favor of a connective tissue evolves, no antibodies
2 are detected that are in favor of an autoantibody
3 disease or autoimmune disease. And in 2001,
4 April -- well, August, August of 2000 Imuran was
5 added and then increased in April of 2001, and in
6 February of 2002 increased again to 150.

7 So starting in August of 2000, April of
8 2001 and February of 2002, now at 150 milligrams of
9 Imuran, we're treating this presumed
10 undifferentiated connective tissue disease with one
11 of the very potent agents and over a period of eight
12 months in going to its maximum dose and nothing's
13 changing.

14 Q Well, the patient's reporting changes
15 for the better; correct?

16 A Fine. Fine. I told you that has
17 nothing to do with being able to make a specific --
18 what I'm saying is, any objective parameter you look
19 at, the protein in your urine didn't change, the sed
20 rate didn't change, the complements did change. I'm
21 maximally treating this working diagnosis from
22 August of 2000 up to 2003, and then I shift her in
23 August of 2003 to Cellcept and I'm going to another
24 medication, and she has got no change in any
25 objective laboratory parameters.

1 Q So you feel like she should have started
2 suspecting cancer or Waldrenstrom's because the sed
3 rate did not come down sufficiently and there
4 weren't antibodies present, is that the gist of it?

5 A No. You're missing my whole point. So
6 let's go once more.

7 Q Okay. I think I got your point.

8 A Maybe. I'm sorry then. I'm sorry.

9 Q At what time in time did she start --

10 A But you didn't give me a complete. I
11 gave you a number of things, and you're giving me
12 only a part of them back. So let me give you all of
13 them if you want an answer to that.

14 What I'm saying is, we start in August
15 of 2000, okay, treating with a very potent agent,
16 Imuran, a working diagnosis of undifferentiated
17 connective tissue disease. And over the next period
18 of a year we go increasing the doses, and I get -- I
19 don't see any antibody tests that show us that we
20 have a connective tissue disease at that point. The
21 complements are still low, which you did not mention
22 in your question to me. The sed rate is still
23 elevated. And the urine protein is unchanged,
24 basically. Now that I'm not as critical of because
25 urine protein can be a fixed protein leak from

1 previous damage. We know that it gets worse in time
2 later when she gets some renal function changes.
3 Which apparently Dr. Roane didn't appreciate because
4 she states they weren't present when she says it in
5 her deposition, we'll get to that, but they're
6 clearly there.

7 So we've got a number of things going
8 on, and they don't improve with specific treatment
9 for the connective tissue disease which is the
10 working diagnosis.

11 Q They don't improve at all?

12 A The things I just mentioned.

13 Q Right. And your opinion, the sed rate
14 didn't improve at all?

15 A The sed rate remained persistently very
16 elevated.

17 Q Okay. All right. You mentioned
18 earlier, and we'll go back to the deposition in a
19 second, but you mentioned earlier that you didn't
20 really get concerned about Dr. Roane's, the way she
21 was treating the patient until '03; do you remember
22 that testimony?

23 A Well, I mean I'm very critical at '03.
24 I'm critical at the point where she goes to maximal
25 Imuran in February of '02, 150 milligrams, and still

1 things don't change in terms of the laboratory
2 parameters we've been talking about.

3 Q And so as early as '02 you're saying
4 that --

5 A February of '02.

6 Q -- because of the lack of significant
7 changes with regards to the laboratory data,
8 Dr. Roane should have been second guessing the
9 diagnosis; is that what you're saying?

10 A Not second guessing. Should be looking
11 at what potentially is going on here. Not second
12 guessing in saying that she's wrong. You would
13 still keep connective tissue disease in your
14 differential diagnosis, but it may not any longer
15 justify being your working diagnosis.

16 At that point you go back to the drawing
17 board and you re-workup this patient totally.
18 Totally. You don't sit back and just say, hey, I've
19 done it two years ago. This is 2002. I've been
20 treating her for what I think she has, and the
21 abnormalities are still there, they're not classical
22 for what I am treating and so I better look at what
23 other potential things are going on.

24 I'm not trying to be brutal here or take
25 it out on anybody. I'm just saying that's my

1 opinion that in 2002 I would once I -- I wouldn't
2 have -- but if I did -- I'm trying to be as
3 objective as possible here. If I say up until the
4 time where you go to maximal Imuran, which I
5 wouldn't have done, but if you do and it still
6 hasn't changed, then at that point you've got to
7 re-workup the patient. You can't say, I did it
8 once, I'm never going to do it again. Because this
9 is dynamic, it's going on, it's evolving, and you've
10 got to see. Is it evolving into a connective tissue
11 that I'm going to see down the road. Maybe I'll see
12 the antibodies before I see the clinical
13 manifestations. Is it a paraproteinemia that wasn't
14 present back then? Just like the antibodies weren't
15 present back then.

16 Q What would the re-workup include, in
17 your opinion? What would need to be done to -- you
18 say rework the patient, what are we talking about?

19 A Well, a whole complete antibody profile:
20 ANA, anti-DNA, single-strand, double-strand, ENA,
21 RNP, SM, RO, LA, p-ANCA, c-ANCA, and we can go on.
22 But that's basically the antibodies I do. I would
23 be looking at -- I would get an SPEP, I would get a
24 UPEP, because I've got proteinuria which I know, and
25 I've got these low complements which I don't have an

1 explanation for. So I've got to go back through
2 this.

3 Q Do you have an opinion as to whether the
4 SPEP or the UPEP would have revealed anything by
5 this point?

6 A I do.

7 Q You think it would have?

8 A I would. I do.

9 Q Waldrenstrom's or something that --

10 A Some abnormality that would lead you to
11 do a bone marrow biopsy and go forward.

12 Q Why do you believe it would have been
13 discoverable as early as February of '02?

14 A Because she's now been treated with
15 maximal doses with a year, and I think it's a little
16 longer than a year. Let me make sure I'm correct
17 here. She was started on Imuran in August of '11 --
18 of 2000, August 11, 2000. And it was increased in
19 February 27, 2002. So in that approximately
20 18-month period, year and a half, she still has low
21 complements and high sed rate. And at that point I
22 think you would have demonstrated that there was a
23 paraproteinemia causing this and not an
24 undifferentiated connective tissue disease.

25 Q Okay. Are you -- and so you believe

1 part of your expert opinion is that as far as that
2 February 2002 that Dr. Roane breached the standard
3 of care by not doing a re-workup of the patient?

4 A Yes. A reconsideration of where she was
5 in the treatment of the patient.

6 Q All right. You mentioned 2003 to me
7 earlier. Was that just a slip of the tongue or is
8 there something else in '03 that caught your --

9 A Well, there was something else in '03.
10 August of '03 she shifted from Imuran to Cellcept.
11 And again you're now shifting to another specific
12 drug for connective tissue disease without doing the
13 workup.

14 So if that -- again, a workup should
15 have been done. I'm saying Imuran has failed and
16 I'm going to go to Cellcept, before I do that I'm
17 going to do another workup.

18 Q Which would be define the same -- the
19 workup would be the same thing you told me before?

20 A Yeah.

21 Q And you believe that was --

22 A And more depending upon what you find.
23 I mean, that's just the screening test that you'd be
24 doing.

25 Q Okay. But you, I presume, based on what

1 you told me from February of '02, if a re-workup
2 were done in August of '03, you believe it would
3 have discovered -- it would have led you to
4 discovering the true underlying illness, the
5 lymphoma?

6 A Yeah.

7 Q And you believe that was a breach of the
8 standard of care, that failure to re-workup in
9 August of '03?

10 A I do. I mean, you're shifting from
11 Imuran to Cellcept and you haven't really -- there's
12 nothing to change in the patient that, you know,
13 you're treating the protein in the urine.

14 Q Okay. All right. Let's go back to our
15 list and just keep going down the list of concerns
16 that you have outlined in the deposition.

17 A 130. And by the way, some of these may
18 just be --

19 Q I understand. Yeah, I mean, if
20 they're -- if it's just a comment but not a
21 criticism, we may just move right on to the next
22 one. So let's just see what you have.

23 A On Page 129: Certainly if there were
24 component, she says in her answer.

25 Do you normally refer to someone else to

1 treat that particular disease?

2 And they're talking about the active
3 interstitial nephritis.

4 Okay. Answer on Page 129, Line 19:
5 There's an initial workup for that disease to
6 determine what caused it. And certainly if there
7 were a component of renal insufficiency --

8 And she's cut off a little bit.

9 Uh-huh.

10 -- a nephrologist would follow her
11 frequently for this.

12 Question: Right. Did she have, over
13 the years that you saw her, a complement of renal
14 insufficiency?

15 And she says: Never.

16 And that's not true.

17 Q Is this what you mentioned earlier? I
18 think you mentioned something.

19 A Yeah, the creatinine clearance, when we
20 look at it --

21 Q Just tell me what you're referring to.

22 A Yeah, I will. Her creatinine clearance
23 on 6/9/03 was 82.2. And normal is 92 to 132.

24 Q Bear with me for one second. Give me
25 the date again.

1 A 6/9/03, Roper Main.

2 Q 89.2?

3 A What?

4 Q Did you say it was 89.2?

5 A No, 82.2.

6 Q Oh, I'm sorry.

7 A Then there was another creatinine
8 clearance in here that was low. I think it was even
9 a little lower, but I got to find that for you.

10 Q Well, do you mind if I talk about that
11 one first? I mean I'm happy for you to find the
12 second one. What's the significance of this low
13 creatinine clearance to you?

14 A Well, you know, at least it indicates
15 that there's two possible reasons. You can have it
16 from an inadequate collection.

17 Q Okay.

18 A She had 1100 cc's of urine there on that
19 24-hour. Or because the kidney in the 24-hour
20 period isn't able to excrete sufficient creatinine,
21 and so -- because the glomerular function has gone
22 down. And in this situation it can be indicative of
23 something, immune complexes or paraproteins that are
24 interfering with glomerular filtration.

25 Q Well, did the creatinine clearance

1 laboratory findings.

2 Q Well, do you agree that sometimes you
3 have to diagnosis based on a process of exclusion?

4 A Yes.

5 Q Do you agree that the records reflect
6 that after being put on the Imuran Ms. Marshall
7 reported being less fatigued, not as achy and
8 reported no side effects?

9 A Yes.

10 Q And she reported on more than one
11 occasion, after being put on Imuran, that she was,
12 quote, unquote, feeling better?

13 A Yes.

14 Q That she reported at various times that
15 she was, quote, doing well, end of quote?

16 A Yes.

17 Q Do you agree that after she was switched
18 to Cellcept she felt like she was doing better with
19 the Cellcept and she was not having much trouble
20 with joint pain?

21 A Yes. That's what she stated.

22 Q Right. That's her subjective report,
23 yes. At some point, as you know, Dr. Roane sent
24 Ms. Marshall over to Dr. Dodds for a consult for the
25 chronic proteinuria?

1 A Yes.

2 Q And that was reasonable to do?

3 A Absolutely.

4 Q Did you agree with me earlier that the
5 protein creatinine ratio is a comparable measure
6 with the 24-hour urine; do you agree with that?

7 A Twenty-four hour protein?

8 Q Yes.

9 A It's got comparability, yes.

10 Q And you would agree that Dr. Roane
11 continued to monitor the proteinuria?

12 A Yes. But not the kidney function
13 necessarily. I think 24-hour urine would have been
14 at least yearly with the creatinine clearance would
15 have been desirable.

16 Q The only abnormal creatinine clearance
17 that you've been able to identify, today anyway, is
18 that one from June of '03 that you told me about
19 earlier?

20 A Yes.

21 Q All the other ones, with the exception
22 of this possible second one that you can't identify,
23 but you'd agree all the other creatinine clearance
24 were normal?

25 A Yeah. There weren't many. There were

1 about two or three others. By the way, so I don't
2 forget. Is this one of mine?

3 Q I gave you your original back.

4 A Did you?

5 Q Yeah, it's right -- that's it right
6 there. Your hand's on it. Isn't that it?

7 A No.

8 Q Oh, I'm sorry.

9 A That's my report.

10 Q All right. We'll find it before we
11 leave. You can have this one for now, but I should
12 have the original somewhere.

13 All right. We've gone through the
14 deposition and talked about the points of interest
15 where you had concerns about certain aspects for
16 testimony. Is it fair to say that you attempted to
17 note the instances where you disagreed with her
18 testimony? That was the exercise that you
19 undertook; correct? Where you listed those various
20 pages and underlined?

21 A Well, I tried to understand what she was
22 thinking and doing. But yes, I mean, basically I
23 was more for understanding of something that was
24 beyond what was on the paper or notes.

25 Q Are there any other criticisms of

1 Dr. Roane that we have not yet discussed that you
2 plan on testifying about at trial?

3 A I do not believe so.

4 Q As you know, she was treated by
5 Dr. Roane for a period of time from around 2000 to
6 2007?

7 A That's my understanding.

8 Q Were there any other points along the
9 time line of events that you have particular
10 concerns? You've identified a couple, 2002, 2003.
11 Were there any other points in time along that
12 spectrum that you believe you're going to be
13 particularly critical of?

14 A Well, I think just like we take care of
15 our patients with annual exams, physicals, and we're
16 more appropriately doing that than their internists
17 in patients with systemic rheumatic diseases such as
18 an undifferentiated connective tissue disease. And
19 so most rheumatologists will yearly do a more
20 complete evaluation with laboratory studies,
21 particularly when there's some features that are
22 atypical and may not be fitting with our normal
23 patients have. So I would say from 2004, 2005,
24 2006, 2007 she should have had yearly exams looking
25 at the laboratory studies we've been talking about

1 until you come to a definitive diagnosis. Which
2 never happened.

3 Q All right. Anything else? I'm just
4 trying to get a comprehensive list. Anything else
5 other than that additional criticism, if you will,
6 of this yearly reassessment?

7 A Yeah.

8 Q Is that it?

9 A No. That's it.

10 Q And you understand I'm just trying to
11 make sure I don't hear something new or different at
12 trial. That's why I'm giving you every opportunity
13 to add to this list.

14 A Well, if I've forgotten something, he'll
15 tell me, he'll ask me about that at the end, I'm
16 sure. But none that I can think of right now. Of
17 course, after four hours or three-and-a-half hours
18 I'm a little fried.

19 Q You have given me some testimony about
20 points in time where you believe the cancer was
21 there. I'm going to ask it a slightly different
22 way. Do you contend to -- or do you have an opinion
23 as to when the cancer first became detectable?

24 A Not anything other than what I said
25 earlier. I think after a year and a half of Imuran

1 STATE OF SOUTH CAROLINA
2 IN THE COURT OF COMMON PLEAS
3 COUNTY OF CHARLESTON

4 - - -

5 VIRGINIA L. MARSHALL and : C/A No. 2011-CP-10-934
6 TODD W. MARSHALL, : and 2011-CP-10-4057
7 Plaintiffs, :

8 vs. :

9 KENNETH A. DODDS, M.D., :
10 CHARLESTON NEPHROLOGY :
11 ASSOCIATES, LLC, and :
12 GEORGIA ROANE, M.D., :
13 Defendants. :

14 - - -

15 Monday, July 29, 2013

16 - - -

17 ORAL DEPOSITION of BARRY L. SINGER, M.D., taken
18 at 1544 DeKalb Pike, Norristown, Pennsylvania,
19 scheduled for 11:00 a.m., commencing at 11:15 a.m.,
20 before Gina E. Scheetz, Registered Merit Reporter,
21 Certified Realtime Reporter, Certified LiveNote
22 Reporter, Certified Shorthand Reporter, Licensed
23 CaseViewNet Realtime Provider and Notary Public.

24 - - -

25

1 for identification.)

2 BY MR. WILSON:

3 Q And have the opinions set
4 forth in this Affidavit changed in any way?

5 A No.

6 Q These still represent your
7 opinions in the case?

8 A It's still my opinions that if
9 she had had the SPEP and UPEP in 2005 or
10 2004, her course would have been different,
11 yes.

12 Q You think if she would have
13 had the UPEP -- and by "she," Ms. Marshall?

14 A Mrs. Marshall, um-hmm.

15 Q -- had the UPEP or the SPEP in
16 2004 it would have shown Waldenstrom's?

17 A Yes, because she had the high
18 protein in the urine. I believe that was
19 from the Waldenstrom's. It wasn't as
20 advanced as it was in 2010, and I'll go into
21 that later during the dep, I'm sure.

22 Q But your opinion to reasonable
23 medical certainty is probably if they would
24 have done a test in 2004 it would have shown
25 Waldenstrom's?

1 A Yes, sir.

2 Q All right. Did you do any
3 research or anything into this case?

4 A Not specifically, no, sir.
5 I -- I'm a hematologist. My knowledge of
6 Waldenstrom's and macroglobulinemia goes
7 back. I'd have to review anything specific,
8 no.

9 Q So when we go to try this
10 case, as we sit here today, you don't have
11 any intention of bringing any articles or
12 publications to trial?

13 A No, sir.

14 Q Okay. I would just ask you
15 that if you do or if you're asked to do that
16 by any of the attorneys that you let your
17 attorneys know so that they can let me know
18 so that I can get a copy of them. Okay?

19 A Okay.

20 Q What we have is you've got
21 your file here with you that I appreciate.

22 MR. WILSON: Carter, he's got
23 several chronologies and statements
24 of facts and time lines. I want to
25 mark all three of these separately.

1 A In my career, probably 15, 20.

2 Q And that's in about 40 years?

3 A In 40 years, yes, sir.

4 Q And the last one you would
5 have treated, approximately, would have been
6 about five years ago?

7 A Four or five years ago, yes,
8 sir.

9 Q Okay. Without telling me the
10 patient's name, obviously, tell me about
11 that patient. What was the presentation?

12 A That patient I think had a
13 hyperviscosity syndrome. He had a stroke,
14 and they checked him up, worked him up and
15 found he had an abnormal protein, and they
16 sent him over for me to stage him and work
17 him up and treat him, and we treated him
18 with some chemotherapy. Unfortunately,
19 there's no cure for the disease, and it
20 progressed over a period of time. He
21 eventually succumbed to it, but he lived
22 four or five years.

23 Q What is the average life
24 expectancy for a patient diagnosed with
25 Waldenstrom's?

1 A It depends on the type. Some
2 have what we call a smoldering type and they
3 don't produce a lot of protein. They don't
4 have organ involvement. They just have the
5 abnormal finding of the IgM protein
6 elevation. Those can live a normal life.

7 Then there's others who have
8 progressive disease, and despite whatever
9 you treat them with, it's -- the protein
10 increases and they usually get a
11 complication, like a stroke or an infection,
12 which is common because they don't have
13 normal immunity and they succumb to those
14 things, and that's usually within a few
15 years.

16 Q Have you made a determination
17 of the type that Mrs. Marshall has, whether
18 it would be considered smoldering or
19 progressive?

20 A Well, smoldering doesn't have
21 to be treated. Hers needed to be treated
22 because she had the high sed rate and she
23 was symptomatic and she was producing ten
24 grams of protein by that time, so you want
25 to prevent renal failure and renal shutdown,

1 so you would treat her.

2 Others that have less
3 aggressive disease you can watch and wait.
4 I've done that, but most -- most, if they're
5 symptomatic when they present, have to be
6 treated.

7 Q Okay. And I guess the flip of
8 that would suggest that if a patient that
9 has Waldenstrom's is not symptomatic with
10 it, you probably wouldn't begin treatment?

11 A Correct.

12 Q And what is your understanding
13 of the basis of that?

14 A Only because, one, it's like
15 low-grade lymphoma. They're not fully
16 curable, so why expose them to chemotherapy
17 or any treatment? Even though today we have
18 monoclonal antibodies, we don't have to use
19 them right away.

20 Once the patient has organ
21 involvement or is symptomatic, then you have
22 to treat because it's usually progressive
23 after that.

24 Q Okay. What is your
25 understanding of how Mrs. Marshall's

1 physical condition is currently?

2 A The last note I read from
3 Doctor Orcutt, her oncologist/hematologist,
4 I think was in '11, and she seemed to be
5 stable at that point. I mean, her disease
6 was progressive because she was still
7 getting the Velcade, but she was functional,
8 and not examining her myself, that's all I
9 can say. I mean, I've seen patients like
10 that, you know, do reasonably well for a
11 period of time.

12 Q Okay. Since Doctor
13 Orcutt's -- I'm going to give you some
14 medical records. If you could just -- I bet
15 they are marked.

16 A Um-hmm.

17 Q If you could just tell me the
18 last note you relied on from Doctor Orcutt
19 to give you your understanding of Ms.
20 Marshall's current condition.

21 A Okay. I think these are older
22 ones from Orcutt. The original ones are --
23 yeah, that's through September 2010.

24 I did have a drop -- they
25 drop-boxed me some other records that had a

1 response to treatment would have been much
2 better if she had been treated earlier.

3 Q All right. And Mr. Scott
4 represents Doctor Roane, so I'm sure he'll
5 have questions. I want to save some for
6 him.

7 A Sure.

8 Q But I guess as we sit here
9 today, there's no -- that you're aware of,
10 there's no evidence that the failure to
11 diagnose Waldenstrom's in 2004 for Ms.
12 Marshall has led to any complications;
13 correct?

14 A Thus far.

15 Q Okay. Let's take a two-minute
16 break.

17 A Sure.

18 - - -

19 (Whereupon, there was a short
20 recess.)

21 - - -

22 BY MR. WILSON:

23 Q Doctor Singer, if you could
24 pull out your Affidavit if you have a copy
25 of it and we can work through it.

1 your opinions haven't changed other than
2 what's in this Affidavit?

3 A Correct.

4 Q Okay.

5 A I've had more opinions
6 certainly since I have had a chance to
7 review other records, but my opinions, as
8 stated there, haven't changed.

9 Q Sure.

10 All right. The first opinion
11 in Paragraph 4 is, "Based on my review of
12 the records, it is more likely than not that
13 the plaintiff had cancerous protein in her
14 urine beginning in February 2005 when she
15 treated with Doctor Kenneth Dodds and this
16 cancerous protein could have easily been
17 identified by performing a UPEP and/or SPEP
18 tests"; correct?

19 A Yes.

20 Q We established earlier that
21 you're aware that Mrs. Marshall saw Doctor
22 Dodds in September of 2004?

23 A Yes, sir.

24 Q And it would be your testimony
25 that she had cancerous protein in her urine

1 at that time as well?

2 A I believe she did.

3 Q And it would be your opinion
4 that Doctor Dodds failed to diagnose the
5 cancerous protein at that time as well?

6 A Yes, sir.

7 Q Okay. Is there a reason why
8 you didn't include September 2004 on your
9 Affidavit?

10 A No, sir.

11 Q Were you asked to start your
12 opinions in February of 2005 for any reason?

13 A I don't know, sir.

14 Q You don't know whether you
15 were asked to do that?

16 A No. No.

17 Q Okay. Because Paragraph 5
18 specifically talks about the urine
19 collections from February 7th of 2005, but
20 doesn't mention September of 2004.

21 A Well, she had elevated protein
22 all the time she was seeing Doctor Dodds.
23 It dropped a little from 4-something,
24 dropped down to 3-something and went back up
25 again --

1 Q Okay.

2 A -- but I don't think it
3 differs that significant. It just meant
4 that she had abnormal protein.

5 Q All right. Do you think she
6 had cancerous protein in 1999?

7 A No. I think she had a SPEP
8 then and that was negative.

9 Q And you're aware that she had
10 proteinuria four or five years prior to 1999
11 as well?

12 A Yes. She had the episode of
13 interstitial nephritis, which I don't think
14 had anything to do with her Waldenstrom's.

15 Q And what time frame are you
16 talking with that?

17 A When she was admitted to the
18 hospital in 2000, I think.

19 Q All right. She was also --
20 when she first saw Doctor Dodds was 1999.

21 A Oh. That -- excuse me. It
22 was 1999, when he saw her in the hospital
23 for that episode.

24 Q Okay. You said you thought
25 she had a touch of interstitial nephritis in

1 1999?

2 A I think that's what the
3 diagnosis was at that time and brought on,
4 perhaps, by medication. I don't know. But
5 she had electrophoresis then and it didn't
6 show up, so I would say she didn't have the
7 macroglobulin then.

8 Q Do you know what her diagnosis
9 became from Doctor Roane?

10 A Oh, she had it when she saw
11 Doctor Roane. After she left the hospital,
12 she was diagnosed with a mixed --

13 Q Connective tissue disorder?

14 A Disorder, yes.

15 Q Which was believed to be the
16 basis of the proteinuria in 1999?

17 A In retrospect, but I think she
18 saw Doctor Barfield in the hospital, and he
19 felt that she had no connective tissue
20 disorder, so I'm not sure where Doctor Roane
21 got the diagnosis from.

22 Q Okay. Where did you get the
23 diagnosis of -- you said something about you
24 believe it could have been the medications
25 causing this.

1 A Well, that's one cause of
2 interstitial nephritis, antibiotics, NSAIDs.
3 I don't know what caused it. I mean,
4 apparently, she responded to steroids, did
5 well and that was it.

6 Q Okay. How does it affect your
7 opinion, if any, if there's indications that
8 Mrs. Marshall had proteinuria as early as
9 '95?

10 A '95?

11 Q Yes, sir.

12 A I don't know what the cause of
13 that was. If she had a normal SPEP, then
14 that pretty much rules out an IgM clone.
15 She didn't have -- I don't think she had a
16 UPEP back in '99. I think it was a serum
17 electrophoresis, if I recall.

18 Q Yes, sir. And I just asked
19 'cause you mentioned Doctor Barfield?

20 A Yeah.

21 Q Doctor Barfield has a note
22 from July 17th, 1999, that says five years
23 ago -- "Five to six years ago attended a
24 weight loss clinic where she was told she
25 had proteinuria. No follow-up regarding

1 this since then."

2 A That's the only mention that
3 we have of that, so I -- I really don't know
4 what to make of it.

5 Q Okay. Does it affect your
6 opinion in any way?

7 A No, no.

8 Q All right. Well, as -- okay.
9 Prior to this deposition, were
10 you aware of that?

11 A Oh, yeah. I read Doctor
12 Barfield's note.

13 Q All right. And you're aware
14 that there was a biopsy done in 1999?

15 A Correct.

16 Q And what did the biopsy show?

17 A It really didn't show much.
18 It didn't show any evidence of a glomerular
19 disease. I think it just showed what they
20 thought she had, interstitial nephritis.

21 Q All right. And it shows no
22 deposition of immunoproteins?

23 A Correct.

24 Q What's the --

25 A It would --

1 Q I'm sorry. Go ahead.

2 A No. There wasn't any evidence
3 on the biopsy either, no.

4 Q Okay. If Mrs. Marshall would
5 have had Waldenstrom's in 1999, what would
6 the biopsy have shown?

7 A It doesn't damage the kidney,
8 per se, and so you wouldn't see any
9 glomerular disease. You might see increased
10 casts, but that's usually in multiple
11 myeloma. I don't know what you would see.
12 I haven't read biopsies or seen biopsies
13 done on patients with IgM disease, so I
14 don't know.

15 Q All right. Well, let's go to
16 the SPEP test that you referenced.

17 A Um-hmm.

18 Q She had an SPEP done?

19 A Right.

20 Q And what did the SPEP show?

21 A I think it showed a normal
22 neural electrophoresis.

23 Q And no monoclonal bands?

24 A Correct. Now, if she had
25 disease then and didn't have a monoclonal

1 band, it could have been because it was just
2 developing a few years later, you know, the
3 abnormal colon, but it wasn't -- obviously,
4 she didn't have active disease or any
5 disease if the SPEP was negative.

6 Q All right. You said it could
7 have been. You don't know that.

8 A No, no. I said, obviously, it
9 developed sometime after that.

10 Q All right. And there's some
11 visits in between '99 and 2004 with Doctor
12 Roane, and I'll leave those for Mr. Scott to
13 deal with, but as we get to September of
14 2004, that is the first time Doctor Dodds
15 sees Mrs. Marshall. Are you aware of that?

16 A Yes, yes.

17 Q All right. And you said it's
18 more likely than not that she had
19 Waldenstrom's in September of '04.

20 A Sure. She had been on the
21 Cellcept and the Imuran then I believe for a
22 period, and now I believe the disease was
23 more active.

24 Q What forms the basis of that
25 opinion?

1 A Because she had the real high
2 proteins. When you do a 24-hour urine for
3 protein and you only have -- I think Doctor
4 Luke explained it in his deposition better
5 than I can. He's a nephrologist -- there's
6 a disparity between the protein test and the
7 dip stick, and what actually you collect in
8 24 hours, you're obviously looking for some
9 abnormal protein in the urine, and I believe
10 if that had been done, an SPEP then or UPEP,
11 she would have been diagnosed with her
12 disease.

13 Q The basis of your opinion that
14 you think she has Waldenstrom's in September
15 of 2004 is because she has elevated
16 proteinuria?

17 A No. She had an elevated
18 24-hour urine. She had that done each time
19 I think she saw Doctor Dodds, if I'm not
20 mistaken, and all of them were elevated.

21 They weren't as high as they
22 were five years later at 10 grams, but she
23 had 3 and a half and 4 grams, and I believe
24 she had limited disease then, was continued
25 on the Imuran and the Cellcept for a period

1 And you were talking about
2 signs and symptoms. In fact, the notes you
3 have from Doctor Orcutt as late as November
4 of 2011, you testified she didn't have any
5 complications at that time?

6 A At that time, no.

7 Q And that would have been
8 either from liver, kidney or spleen;
9 correct?

10 A Correct.

11 Q All right. So if she didn't
12 have it in 2011, would you have presumed she
13 didn't have it in 2004 or 2005?

14 A I would agree.

15 Q Okay. So the only reason if
16 anybody -- if any oncologist in North
17 America would have started Waldenstrom's on
18 Ms. Marshall, it would have been for her
19 proteinuria?

20 A Yes, sir.

21 Q And isn't there also
22 literature out there to suggest that the
23 mortality rates for patients treated with --
24 early for Waldenstrom's as opposed to
25 treated later in the diagnosis for

1 type of symptoms can cause an elevation in
2 proteinuria?

3 A Increased, but not to 4, but
4 they might cause it to change a little from
5 the 3 to 4, but not to cause 4, correct.

6 Q I understand that, but it
7 could have caused the --

8 A Change?

9 Q -- change from 3.5 to 4?

10 A Yes.

11 Q And it would have been
12 reasonable to assume that it could have been
13 the result of --

14 A It could have, yes.

15 Q All right. And as far as the
16 times when Doctor Dodds sees her, the four
17 times in 2004 and 2005, her proteinurias
18 while she's seeing him are relatively
19 stable. Would you agree with that?

20 A Correct.

21 Q And as far as his -- the times
22 he saw her in 2004 and 2005 as compared to
23 1999, not much has changed; correct?

24 A Correct.

25 Q And in 1999 and up until she

1 mixed connective tissue disease which they
2 believe caused the proteinuria in '99 --
3 okay?

4 A Well, that's the point -- the
5 point I have is that she should have been
6 worked up again. I mean, I don't know how
7 many times I have to reiterate that.

8 The mixed connective tissue
9 disorder, in my opinion -- I mean, whatever
10 the rheumatologist felt or was, fine, but
11 when you see a patient, look at what Doctor
12 Price -- I mean, that's what -- the patient.

13 Q That it should have been done?

14 A The point is, when you see
15 this much protein in the urine, it's so easy
16 to do a test. One little test. I mean, a
17 blood test or anything, and you make the
18 correct diagnosis. That's all I'm saying.

19 Q Now -- and I understand
20 that and this being one little test, but
21 what I asked you 90 seconds ago was that it
22 was reasonable to rely on the diagnosis of
23 mixed connective tissue disease and you said
24 yes.

25 A I said that whatever Doctor

1 Q The standard of care in
2 medicine does not require perfection;
3 correct?

4 A Correct.

5 Q You gave a percentage of your
6 work that's plaintiff versus defense.

7 Is the large majority of your
8 defense work done within a 2 or 300-mile
9 radius of your practice area?

10 A It's in Pennsylvania. I think
11 most of that would be within 2 or 300 miles,
12 yes, sir.

13 Q Okay. So fair to say --
14 saying it another way, if I were to ask you
15 how much of your work outside of the State
16 of Pennsylvania is dedicated to plaintiff's
17 work versus defense work, would it be closer
18 to 95 than a hundred percent plaintiff?

19 A Yes, sir.

20 Q Did you give us earlier -- and
21 I apologize. I really am trying to cut out
22 some of these questions, but did you give us
23 earlier an average life expectancy for
24 someone with Waldenstrom's disease?

25 A I said that they could live

1. several years after diagnosis depending on
2 how advanced it was.

3 Q Okay. What does that -- I
4 mean, is there a way to be any more specific
5 about that?

6 A Not really, 'cause it
7 depends -- every disease -- every patient is
8 different. If they present with
9 hyperviscosity, they'll probably only live a
10 year or two, if they live that long.

11 If they present with
12 polyneuropathy, they can live longer if
13 that's their worse side effect. It depends
14 on what organs are involved, 'cause every
15 patient is different.

16 On the average with myeloma,
17 we say six to ten years is the longest.
18 With Waldenstrom's, it's probably four or
19 five years.

20 Q Okay. So according to the --
21 at least the average that you gave me, Ms.
22 Marshall, she's beating the average life
23 expectancy right now if you assume, as
24 you -- if I take your -- your position that
25 she's had the disease back in the mid 2000s,

1 she's outlived the average life expectancy?

2 A Well, I wouldn't put it that
3 way because you have to go from diagnosis.
4 Her course would have been different, but
5 considering that she did have the disease,
6 she has lived five years, yes.

7 Q All right. Bear with me.
8 I'm -- I'm getting there. (Reviewing.)

9 MR. SCOTT: I apologize for
10 the delay, everyone. I'm getting
11 close. I'm just looking over a bunch
12 of different materials. (Reviewing.)

13 BY MR. SCOTT:

14 Q Doctor, you don't -- do you
15 agree that she did have the interstitial
16 nephritis in 1999?

17 A I already said that twice,
18 sir.

19 Q Sorry.

20 A Please.

21 Q Have you attempted to
22 determine whether she could have had an
23 ongoing chronic aspect of interstitial
24 nephritis for any extended period of time
25 after the hospital?

Exhibit 5 to Dr. Singer Deposition

TIMELINE

VIRGINIA MARSHALL

Week of 07-07-14, 1999 Develops flu symptoms and a fever that worsens. Goes to see Dr. Milton Costa as a walk-in and after having tests performed believes she has a viral infection and is sent home.

7-9-99 Has CBC performed which shows hemoglobin is 12.8

7-12-99 Has CBC performed which revealed a change in hemoglobin at 11.8

White blood cell count on July 12 was 8.5 with very minor leftward shift; platelets 274,000. Metabolic panel performed on July 12 revealed CO2 depressed at 20, creatinine elevated at 1.5, albumin low at 3.0. LFT's were normal. Other electrolytes were normal. Calcium was normal. A urinalysis was performed on July 9 and was normal.

Returns several times that week because she wasn't any better and her fever was getting higher.

07-12-99 (?) Has chest x-ray ordered by Dr. Costa and it came back normal

She is referred to Dr. Katherine Minnick because he didn't know what it was. By this date her fever is 104 constantly with chills/rigors

07-14-99 Sees Dr. Minnick.

She is admitted to Roper Hospital by Dr. Minnick in an attempt to capture an organism and observe her pattern of rigors. Other labs to be obtained include chemistries, a CBC, sedimentation rate, CRP, and monospot. Additional blood cultures will be obtained with rigors or elevated temperatures.



Admitting diagnosis

7-16-99

Nephrology consultant, Dr. Kenneth Dodds was brought in to the case

7-17-99

- Renal ultrasound performed which revealed bilateral enlarged kidneys without hydronephrosis.
- CT Scans without contrast were performed to include abdominal and pelvic scan. The only finding was a small amount of ascites on the pelvic CT and lower abdominal CAT scan
- Sinus CT and neck CT scans were performed with no active process uncovered.
- Additional serologic workup was undertaken. Rheumatoid factor was negative. ANA negative. P-ankh and C-ankh negative, RPR negative. Sed rate at admission was quite high at 143. C-reactive protein also quite high at 35.

Renal biopsy was performed and initial review was performed by Dr. Sally Self at MUSC.

Dr. Carlisle Barfield called for consult because of "hectic fevers, marked inflammatory response and renal failure; WBC and platelets not elevated, please give opinion." history states that 5-6 years ago Ms. Marshall attended a weight loss clinic where she was told she had proteinuria. There was no follow-up on this.

7-18-99

Proteinuria has been detected on urinalysis and was quantitated on 24-hour urine collection and over six grams of protein was being excreted on collection

Labs ordered by Dr. Minnick

Creatinine- 24-hour urine

-	24 hr. tot. vol	3150
-	U Creat mg/dL	29.8
-	U Creat gm/24 hr.	0.9

Protein - 24 hour urine

-	U protein mg/dL	194.8 H
-	U protein 24 hr.	6136.2 H
-	24 hr. total vol.	31.50

7-26-99

Discharged from Roper Hospital

Discharge Diagnosis(es)

- Acute renal failure
- Tubulo interstitial nephritis of uncertain etiology
- Febrile illness of uncertain etiology
- Anemia induced by the underlying process

Procedures:

- Renal biopsy on July 20, 1999
- Transfusion of packed red blood cells July 18 and July 19, two units

07-29/99

Follow-up with Dr. Minnick. Diagnosis: Acute Renal Failure

Continued follow-up appointments with Dr. Minnick. Many more tests were performed and refers her to an ENT doctor for swollen glands in her neck/collar bone area (these swollen glands come and go) (Client's Diary)

8-1-99

Calls Dr. Minnick as she was out of Prednisone and had developed fevers and myalgias as she had had in the past.

8-2-99

Resumes 10 mgs of Prednisone and is still on it. Creatinine is still at 2.0

8-5-99

Ms. Marshall sees Dr. Minnick and has no specific complaints.

Labs ordered today -- repeating Ehrlychia and Salmonella serologies. Will drop back her Prednisone to 5 mgs for the next 12 days until her next visit.

8-24-99

Sees Dr. Minnick. Diagnosis: Lymphadenopathy, FUO, renal insufficiency

Lab work: CBC, BMP, SED rate

Dr. Hoy examines her and says he doesn't know if the glands are swollen or it could be fat pads in her neck.

09-02-99

He orders a CT scan of her neck. The CT is negative.

She is released by Dr. Minnick

03-14-00

Goes to see Dr. Costa (general medical) because she hadn't been feeling well and wanted to see what could be done about all the weight gain she was experiencing from the steroid medications.

Blood work was done and he refused to treat her because her SED rate was too high. She was told to go back to Dr. Minnick.

SED rate	105	H	0-20
RDW	14	H	11.5-14.5
B/C Ratio	0.90	L	1.00-2.20

3-31-0

Follow-up with Dr. Minnick. Diagnosis: Fatigue, myalgias, fevers

Lab work: RF, ANA, SPEP, UA

March-May 3, 2000

Reports that she felt her health had gradually returned to baseline. Beginning in Jan or Feb. she has been having 4-5 episodes per month of fluish syndromes with intermittent fevers which go up to 100, feels achey, tired and has myalgias, but no headaches. She describes that she has dry eyes. Feels some fullness in her lymph nodes is fluctuating, never to the degree that it was last August. She feels that her skin is dryer than it was last August. She has no joint pains, but has occasional backache. No recurrence of pain in her hips. She has no rashes, but does have macular distribution of acneiform lesions over the face. Dr. Costa did a lipid panel, CBC and CMP. All were within normal range. TSH was also normal. Sed rate was performed on March 10 and 18th and was 105 and 97 respectively. She brings with her a copy of her 8-96 labs indicating 1+ protein on urine dipstick with trace blood.

Obtains a rheumatoid factor and ANA and see if they are finding progression of a syndrome that can be better identified. Also having urine checked to assess for ongoing presence of protein and a serum protein electrophoresis looking for any clues regarding the nature of this inflammatory response.

4-17-00

Sees Dr. Minnick. She is feeling somewhat better these last two weeks. She is having some trouble with her teeth.

Diagnosis: Fatigue, myalgias, fevers

The left supraclavicular fossa is somewhat full without discrete adenopathy. Shoddy anterior cervical adenopathy present - non-tender, non-fixed, not hard but rubbery. She has evidence of some periodontal disease, but no evidence of frank infection. She continues to have acneiform type lesions in a malar distribution.

Rheumatoid factor and ANA from 3-31 returned negative. Serum protein electrophoresis was performed. Interpretation indicates relative elevations of beta complement regions without monoclonal protein. Urinalysis last time indicates 1+ protein on dipstick testing. 24-hour urine has not been done she was hospitalized last year.

Performed testing to include ANCA sytoplasmic and peripheral, quantitative immunoglobulins, complements including CH-50, C3 and C4, cryoglobulins, a sed rate and a peripheral smear. Will put in reserve the assessment of her abdomen with contrasted CT scan and possible bone marrow.

			Normal Range
IGG (MG/DL)	675		613-1295
SED rate	117	H	0-20
RFP	1.6	H	0.0-0.9
C3	6.74	L	86.0-184.0
C4	<10		19.7-58.9
CH 50(CAE)	59		48-153
PROT 3	<2		<2
MYELOP	<6		<6

5-3-00

Follow-up visit with Dr. Minnick. She asks if she would be willing to go back to a Rheumatologist. She agrees and an appointment is to be set up with Dr. Georgia Roane.

Labs: CBC w/diff, CMP send to Roper

05-12-00

Sees Dr. Roane and has some labs done.

Urinalysis

- Protein 100*

05-16-00

Mrs. Marshall is referred to Dr. Roane from Dr. Minnick

06-06-00

Sees Dr. Roane again

Is sent back to see Dr. Dodds for treatment of constant proteinuria. Dr. Dodds gives her a prescription for Diovan saying it would help with her kidney filtration.

Dr. Roane agrees to keep writing the prescription renewal for the Diovan as long as it was okay with Dr. Dodds.

During these years, she has many infections: kidney, bladder, and respiratory in which she needed antibiotics.

She decided to have a regular physician for general health issues and began seeing Dr. Beth Hughes (internal medicine). She knew about the autoimmune disease and proteinuria and the doctors that she was seeing. She did various labs and tests over the years, but didn't address the proteinuria. She is her doctor until 2009.

06-09-00

Sees Dr. Roane. She is feeling much better and the rash has improved as well as the arthralgias. She has not had a temperature in the past week or two and her mood and degree of fatigue are also much improved. She started feeling better within about a week of beginning medicines from her last visit.

PE: She still has some erythematous papules on the right cheek and the doctor continues to feel right and left small cervical nodes

Plan:

- Continue Plaquenil and Prozac
- SED rate is 112, compliment levels are pending
- Follow-up in 2 months

8-11-00

Sees Dr. Roane. She is still tired. Feels she has fluid in her ear; UTI symptoms cleared; no joint pain. SED rate 110.

Impression:

- UCTD
- UTI -- resolved

- D/C'd smoking
- Imuran

Plan:

- Continue Plaquenil 400 QC
- Use OTC decongestants
- Continue Prozac
- ??
- WSR, creatinine
- Come back in 2 months

10-11-00

Sees Dr. Roane. She is feeling better with Plaquenil, but fatigue is still a problem.

Impression: Undifferentiated connective tissue disease. She still is not feeling well and has run a SED rate of greater than 100 on her last two visits

Plan:

- Try Prednisone 10 mg QD to see if this helps, whether or not her SED rate is decreased and whether or not it causes any side effects. The next visit the dose will either be decreased or substituted with another medicine.
- SED rate is 88, which is improved
- Continue Plaquenil and Prozac
- Follow-up in 4 weeks

10-26-00

Sees Dr. Roane. She is taking Prednisone. Tired, but can't sleep.

Plan:

- CBC, CMP, CWSR
- Discontinue Prednisone
- Tylenol, Sudafed
- Continue Plaquenil
- Continue Prozac

11-08-00

Sees Dr. Roane. She says she felt better 4 days after stopping Prednisone. She still feels fatigued, but otherwise doing okay.

Impression: Undifferentiated connective tissue disease. Fatigue is her primary complaint. We have discussed questions and issues which she has raised, which include DHEA therapy, which I do not recommend at this time, and

issues about diet of which the doctor has no particular opinion

Plan:

- Continue Prozac and Plaquenil
- Follow-up in 2 months

1-09-01

Sees Dr. Roane. She is still fatigued. She has good days and bad. SED rate is 88.

Impression: HCTD -better on Plaquenil; depressed.

Plan:

- Try Prozac 40 gd
- Try Imuran 50 gd
- Continue Plaquenil 400 gd
- WSR
- 4 weeks

2-08-01

Sees Dr. Roane. She is feeling better and is less fatigued. She has had no side effects with Imuran

Plan:

- Increased Imuran to 100 mgs. A day
- Continue Plaquenil and Prozac
- SED rate is 75 and CBC shows a minimal anemia with hemoglobin of 11.9. Creatinine is pending
- Follow-up in 4 weeks and may repeat a urinalysis at that point.

4-18-01

Sees Dr. Roane. She feels like she is doing fine. A little more tired this past month. She did not take much of the Meridia due to the cost.

Impression: Last blood work showed urinalysis with only 30 mg of protein. SED rate is 72. Creatinine is normal at 0.8. Compliment levels were slightly low with C3 at 71 and C4 at less than 10.

Plan:

- Continue Imuran, can increase to 150 if needed and continue Plaquenil
- CBC and SED rate and follow-up in 6 weeks.

8-29-01

Sees Dr. Roane. Overall she is doing well.

Impression: Recent laboratory studies show a creatinine of 0.6, albumin 3.9, and normal CBC with a hemoglobin of 11.8

Plan:

- Continue Imuran 100 mgs but can be increased if she has a flare up. Continue Plaquenil, Prozac and aspirin
- Follow-up in 3 months

11-28-01

Sees Dr. Roane. She is doing well and feels as though she may be getting back to normal.

Plan:

- Continue Imuran, Plaquenil, Prozac and Aspirin
- SED rate is 80; CBC shows a hemoglobin of 11.8 which is good. Creatinine, complement levels and urinalysis are pending.
- Follow-up in 3 months

1-10-02

Letter from Dr. Boatwright -- Ophthalmologist -- to Dr. Roane who states he has examined Ms. Marshall and there is no evidence of Plaquenil toxicity. She is to return in 6 mos.

2-27-02

Sees Dr. Roane. She has been doing okay, but having a little more fatigue and achiness, specifically in the middle of her menstrual cycle.

Impression: Undifferentiated connective tissue disease. She is becoming a little more symptomatic.

Plan:

- Increase Imuran to 15 mgs q day
- Stay with Plaquenil and Prozac
- SED rate is 93 and CBC shows a mild anemia with a hemoglobin of 10.5 and white count of 5.4. Complement levels, creatinine and urinalysis are pending.
- Follow-up in 3 months.

5-22-02

Sees Dr. Roane. She is doing better although she has had a little trouble with some symptoms through the ears, but started taking Sudafed

Plan:

- Continue Imuran, Plaquenil and Prozac

- SED rate is 71 and CBC shows hemoglobin of 11.7
- Follow-up in 3 months

6-28-02

Sees Dr. Roane. She had a spontaneous skin lesion but it has improved. She has had some paresthesias or atypical cramping pains come and go through the foot and leg and she has been worried about a vascular problem.

Impression: Her recent symptoms are nonspecific and does not represent a significant problem and there is no evidence of a significant vascular problem.

Plan:

- Continue Imuran, Plaquenil and Prozac
- Follow-up as scheduled

8-21-02

Sees Dr. Roane. She is feeling pretty good.

Impression: Mixed or undifferentiated connective tissue disease. She has had a photosensitive skin reaction, but this is improved.

Plan:

- Try Wellbutrin for a week in place of Prozac
- Continue Imuran and Plaquenil
- SED rate is 70, CBC shows minimal anemia with a hemoglobin of 11.9. Complement levels, creatinine and urinalysis are pending
- Follow-up in 3 months

11-20-02

Sees Dr. Roane. Had a biopsy of lesion on ankle, but it was benign. She tried the Wellbutrin and feels less tired, but is starting to feel somewhat tearful.

Plan:

- Try Effexor in place of Wellbutrin
- Continue Imuran and Plaquenil
- CBC is fine and see her in 3 months

02-18-03

Sees Dr. Roane and feels as though her symptoms are well controlled. The Effexor was making her dizzy and she stopped taking it.

Plan:

- Continue Imuran and Plaquenil

- SED rate is 80, CBC unremarkable. Urinalysis, creatinine and C3 and C4 levels are pending
- Try Meridia to help with weight loss or go back on Prozac
- Follow-up in 3 months

5-13-03

Sees Dr. Roane and is actually feeling pretty well.

Plan:

- Try Wellbutrin 150 and stay with Prozac in evening
- Continue Imuran 150 mg a day and Plaquenil 400 mg a day.
- SED rate is 76 and CBS shows a minor anemia with a hemoglobin of 11.5 and a hematocrit of 33
- She is due for a complete 24-hour urine
- Follow-up in 3 months

06-09-03

Lab tests: (Dr. Roane)

Protein, 24-hour urine

- U protein mg/dL 330.4 H
- U protein 24 hr. 3634.4 H

Creatinine clearance 82.2 L

8-12-03

Sees Dr. Roane and is doing okay or at least about the usual. She has worsening pain and fatigue around time of her menstrual period.

Recent 24-hour urine showed a total 24 hour protein of 3.6 grams with a creatinine clearance of 82 ml/min. Last SED rate was 76 and last complement levels which were in February were down from usual with C3 of 58 and C4 of less than 10

Plan:

- Try CellCept 500 mgs B.I.D. in place of the Imuran
- SED rate today is 60 and CBC shows hemoglobin of 12. Complement levels, double stranded DNA, urinalysis and culture and creatinine are all pending.
- Follow-up in 4 weeks

9-09-03

Sees Dr. Roane. She is doing OK. At first CellCept made her very drowsy, but she is tolerating it OK now. She has noted no difference in terms of how she is feeling

Plan:

- CBC shows a normal white count of 5.2 with a hemoglobin of 11.8 and hematocrit of 34.4 which is almost stable from previous. SED rate is 68
- Increase CellCept to 500 mgs in the AM and 1,000 mgs in PM and follow her CBC closely
- Continue Plaquenil 400 mgs, Wellbutrin 500 mgs and Prozac 20 mgs
- Follow-up in 4 weeks

10-16-03

Sees Dr. Roane. She feels good with not much trouble with joint pain although she still has sore throats and feels like she may be slightly depressed.

Labs are unchanged with a persistently elevated SED rate of 70 and hemoglobin of 11.7.

Plan:

- Continue CellCept 500 mgs. And 1000 mgs and Plaquenil
- See Dr. Diana Rosen-Lowndes who can regulate the Wellbutrin and Prozac or make any changes.
- Follow-up in 6 weeks.

11-25-03

Sees Dr. Roane. She is doing better overall as far as her arthritis and connective tissue disease. She is happy with CellCept. She had an upper respiratory infection which is clearing with Levaquin

Impression:

- Mixed connective tissue disease and SED rate is better at 64 and CBC shows no anemia
- Resolving bronchitis

Plan:

- Continue Cellcept 500 mgs. Q.A.M. and 1,000 mgs Q.P.M., Plaquenil, Wellbutrin and Lexapro
- Follow-up in 2 months.

3-19-04

She sees Dr. Roane. She is doing okay, but still has problems with fatigue and with fluid retention and weight gain. She asks about some pain through the anterior ribs which occurs mainly when she is walking or sitting for a long period of time. She is having no side effects from her medications.

Impression:

- Mixed connective tissue disease with nephritic syndrome. Prior renal biopsy has been more along the lines of acute tubular necrosis.

Plan:

- Increase CellCept to 1000 mgs. B.I.D. to see if it helps
- Celebrex for rib pain
- Continue Plaquenil
- CBC shows a hemoglobin of 11.6 and hematocrit to 37 and is otherwise normal. SED rate is 68. A urinalysis, culture and creatinine will be ordered
- Return in about 7 weeks to be sure counts are OK on the extra CellCept. A 24-hour urine will be ordered then.

Lab tests:

- Creatinine	0.8
- Protein	100
- WBC/HPF	3-5

5-07-04

Sees Dr. Roane. She is doing well with the Cellcept and has found the Celebrex really helped her in terms of generalized feeling better.

Plan:

- CBC is normal and SED rate is actually a little improved at 58. Increase CellCept to 1000 mgs in the morning and 1500 in the evening. Will probably try to go up to a total dose of 1500 mgs B.I.D.
- Continue Plaquenil
- Take Celebrex when needed
- Follow-up in 2 months and will get a 24-hour urine once the CellCept is maximized.

7-16-04

She sees Dr. Roane. She feels no better. She doesn't have joint pain on a regular basis but on days when she does, it is more intense than it used to be. Her fatigue is unchanged.

Plan:

- SED rate today is 62 and CBC shows hemoglobin of 11.7 with normal white counts and platelets. Creatinine and complement levels are pending

- Go ahead and get 24-hour urine for protein and Creatinine clearance
- Continue CellCept
- Follow-up in 2 months

Lab results from this day are:

Creatinine 0.9

Immunology/Serology

- c3 Complement 78.8 L
- c4 Complement 3.7 L

08-16-04

Has labs performed as requested by Dr. Roane

- Protein, 24-hour urine—
 - u protein mg/dL 312.6 H
 - u protein 24 hrs. 3516.8 H
 - 24 hr. tot. vol. 1125

Creatinine Clearance: 113.9

09-07-04

Mrs. Marshall applies for Disability Benefits

9-15-04

Sees Dr. Dodds for the first time since her hospitalization in 1999. She wants to see what treatment might be given for her proteinuria in addition to the other medications she is on. She believes that this might decrease the possibility of renal failure in the future.

On New Patient form she lists major medical problems as:

- Mixed connective tissue disease 4-5(+) years
- Renal failure (acute)

She states that her grandmother had a history of kidney disease/diabetes.

She had hepatitis in 1995

Her urinalysis has greater than 300 mg/dL of protein, negative blood and glucose, specific gravity 1.030, and a pH of 5.0. Numerous white blood cells and bacteria are noted.

Plan: There was no reason to take Celebrex, but thought it was reasonable to try either a ACE inhibitor or an angiotensin receptor blocker for her proteinuria. She is given samples of Diovan to begin 80 mg q.d. for a week

and then increase to 160 mg q.d. for 2 weeks and then, if there are no problems increase this to 320 mg q.d. A urine C&S is ordered. She is to come back in a month and a half and would like to have a BMP done shortly before that visit.

9-17-04

Sees Dr. Roane. She feels she is holding steady. She has seen Dr. Dodds and is trying Diovan. She is doing fine so far. Her 24-hour urine shows 3.5 gm of protein in 24 hours and creatinine clearance of 113 ml/min.

Plan:

- Staying with CellCept 1,000
- Diovan per Dr. Dodds
- SED rate is 60 which is fine and CBC shows hemoglobin of 11.7 which is stable
- Follow-up in 2 months

11-11-04

Sees Dr. Dodds. She is feeling very well. Her immunosuppressive therapy is causing no problems and has no complaints.

Blood work shows creatinine to be 0.8, BUN 12 and the electrolytes are normal.

Plan: No changes in her medicines. See back in next 3-6 mos.

02-07-05

Dr. Dodds has her do 24-hour urine:

		8/604
- U protein mg/dL	329.2H	312.6
- U protein 24 hr	345.1 H	3516.8
24 hr. total vol	925	
		11/11/04
Creatine:	1.0	0.8
BUN	14	12

2-09-05

Sees Dr. Dodds. She feels better than she did 2-3 years ago with less fatigue and absence of joint aches. She is not having any fever. She notes that she still feels tired a lot of the time, however.

Blood work done 2 days ago shows the creatinine to be 1.0, BUN 14, bicarbonate 20 and potassium 3.8
A 24-hour urine collection done 2 days ago had 3045 mg/day of protein in her urine

Impression: Stable nephritic range proteinuria in a patient with poorly characterized mixed connective tissue disease and normal renal function. Although it cannot be proved, I imagine it is beneficial to continue taking an ARB agent.

Plan: No changes in her medicines. See her in about 6 months and do a 24-hour urine protein and a BMP at that time.

4-27-05

Sees Dr. Roane. She has been doing pretty well. She has tried Diovan and it helped with proteinuria a bit. In the last day or two she has felt as if she is developing a bladder infection.

Recent CBC showed a hemoglobin of 11.3 and was otherwise normal

Plan:

- Urinalysis with culture and will call with results
- Continue CellCept, Plaquenil, Celebrex, Lexapro and Diovan
- Follow-up in 2 months

5-23-05

Has appointment with Dr. Hughes because of a sprained ankle - weigh 242

Thyroid Studies done

- 1.33 0.35-4.94

6-29-05

Sees Dr. Roane. She is feeling pretty good with just occasional minor flares of fatigue and arthralgia.

Plan:

- Continue Cellcept, Plaquenil and try Celebrex a little more regularly and see if it helps her hip
- SED rate is 55 and CBC is unremarkable other than a hemoglobin of 11.1
- Follow-up in 3 months. She's to see Dr. Dodds in the interim with a 24 hour urine.

9-07-05

Sees Dr. Hughes because of a nonproductive cough and sore throat for 10 days.

Given a Zpak.

Notes: lymph node enlarged in R supraclavicular and R groin. Needs eval. SLE vs. other labs

9-12-05

Has Hematology testing done

RBC	4.05L
HGB	11.8L
HCT	35.2L
RDW	15.3H

Has Chemistry testing done

Protein, 24-hour urine		
U Protein mg/dL	555.9H	.0-13.5
U Protein 24 hr	4169.3H	0.0-165.0
24 hr. total vol	750	

Creatinine clearance		
24 hr. total vol	750	ML
Creat Clearance	103.2	92.0-132
U Creat mg/dL	190.8	0.8-1.8
U Creat gm/24hr	1.4	0.5-1.3
Serum Creat	0.8	0.5-1.3
Weight (lbs)	254	
Surface area	2.08	

Metabolic panels/chemistry

Creatinine	0.8	0.5-1.3

9-15-05

Sees Dr. Dodds. She feels that her arthritis/mixed connective tissue disease medicines are well-balanced now and she is not bothered much by either aches or fatigue. She continues to have a low-grade fever. She states that had an upper respiratory tract infection recently and was treated by the use of Zithromax when she had her last 24-hour urine collection.

Impression: Stable proteinuria in a patient with mixed connective tissue disease. In fact, considering that the patient had had a febrile illness during this urine collection,

this may actually represent somewhat less protein than before.

Plan:

- Have a BMP and 24-hour urine protein ordered shortly before 6 month check-up

9-28-05

Sees Dr. Hughes for gland re-check. Glands still swollen, R side pain. Has cough still – much better.

Notes:

- 1) Adenopathy – getting smaller – should resolve or get smaller
- 2) Obesity – Phenteramine 3000 NRF
- 3) Musculoskeletal pain – Tylenol and Celebrex
- 4) Cluc – get 306 ____ done

9-29-05

Sees Dr. Roane and is doing quite well. She is trying a low dose of oral contraceptive to see if this will help with her symptoms which seem to be associated with menses. She is on Lexapro and doing well.

24 hour urine has shown 4.2 g of protein. One year ago she had a 3.5 g. Renal function remains normal

Plan:

- Continue CellCept, Plaquenil and Celebrex
- Follow-up in 3 months

10-19-05

Has Glucose Tolerance studies done – 1 hr. and 3 hr.

Results:	Fasting	114 H
	1 hr.	274
	2 hr.	116
	3 hr.	58

11-04-05

Sees Dr. Hughes for cough and cold

Notes:

- 1) URI – Ketek Pak
- 2) Refill Phenteramine

11-14-05

Sees Dr. Hughes for chest pain – weight 240
Prescribed Indocin 50mg #30 and IPA.CXR

11-14-06

Has a JXR Chest PA & Lat Two Views because of chest pain.

Findings:

Heart and vascularity are normal. The lungs are clear and well aerated. No focal infiltrate or effusion.

Has a ECG which is normal and her sinus rhythm is normal

11-17-05

Sees Dr. Hughes for a recheck.

Notes:

- 1) Pleurisy -- much better. Continue Indocin and protonix

1-04-06

Sees Dr. Roane. She is doing well other than a recent respiratory infection which resulted in some pleurisy. She took Indocin briefly but has been off of this for 4 weeks.

Plan:

- Continue cellCept, Plaquenil and Celebrex
- SED rate is excellent at 30 and CBC is normal
- Follow-up in 3 months

2-02-06

Sees Dr. Hughes for check-up/follow-up. She has a strong urine odor, frequent UTI's, fatigue

Notes:

- 1) Obesity -- Phenteramine
- 2) UTI -- not present
- 3) Prottenuria -- for nephritic syndrome

4-5-06

Sees Dr. Roane. She is feeling pretty good. She notes that her skin is darkening and has some burning with urination. She has also had some pain in her left elbow, but the similar symptoms in the right elbow have cleared.

Plan:

- Mixed connective tissue disease with the primary manifestation of proteinuria
- Hyperpigmentation of the skin which is almost certainly due to a medication, the likely culprit is Plaquenil, however Celebrex is also a possibility
- Possible urinary tract infection
- Left lateral epicondylitis

Plan:

- Will check a urinalysis with culture
- Checking urine protein and creatinine. SED rate is 57, CBC is normal including a normal white count. LFT's and creatinine are pending.

- Talk about holding Plaquenil or Celebrex but she is afraid that she will be symptomatic with either of these changes.
- She will wear sunscreen
- A cortisone injection is an option for her left elbow, but she would like to start with a forearm band
- Continue CellCept, Plaquenil and Celebrex
- Follow-up in 3 months

7-5-06

Sees Dr. Roane. She is doing well and actually feels good. No more bladder symptoms or elbow trouble.

Plan:

- SED rate is 40. CBC is normal
- Renal function is stable and no changes have been made in medications – CellCept, Plaquenil and Celebrex
- Follow-up in three months

8-11-06

Sees Dr. Hughes for abdominal pain

Notes:

- 1) Diverticulitis – Avelox 400 mg.
- Follow-up next week

9-11-06

Sees Dr. Hughes for follow-up on abdominal pain – nearly daily, but none since Thursday. Mostly at night – 2-3 hours after eating. Occasionally has nausea with it. Has tried Pepto Bismole and Pepic rd – weight 218

Notes;

- 1) Likely is GB – possibly duodenal ulcer
- Given Nexium 40 D
F/U in 10 days

9-12-06

Has an Abdominal US as the patient has abdominal pain and nausea and there is a history of renal failure.

Impression: Multiple gallstones are present without evidence of significant biliary ductal dilatation. The left kidney is upper limits of normal in echogenicity with both kidneys normal in overall size.

9-21-06

Sees Dr. Hughes for f/u re: abdominal pain – somewhat better, not as severe as before

Notes:

- 1) Depression – Lexapro 20
- 2) Nexium did not _____
- 3) Phenteramine – lose weight before surgery and post-op

10-04-06

Sees Dr. Roane for regular update. She is doing pretty well from the standpoint of her autoimmune disease. Gallstones have come up and she is seeing Dr. Parker with the consideration of Cholecystectomy.

Plan:

- SED rate is 49 and CBC normal. Metabolic panel and urine studies are pending
- Continue on medications except before any surgery and after
- Follow-up in 3 months

10-9-06

Sees Dr. Telfair Parker for evaluation of presumed symptomatic cholelithiasis.

There was some concern about the possibility of diverticulitis and she was treated with antibiotics. She has now had a gallbladder ultrasound revealing multiple gallstones with no complicating features. Liver function tests have all been within normal limits.

Impression: Symptomatic cholelithiasis

Recommendation: Laparoscopic cholecystectomy which will be scheduled

12-29-06

Sees Dr. Hughes for fever – 3/4 days -103.0, has had body aches for 3 days

Notes:

- 1) Viral vs. Bacterial vs. SLE
- 2) Pred. 20
- 3) Avelox 400
- 4) Advil
- 5) Tylenol arthritis
- 6) Wants testing done on blood and CBC

Has testing done

Chemistry:

Creatinine level is 0.7(f) 0.5-1.3

(f) Estimated GFR = 97 ml/mi/1.73sq.m

Microbiology/Blood cultures and tests

- No microorganisms isolated

Hematology

- WBC 14.3 H
- Neutrophil % 80.4 H
- Lymphocyte % 9.8 L
- Sed rate 102 H

1-03-07

Sees Dr. Hughes for a re-check. - feeling much better

Notes:

Bacterial infection - finish Abx; D/C Pred.

1-05-07

Sees Dr. Roane. She became ill on Christmas. Saw Dr. Hughes who gave her Avalox. No clear etiology. Was also off CellCept briefly

Plan:

- Stay on meds
- Resume Diovan
- Continue CellCept, Plaquenil and Celebrex
- Follow-up in 3 months

4-04-07

Sees Dr. Roane. She has been doing quite well since her last visit with no real issues. She is taking her medications without side effects.

Plan:

- SED rate is 65 which is stable and CBC unremarkable. Creatinine, urinalysis with culture and urine protein and creatinine are all pending
- Continue CellCept, Plaquenil and Celebrex if needed
- She remains on Diovan 320 mg Q.D.
- Follow-up in 3 months

4-20-07

Sees Dr. Hughes for neck pain which she has had since Sunday

Notes:

R neck, R arm tingling off and on. Dropped coffee pot, difficulty writing; constant numbness, pain in R deltoid

- Neck pain with Radiculopathy
- Ibuprofen 800
- Soma
- Lortab

4/23/07

Has MR Spine Cervical w/o crst MRI because of neck pain
Impression:

- Broad-based disc bulge, eccentric to the right at C6-7, with moderate to severe spinal canal stenosis, severe right neural foraminal stenosis and moderate left neural foraminal stenosis.
- Broad-based disc bulge, eccentric to the right at C5-6, with moderate spinal canal and moderate bilateral neural foraminal stenosis.

XR Spine cervical 2 or 3 views – MRI Comp only

7-11-07

She sees Dr. Roane. She has been out of CellCept for about three weeks and is noting fatigue and arthralgias returning.

Impression:

- Missed connective tissue disease with proteinuria and arthritis. She has been off of CellCept for six weeks with only minimal increase in clinical symptoms
- Left fibular fracture
- Cervical disc disease

Plan:

- CBC today is normal and SED rate 55 which is stable. Urinalysis with urine protein and creatinine, as well as CMP, are pending as are C3 and C4.
- Resume CellCept and continue Plaquenil and Celebrex
- Follow-up in 3 months

10-10-07

Sees Dr. Roane. She has resumed the CellCept and there is dramatic improvement.

Plan:

- CBC is fine and SED rate is 84. C3 and C4 and chemistries are pending
- Continuing CellCept 1,000 mg Q. A.M. and 1500 mg Q. P.M.

- Continuing Plaquenil 400 mg Q.D. and Celebrex if needed
- 12-05-07 Sees Dr. Hughes for deep chest congestion, SOB
Notes:
1) Pneumonia – Avelox 400
2) Testing to be ordered and done
- Has chest x-ray PA & Lat Two Views because of shortness of breath
Impression:
- No active disease is seen within the chest. No acute infiltrate or abnormality is seen.
- 1-30-08 Sees Dr. Hughes because of a cough – patient doesn't like Celexa, grits teeth, likes Lexapro. Advair
Notes:
1) Cough variant asthma? – VOXR
2) Chest exam to be done
- 01-08 Decides to quit taking her medications. Her last visit and prescription refill from Dr. Roane was 9-07
- After discontinuing her medication she was okay for awhile, but still had fatigue, aches and fever which she had had during her treatment with Dr. Roane. Knowing she needed to get a follow-up for her proteinuria, she decided it was a good time to find a new slate of doctors.
- 1-30-08 Has a Chest PA and Lateral
Compare to same exam from 12/05/07
Impression:
- No active disease can be appreciated radiographically.
- 2-12-09 Sees Dr. Hughes – failed urine test and had fever during CPE .- Keonox*, gluc -; +protein;
Notes:
1) Keonuria – pt hadn't eaten yet that day
2) SLE – pt. of meds – so far so good
3) HTN/Renal drug – start Benazepril;
4) Nephrotic syndrome – pt. has chronic proteinuria
5) Come back when get insurance for labs
- Testing done:

Glucose -- Negative
Bilirubin -- Negative
Ketones -- Trace
Specific Gravity -- 1.005
Blood -- Negative
PH -- 6.0
Protein -- 100++
Urobilinogen -- Normal
Nitrates-Negative
Leukocytes -- Negative

2-26-09

Goes to Roper ER because of heart palpitations

Past week has had intermittent arm numbness and lightheadedness. She is just now getting back on blood pressure medicine after off for a long period of time. She notes a long history of lupus or lupus-like connective tissue disorder and hypertension. She has noticed during the past several days generalized weakness. At work she had her pulse checked and it was over 100. She denies any chest pain.

Her EKG and heart rate has come down from 130's down to the mid 80's. She did have an elevated d-dimer level, but the CAT scan was essentially negative for PE. The patient states her sed rate is generally over 100 and is in control and it's in the 50's.

She is discharged and told to arrange a follow-up appointment with Dr. Hughes and Dr. Roane.

6-17-09

Sees Dr. Hughes for possible strep throat. Test is negative for strep. Started with discomfort on right side of head then sore throat. Has an hx of SLE and mixed connective tissue disease. States that her labs are usually normal except for ESR of 50s on immunosuppression, 100s off. She is off of immunosuppression now. No congestion. No GI symptoms of dysuria. No rash

Notes:

- 1) Rheum -- check ESR & CBC & BMP, pt. had labs ordered so add on previous order; evaluate creatinine with labs since off of meds, if elevated ESR will likely need steroids
- 2) Sore throat -- if not rheum, then likely viral pharyngitis, treat symptomatically

9-01-09

Sees Dr. Shanon Honney (Internal Medicine) and gets Lexapro 20 mg. prescription filled.

Pt. states she stopped taking cellcept/plaquenil last spring. Pt. advised to see Dr. Silver for 2nd opinion/management. Pt. tried Imuvan, cellcept plaquenil. Complement levels improved with cellcept and plaquenil. She needs a referral to see Dr. Pride. She has not been seen by Dr. Roane in a year.

Was on vacation in July and noticed diffuse achiness with f/c then about 1-2 weeks later, but with no fever. Notes sensitive skin myalgias, diffuse myalgias, dartiralgias...later for about 1-2 weeks with

9-10-09

Mrs. Marshall calls Dr. Honney's office saying that they had set her up with the wrong nephrologist. She wants to see Dr. Pride, but doesn't have his number.

1-14-10

Makes an appointment with Dr. Shannon Honney (internal medicine) and after explaining her history she wants her to go back to nephrologist for her kidneys because of the amount of protein. An appointment is made with Dr. Eric Pride who works in the same group Dr. Dodds had (Dr. Dodds had retired by this time).

1-07-10

Sees Dr. Pride (nephrologist) for a recheck of proteinuria follow-up visit. She has a longstanding hx of proteinuria, often nephritic range, going back > 10 years. Also with MCTD previously on cellcept/plaquenil. Was on diovan 320 mg a day for proteinuria previously, last 24 hr. urine 3.50 grams in 2005. Self discontinued diovan and all immunosuppressives 2 years ago. Last creatinine 0.9 2/26/09. General Review of systems: Present - feeling well. Not present - weight loss, anorexia and fatigue. He performs lab tests:

1-07-11

-UA-PH	6.0
-Protein /Creat Ratio	10024 (abn) mg.
-Protein, Total, Urine	821.0 (abn) mg

Assessment:
Proteinuria (791.0)
Mixed Connective Tissue Disease
Interstitial Nephritis with ARF in 1999, resolved.

Note: If proteinuria is in fact better as I suspect it will be (only 100 mg/dL on U/A as opposed to usually > 300 mg/dL previously) on spot ration probably reasonable to observe off meds, although I did also encourage rheumatology f/u

1-08-10

The following day a nurse calls and says Dr. Pride wants her to do a 24 hour urine test because he is concerned about the protein counts.

Urine p/c 10, unexpected based on U/A, Cr 0.9 and albumin 3.9. He will have her do 24 hr. urine for CrCl, protein and UPEP to reevaluate.

She can't do this right away because she is on antibiotics for another infection.

01-28-10

She has the 24 hour urine test. She is called back to Dr. Pride's office for additional labs to be drawn and to see him.

Dr. Pride tells her that there were abnormal proteins (cancer protein) present in her urine and he was referring her to an oncologist/hematologist. He also told her that he felt that the abnormal protein had probably been present since her hospitalization in 1999 and the test to differentiate the protein had not been done before. (UPEP)

He does some additional lab tests one of which was a serum electrophoresis (SPEP-detects abnormal protein in blood)

02/03/10

Addendum note by Dr. Pride
1/29 creat still 1.0, calcium normal but has 9077 mg/day proteinuria, 24 hr CrCl 84 ml/min but the proteinuria is mainly a monoclonia protein. 5.65 grams/day of kappa light chain. Will get CBC and SPEP but will need hematology referral for likely bone marrow biopsy.

02-18-10

Addendum note by Dr. Pride
SPEP with 0.8 g/dL Mspike, Hgb 10.1 - Discussed monoclonal gamopathy with Mrs. Marshall and her sister last week.

02-24-10

She has her initial visit with Dr. Orcutt (oncologist) for evaluation of monoclonal gammopathy.

He goes over her history and recent lab results. He tells her that the SPEP had abnormal proteins as well although they weren't as high as the abnormal proteins in the urine. He agrees with Dr. Pride that the abnormal proteins had been in the urine all along. (not in the record)

Impression: Monoclonal gammopathy, IgM subtype, worrisome Waldenstrom's macroglobulinemia. Pt. has long standing history of nephritic syndrome attributable to perhaps mixed connective tissue disorder or other findings.

She is to have a bone marrow aspiration and biopsy, bone survey and CT scan of chest, abdomen and pelvis to evaluate for lymphadenopathy and/or splenomegaly.

Also, additional labs will be drawn to include a serum beta-II microglobulin level. Additional studies on the bone marrow aspiration to include flow cytometry.

02-26-10

She has a bone marrow biopsy and aspiration in Dr. Orcutt's office.

Following week

CT scan and x-rays are done.

3-9-10

Mrs. Marshall calls Dr. Honney's office for an antibiotic to be called in for her for nasal, chest, sore throat that started on Sunday and thinks she has a low grade fever. She says she will be in soon for antidepressants.

Dr. Honney wants her to come in. She refuses.

03-11-10

She sees Dr. Orcutt for a follow-up appointment and for ongoing evaluation and management of her newly diagnosed lymphoma/myeloma. She had a bone marrow aspiration and biopsy recently. She has had a sizeable proportion, some 50-60% of her nucleated cells composed of what appears to be low grade lymphoma. An additional component of plasma cells were appreciated as well. Lab results suggest that results were most consistent with a lymphoplasmacytic lymphoma or marginal zone lymphoma with extensive plasmacytic differentiation. It is noted on the CBC obtained at the time of her bone marrow aspiration and biopsy that she had leukocytosis with relative

lymphocytosis as well, indicative of possible leukemic type presentation of this lymphoma. The CT scan showed only borderline lymphadenopathy and splenomegaly, nothing really significant there. Her beta-II microglobulin was elevated. The metastatic bone survey showed no evidence of destructive bony lesion.

He again tells her that this is no doubt the cancer had been there a long time, but he did not know for how long. (not in doctor's notes)

She has a PET scan and is to return in a week for treatment plans.

The treatment plan is to use a chemo drug named Rituxin on a weekly basis for 4 weeks. After 4 weeks, labs and urine tests would be done to see if the Rituxin treatment needed to be continued. After the first 4 weeks there was some decrease in the urine protein and another round of the Rituxin/chemo was started.

A discussion was had about stage IV diagnosis and the limitation of the ability to cure patients with this type of presentation, but do hope for long term disease control and life expectancy hopefully measured in years at this point with reasonable degree of success.

3-22-10

She sees Dr. Orcut for a routine follow-up. She has undergone a PET-CT which showed only minimal uptake in the left external iliac node with SUV of 2.3. She continues to have fatigue, low grade fevers, flu like symptoms and anorexia.

While chemotherapy had been discussed earlier if the diagnosis proved to be a more substantial diagnosis, this fortunately seems not to be the case. This falls into a category of LPL or Waldenstrom's macroglobulinemia, particularly given the IgM component of her diagnosis.

Labs: Persistent lymphocytosis with 4800 lymphocytes, WBC-9800, Hemoglobin-9.5, hemtocrit-29.9, platelets-194,000, Renal function and electrolytes unremarkable. Nonfasting glucose-131

Echocardiogram obtained and shows an estimated LVEF of 50-55%. Nothing else of significance was appreciated on the echo.

She will initiate her first cycle of chemotherapy consisting of Rituxan as a single agent and repeat it for 4 weeks and will readdress the issues of serum and urine protein analysis. As soon as an adequate response has been received, 4 additional treatments would be appropriate, initially.

3-23-10

Addendum Note by Dr. Pride
On rituxan for BMbx c/w Waldenstrom's
Macroglobulinemia (Dr. Orcutt)

3-25-10

She follows-up with Dr. Orcutt for a follow-up appointment for initiation of her first cycle of Rituxan treatment. She has started on her Allopurinol, Acyclovir and Bactrim prophylaxis.

Plan:

- She is started on Rituxan therapy given the CD20 positivity of her LPL diagnosis pathologically.
- She will be back in 2 weeks for her 3rd treatment and resubmit urine and serum studies for monitoring her M-protein component. She will anticipate at least 4 weekly infusions of Rituxan for her first cycle.

4-9-10

Ms. Marshall sees Dr. Orcutt for a follow-up appointment. She has done reasonably well with her last infusion of her Rituxan although her first infusion created a fairly significant febrile and immunologic reaction with fever, chill and achiness. Currently in week 3 Rituxan.

Labs: WBC - 4600, hemoglobin - 8.7, hematocrit - 28.1, MCV - 93, MCH - 29, platelets - 114,000.

Plan:

- Sent some additional labs to help identify etiology of the anemia
- Anticipate Rituxan at least through next week and perhaps 6 or 8 total weeks depending upon her degree of response based on a repeat of her M-protein levels, both serum and urine, which we will have obtained by next weeks visit.

4-16-10

Ms. Marshall sees Dr. Orcutt for follow-up and for ongoing evaluation and management. Ms. Marshall had a 24-hour urine collection on Monday returned and the urinary protein levels have decreased by 1 g in 24 hours from 5500 mg to 4500mg. She has had a decrease in her M-protein by about 50% per unit volume from 800dl to about 450dl.. She is otherwise doing reasonably well.

Labs: WBC-4800, hemoglobin-9.0, hematocrit - 28.5, normal RBC indices, platelets-164,000. BUN - 7.0, creatinine - 1.1, calcium - 9.6, AST - 53, remainder of LFTs normal. LDH slightly elevated through not significantly. Nonfasting glucose-188.

Dr. Orcutt recommends continuation of Rituxan for the full 8 week treatment given the degree of response. The SPEP and quantitative studies from the serum are pending at this point. She is to start Aranesp given the degree of anemia and the symptoms that she has experienced.

4-30-10

She sees Dr. Orcutt for a routine follow-up. She has been receiving Rituxan with a favorable response to therapy. She has been started on Aranesp in accordance with the extent of anemia. She has had little impact on her hemoglobin/hematocrit levels otherwise.

Labs:

- WBC - 5200, hemoglobin - 9.4, platelets - 187,000. Remainder of the labs are pending at this time.

Impression:

- Lymphoplasmacytoid lymphoma with M-protein exhibiting IgM characteristics with kappa light chain restriction, currently week 6 Rituxan
- History of acute renal failure with interstitial nephritis and proteinuria
- Mixed connective tissue disease?
- Anemia, currently on erythropoietin
- Thrombocytopenia, resolved

Plan:

- Continue for 8 total infusions of Rituxan given on a weekly basis. She has had a favorable response thus far from a clinical perspective.

- Restage her with a 24-hour urine collection, SPEP and scans once finished, probably a month or so after her last infusion. She is to have an SPEP drawn today for completeness.

5-14-10

Mrs. Marshall returns to see Dr. Orcutt. For a follow-up with no particular problems except for fatigue.

Labs:

WBC – 4600, hemoglobin – 9.9, platelets – 232,000. Remainder of the labs are pending at this time.

Impression:

- Lymphoplasmacytoid lymphoma with M protein exhibiting IgM characteristics with kappa light chain restriction, currently week 8/8 Rituxan.

Plan:

- Her last treatment with Rituxan today in a planned program of therapy.
- A 24-hour urine collection, serum protein studies and quantitative immunoglobulins as well as her routine labs will be restaged in 4 weeks.
- She is to continue with the Aranesp for her symptomatic anemia.
- The protein studies will be followed at this time.

6-11-10

Sees Dr. Orcutt for follow-up and ongoing evaluation. She's had some restaging studies performed in the interim to include a 24-hour urine collection and serum protein analysis.

Labs:

M-protein – 1.2 24-hour urine shows creatinine clearance of 76.6ml/min and a total volume of only 725cc. The monoclonal protein within the urine sample is 1.6g/dl. Total protein – 325.7 mg. Today on her labs, potassium – 3.5, CO1-21, glucose – 148, BUN – 11, creatinine – 1.1, calcium – 9.4, total protein – 7.5, albumin – 3.7, LDH – 389, WBC – 6400, hemoglobin – 10.3, platelets – 237,000.

Impression:

- Lymphoplasmacytoid lymphoma with M. protein, IgM with kappa light chain restriction s/p 8 weeks of Rituxan with modest response.
- Mixed connective tissue disease?

Plan:

- Update CT scans in search of any progressive lymphadenopathy which at this point would seem unlikely based on her clinical findings.
- Repeat radiographic study for completeness and prior to consideration of additional treatment options.
- Spoke about the potential use of Velcade which is likely her next intervention, also to perhaps include Dexamethasone and/or Revlimid.
- She is to see Dr. Pride shortly for ongoing evaluation of the renal function which despite the significant proteinuria appears reasonably within normal limits at this point.
- The utility of a Life port will be discussed with her but he thinks she can tolerate Velcade injections relatively easily and she is not anxious to have any surgical procedures performed at this point.

6-25-10

Has scheduled follow-up with Dr. Orcutt. She has undergone 8 weekly treatment of Rituxan for 8 weeks with a modest decrease in her measurable serum and urine protein content.

She has scheduled a second opinion at MUSC but nothing has been scheduled as yet. She has been getting along reasonably well, still complaining of fatigue as her principal problem.

Dr. Orcutt recommends consideration of Velcade which she is agreeable to which will be started on Monday. Around the 19th of July, her second cycle of treatment will be initiated.. Her serum protein studies will be repeated when she returns.

7-19-10

Has scheduled follow-up with Dr. Orcutt. She has undergone 8 weeks of Rituxan with partial response, currently day 1, cycle 2, Velcade. She tolerated her first cycle well with the typical side effects.

She is doing quite well with her treatment thus far and anticipate restaging studies after her 2nd or 3rd cycles for follow up of her urinary protein excretion. Serum protein studies are drawn today and are pending.

07-28-10

Has appointment with Dr. Luciano Costa for a second opinion concerning her treatment for LDL.

Assessment Plan:

Patient is assured that she does have LPL and not multiple myeloma even though her bone marrow biopsy does show some increased plasma cells. She is also reassured that her skeletal survey does not show lytic lesions. Multiple treatment options were reviewed, but at this time the recommendation is only the addition of Rituximab to her current regimen with routine restaging

08-03-10

Has a bone marrow biopsy.

8-16-10

Has scheduled follow-up with Dr. Orcutt. She has done well with the Velcade.

PLAN:

- Ms. Marshall is doing adequately well with her treatment thus far. She has exhibited no significant toxicities of concern with the exception of intermittent neuropathy, nausea, fatigue and hematologic toxicities as would be expected.
- She is to return in 3 weeks and a 24-hour urine collection for UPEP, creatinine clearance along with SPEP and immunoglobulins will be performed 1 week prior to her return visit.
- Velcade will be continued for 4-6 cycles then consider options from there depending upon response.
- Re-imaging with CT scans will be anticipated at intervals, but not at this time.

08-27-10

Comes to the Roper Hospital ER because she has chest pain. However, her treatment is taken over by Dr. Orcutt because of her lymphadenopathy. She is admitted to the Hospital for observation.

During her stay she is seen by Dr. Telfair Parker to talk about a left neck node and consider an excisional biopsy.

8-30-10

Has a left neck mass biopsy.

The Pathology Report states that there is no evidence of granulomatous or suppurative inflammation. There is no evidence of metastatic carcinoma. The flow cytometry results showed a predominant population of T-cells with no evidence of a monoclonal B-cell population. A previous bone marrow biopsy (GenOptix on 2/26/10) showed "B-cell lymphoma with a neoplastic plasma cell component, the differential diagnosis includes a lymphoplasmatic lymphoma or marginal zone lymphoma with plasmacytic differentiation." The abnormal lymphoid population was Kappa light chain restricted.

9-07-10

Comes in for her follow-up visit. She has been receiving Velcade routinely and seems to tolerate that well with the exception of a mild to moderate sensory neuropathy.

During her evaluation in the ER at Roper she was found to have enlargement of a left sub-mandibular node which was FNA'd by Dr. West. It was felt to be pathologically benign consistent with reactive tissue. This region has decreased in size substantially fortunately and seems to be improved overall. She has had some concern for orthostatic changes which again are improving significantly and again likely related to an upper respiratory type infectious process. Her 24-hour urine collections and her SPEP is still pending.

She is treated with her 4th cycle of Velcade today. She has had her restaging scans performed during her recent hospitalization. She seems to have had either a stable to slightly responding disease overall and anticipate continuation for 6 cycles if she can tolerate symptomatically. She will be seen again in 3 weeks.

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W.
Marshall,

PLAINTIFFS,

vs.

Kenneth A. Dodds, M.D., and Charleston
Nephrology Associates, LLC,

DEFENDANTS.

AFFIDAVIT OF
BARRY L. SINGER, M.D.

FILED
2011 FEB - 7 PM 12:29
JULIE J. ARMSTRONG
CLERK OF COURT

I, Barry L. Singer, M.D., being duly sworn deposes and says:

1. I am an oncologist duly licensed by the State of Pennsylvania and the appropriate regulatory agency having jurisdiction over the practice of my profession in the location in which I practice (see attached CV).

2. I have actual professional knowledge and experience in the specialty and area of practice in which this opinion is given, as a result of my having been regularly engaged in the active practice in the area of specialty and practice for at least three (3) of the last five (5) years immediately preceding this opinion (see attached CV).

3. The evidence made available to me, for my review, prior to the making of this affidavit includes:

- Medical records of Carlisle Barfield, MD;
- Medical records of Katherine Minnick, MD;
- Medical records of Georgia Roane, MD;
- Medical records of Kenneth Dodds, MD;
- Medical records of Francis B. Hughes, MD;

- Medical records of Shannon Honney, MD;
- Medical records of Eric Pride, MD;
- Medical records of James Orcutt, MD;
- Medical records of Luciano J. Costa, MD; and
- Medical records from Roper Hospital.

Additionally, it is my understanding that discovery is ongoing and that I can expect to receive further information including depositions or medical records and/or reports. Therefore, upon receipt and review of this information my opinions may be further supplemented, altered or changed.

4. Based on my review of the records, it is more likely than not that the Plaintiff had cancerous protein in her urine beginning in February 2005 when she treated with Dr. Kenneth Dodds, and this cancerous protein could have easily have been identified by performing a urine protein electrophoresis ("UPEP") test and/or a serum protein electrophoresis ("SPEP") test.

5. The amount of protein in the Plaintiff's urine in February and September 2005 was a significant amount and should have been an obvious sign that there was an active disease (i.e., cancer) present at that time. Specifically, on February 7, 2005, a 24-hour urine collection revealed 3045 mg/day (3.1 g/day) of protein in the Plaintiff's urine. Thereafter, on September 12, 2005, the Plaintiff had another 24-hour urine test which indicated that the Plaintiff's urine contained 4.2 g/day of protein. This elevated protein count in February and September 2005 should have indicated the need for further testing to determine the cause of the Plaintiff's significantly high urine protein count.

6. When the protein in the urine becomes high, it produces monoclonal protein. Since the Plaintiff had a history of chronic proteinuria, it was medical negligence for her treating physician not to do a UPEP and/or SPEP test to determine the type of protein in the urine.

7. The Plaintiff's treating physician could have easily done a UPEP test to rule out myeloma or monoclonal protein beginning in February 2005. The test is easy to do and would have indicated that there were cancerous protein cells in her urine.

8. In February and/or September 2005, not only would the Plaintiff's cancer have been detected, but it could have been treated properly at that time before it spread to other parts of her body, including the bone marrow.

9. If the Plaintiff's cancer was detected as early as February 2005, then her treatment could have been started immediately. Rituxan therapy would have slowed the disease down in 2005, but instead, the Plaintiff's cancer remained untreated and progressed for five more years until she was properly tested for cancer in January 2010.

10. It is more likely than not that if the cancer was detected and treated in February or September 2005, the cancer would not have progressed and her life expectancy would be longer.

11. With reasonable medical certainty, if a UPEP and SPEP test was performed in February or September 2005, the Plaintiff's cancer would have been detected and treatment immediately started to prevent the cancer from spreading. Therefore, if the cancerous protein had been detected in 2005, the Plaintiff's prognosis would be better and her life expectancy would be longer.

Barry L. Singer
Barry L. Singer, M.D.

SWORN TO before me this
3rd day of February, 2011.

Tina M. Allen (L.S.)
Notary Public for Commonwealth of Pennsylvania
My commission expires: 8/23/12

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Tina M. Allen, Notary Public
Norristown Boro, Montgomery County
My Commission Expires Aug. 23, 2012
Member, Pennsylvania Association of Notaries

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

Virginia L. Marshall and Todd W.)
Marshall,)

PLAINTIFFS,)

vs.)

Kenneth A. Dodds, M.D., and Charleston)
Nephrology Associates, LLC,)

DEFENDANTS.)

AFFIDAVIT OF EXPERT WITNESS
MEDICAL MALPRACTICE CASE
§§s 15-36-100, 15-79-125
1976 SC Code

FILED
2011 FEB -7 PM 12:29
JULIE J. ARMSTRONG
CLERK OF COURT
BY

I, Robert G. Luke, M.D., being duly sworn deposes and says:

1. I am a physician, licensed by the State of Ohio and the appropriate regulatory agency having jurisdiction over the practice of my profession in the location in which I practice.

2. I have actual professional knowledge and experience in the specialty and area of practice in which this opinion is given, as a result of my having been regularly engaged in a combination of active practice and teaching, in an accredited educational institution, in the specialty and area of practice for at least three (3) of the last five (5) years immediately preceding this opinion (see attached CV).

3. This affidavit is made pursuant §15-36-100 of the 1976 SC Code of Laws, which requires that this affidavit must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit.

4. The evidence made available to me, for my review, prior to the making of this affidavit, includes:

20

- Medical records of Katherine Minnick, MD;
- Medical records of Georgia Roane, MD;
- Medical records of Kenneth Dodds, MD;
- Medical records of Francis B. Hughes, MD;
- Medical records of Shannon Honney, MD;
- Medical records of Eric Pride, MD;
- Medical records of James Orcutt, MD;
- Medical records of Luciano J. Costa, MD; and
- Medical records from Roper Hospital.

Additionally, it is my understanding that discovery is ongoing and that I can expect to receive further information including depositions or medical records and/or reports. Therefore, upon receipt and review of this information my opinions may be further supplemented, altered or changed.

5. Through my professional standing as set forth above, I am familiar with the applicable standard of care for nephrologists specifically applicable to the conduct of Kenneth A. Dodds, MD and Charleston Nephrology Associates, LLC. The standard of care requires:

- If a patient has significant proteinuria, the treating nephrologist must determine the cause of the proteinuria. At the very least, in the absence of an obvious cause, the nephrologist must order the proper testing to rule out certain causes of proteinuria, including cancerous myeloma protein (i.e., light chains).
- If the routine urine tests, including Albustix strips and a 24-hour urine test, have inconsistent results (such as in this case negative or low proteinuria

versus high levels by UPEP) then the treating nephrologist has the duty to order additional testing to look for light chains in the urine. The proper testing to check for such protein includes a urine protein electrophoresis ("UPEP") test and a serum protein electrophoresis ("SPEP") test. A UPEP test measures the levels of various proteins in the urine. An SPEP test measures the levels of various proteins in the blood, and it is useful for detecting and measuring the abnormal monoclonal protein level associated with myeloma.

- A nephrologist who is treating a patient for chronic proteinuria has a duty to prescribe the proper medication to effectively treat the patient's condition. In addition, that nephrologist must monitor the patient's progress while on the medication to determine if the medication is treating the patient's condition and/or high proteinuria.
- The medication Diovan is an angiotensin II receptor antagonist ("ARB") which is appropriate for some proteinuric diseases, and could be proper to treat a patient whose primary diagnosis is renal disease. However, it would not be used to treat a cancerous tumor and/or bone marrow that is secreting a protein which is being excreted by the kidney and potentially damaging it. This is termed "overflow" proteinuria.
- As such, if a UPEP and SPEP test is performed initially and reveals cancerous protein, then Diovan would not have been the proper medication to treat the patient's condition or disease.

- There are many appropriate medical care protocols which may apply to this case that may become relevant as this case proceeds and additional information is obtained.

6. I have reviewed the evidence submitted to me, and based upon my expertise, as set forth above, it is my opinion to a reasonable degree of medical certainty that Kenneth A. Dodds, MD, and Charleston Nephrology Associates, LLC, committed the following negligent, grossly negligent and/or reckless acts and/or omissions, which constituted a failure to comply with the appropriate standard of care:

- The Plaintiff, who is currently 47 years old, was diagnosed with acute renal failure in 1999. This was most likely caused by an allergic response to antibiotics which the Plaintiff was taking at that time. The Plaintiff was hospitalized for acute renal failure in 1999, was treated properly with steroids and her condition resolved. At that time, a renal biopsy was performed which did not show a cause for chronic high proteinuria levels. Thereafter, in 2000, the Plaintiff had a blood test in which monoclonal protein was not identified in the urine.
- However, on September 15, 2004, the Plaintiff saw Dr. Kenneth A. Dodds at Charleston Nephrology Associates, LLC with complaints of proteinuria. On that visit, Dr. Dodds ordered a 24-hour urine test. He also gave her samples of Diovan to begin 80 mg once a day for a week and then to increase to 160 mg a day for two weeks. If after two weeks, the Plaintiff had no problems with the Diovan, she was instructed increase to 320 mg a day.

- On September 17, 2004, the Plaintiff saw Dr. Dodds for a follow up visit. Her 24-hour urine test showed 3.5 grams of protein in 24 hours. Dr. Dodds continued her on Diovan and advised her to follow up in two months.
- The Plaintiff saw Dr. Dodds again on November 11, 2004 and no changes were made in her medicine and no additional urine tests were performed.
- On February 7, 2005, the Plaintiff had a 24-hour urine test, ordered by Dr. Dodds, which revealed 3.1g/day of proteinuria.
- On February 9, 2005, the Plaintiff saw Dr. Dodds for a follow up appointment. Dr. Dodds' notes from that visit indicate that the "a 24-hour urine collection done 2 days ago had 3045 mg/day of protein in her urine" (3.1 g/day). According to the assessment/plan, Dr. Dodds did not make any changes in her medication and told her to follow up with him in six months for another 24-hour urine protein test. Dr. Dodds continued to prescribe Diovan even after his noting there was no significant change in the Plaintiff's protein from the prior test in November 2004. The fact that Dr. Dodds continued to prescribe Diovan without properly monitoring the Plaintiff's response to the medication constitutes negligence. If Dr. Dodds would have properly monitored her medication, he would have realized that there was no change in the amount of protein in her urine in response to the medication. In addition, the failure of Dr. Dodds to recognize the fact that the continued elevation of protein in the urine could constitute cancerous protein constitutes negligence. Additionally, Dr. Dodds' further failure to perform the proper testing to determine the reason for the

continuous high protein in her urine, including the possibility of cancerous protein, constitutes a breach of the standard of care. Furthermore, Dr. Dodds did not change the treatment plan in light of the continuous high protein count and instead instructed the Plaintiff to follow up with him in six months for another 24-hour protein urine test.

- On September 12, 2005, the Plaintiff had another 24-hour urine test which was ordered by Dr. Dodds. This urine test indicated that the Plaintiff's urine contained 4.2 g/day of protein and 555.9 mg/dL of protein.
- On September 15, 2005, the Plaintiff followed up with Dr. Dodds for an office visit. Dr. Dodds notes in his records that "a 24-hour urine collection done on 9/12 shows her to have 4.2g of protein in her urine." Dr. Dodds did not order any additional testing at that time to determine the reason for the increasingly high amounts of protein in the Plaintiff's urine. The failure of Dr. Dodds to recognize the fact that the continued elevation of protein in the urine could constitute cancerous protein and his failure to order the proper testing constitutes a breach in the standard of care and constitutes negligence.
- In September 2005, Dr. Dodds performed two routine tests – Albustix strip test and a 24-hour urine test. The Albustix test reported a low amount of protein in her urine while the 24-hour urine test revealed 4.2 grams of protein in her urine. This discrepancy between the two test results should have further suggested to Dr. Dodds that he needed to look for cancer protein (i.e., light chains). The proper way for Dr. Dodds to test for the cancer protein would have been to perform a UPEP and SPEP test.

Failure of Dr. Dodds to recognize that the above test results could indicate cancerous protein and his failure to perform the proper testing, including a UPEP and a SPEP test, constitutes a breach of the standard of care.

- From February 2005 - September 2005, the protein in the Plaintiff's urine had significantly increased which further indicates that additional testing should have been performed. Dr. Dodds' failure to recognize that the increased protein could constitute cancer and his failure to perform additional testing to determine the cause for the increasing protein in the Plaintiff's urine constitutes negligence and a breach in the standard of care.
- In addition, there is no evidence that the events and diagnosis of acute renal failure during the Plaintiff's hospitalization in 1999 explain the events which occurred in 2005. Therefore, Dr. Dodds needed a new approach to treat the Plaintiff's proteinuria when he saw her in 2005, including but not limited to a UPEP and SPEP test to determine the type of protein the Plaintiff's urine. If the UPEP and SPEP test would have been performed in 2005, the Plaintiff's disease/cancer would have been revealed and the proper treatment started.
- Finally, on October 7, 2009, the Plaintiff was referred to Dr. Eric Pride, another nephrologist, for her longstanding history of proteinuria. Dr. Pride's notes indicate that the Plaintiff was previously on Diovan 320 mg a day for proteinuria and that her last 24 hour protein was 3.05 grams in 2005. Dr. Pride immediately orders a 24 hour urine test for protein and UPEP to evaluate the protein.

- In January 2010, a UPEP and SPEP test were finally performed which revealed cancerous myeloma protein. The Plaintiff was subsequently diagnosed with lymphoplasmacytic lymphoma. This was the first time the Plaintiff was ever informed that she had cancer.
- Based on my review of the medical records, it is most likely that the Plaintiff had cancerous protein present in her urine in 2005 when she treated with Dr. Dodds, and this cancerous protein could have easily been identified by performing a UPEP and SPEP test. Dr. Dodds' failure to perform these tests constitutes negligence and a breach in the standard of care.
- With reasonable medical certainty, if Dr. Dodds would have performed a UPEP and SPEP test in February or September 2005, her cancer would have been detected and treated in 2005 – instead of six years later after the cancer had progressed.

7. These violations of the standard of care have proximately caused injuries and damages to the Plaintiff which may be summarized as:

- If Dr. Dodds had performed the proper testing beginning in 2005 to determine the cause of the Plaintiff's high protein, it is more likely than not that the Plaintiff's cancer would have been detected and treated at an earlier stage.
- It is more likely than not that the above negligent actions by the Defendants caused and is continuing to cause the Plaintiff to endure continuous and unnecessary pain and suffering and has led to a further decline in her medical condition.

- Additionally, it is more likely than not the above actions caused the Plaintiff to require and continue to receive medical treatment and incur additional medical expenses and costs.

Robert G. Luke M.D.
Robert G. Luke, M.D.

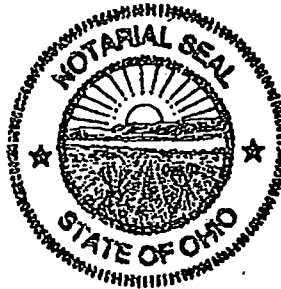
SWORN TO before me this

28 day of January, 20 11

Bonnie Cartaya (L.S.)

Notary Public for Hamilton Co., Ohio

My commission expires: 6/19/2012



Bonnie B. Cartaya, Notary Public
In and For the State of Ohio
My Commission Expires
June 19th 2012

11-CP-10-2586

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Virginia L. Marshall and Todd W. Marshall,

PLAINTIFFS,

vs.

Georgia Roane, M.D. and Rheumatology
Associates, P.A.,

DEFENDANTS.

**AFFIDAVIT OF EXPERT WITNESS IN
MEDICAL MALPRACTICE CASE**

§§s 15-36-100, 15-79-125
1976 SC Code

2011 APR -8 PM 2:53
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

I, Thomas M. Zizic, M.D., being duly sworn deposes and says:

1. I am a physician, licensed by the State of Maryland and the appropriate regulatory agency having jurisdiction over the practice of my profession in the location in which I practice.

2. I have actual professional knowledge and experience in the specialty and area of practice in which this opinion is given, as a result of my having been regularly engaged in a combination of active practice and teaching, in an accredited educational institution, in the specialty and area of practice for at least three (3) of the last five (5) years immediately preceding this opinion (see attached CV).

3. This affidavit is made pursuant §15-36-100 of the 1976 SC Code of Laws, which requires that this affidavit must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit.

4. The evidence made available to me, for my review, prior to the making of this affidavit, includes:

- Medical records of Carlysle Barfield, MD;

- Medical records of Katherine Minnick, MD;
- Medical records of Georgia Roane, MD;
- Medical records of Kenneth Dodds, MD;
- Medical records of Francis B. Hughes, MD;
- Medical records of Shannon Honney, MD;
- Medical records of Eric Pride, MD;
- Medical records of James Orcutt, MD;
- Medical records of Luciano J. Costa, MD; and
- Medical records from Roper Hospital.

Additionally, it is my understanding that discovery is ongoing and that I can expect to receive further information including depositions or medical records and/or reports. Therefore, upon receipt and review of this information my opinions may be further supplemented, altered or changed.

5. Through my professional standing as set forth above, I am familiar with the applicable standard of care for rheumatologists specifically applicable to the conduct of Georgia Roane, M.D., and Rheumatology Associates, P.A. The standard of care requires:

- A rheumatologist has the duty to evaluate and assess a patient rheumatology symptoms and provide a firm diagnosis, including a proper diagnosis of mixed connective tissue disorder. Unexplained fever, chills and rigors are nonspecific symptoms and uncharacteristic of someone who has mixed connective tissue disorder.
- A rheumatologist must recognize that chills and rigors along with fever, a strikingly elevated sedimentation (SED) rate, and lymphadenopathy are

unusual for rheumatology disease and may indicate malignancy like lymphoma.

- A rheumatologist who is treating a patient with chronic proteinuria and persistently high SED rates has a duty to prescribe the proper medication to effectively treat the patient's condition. In addition, that rheumatologist must monitor the patient's progress while on the medication to determine if the medication is properly treating the patient's condition.
- Potent immunosuppressants, such as Immuran and CellCept, must be used to treat specific conditions and not just prescribed to patients who suffer from fatigue and joint pain. In addition, a patient who is prescribed potent immunosuppressants should be closely monitored while on the medication to determine the effectiveness of the medication in treating the patient's underlying condition.
- If a patient has significant proteinuria and is not being followed by a nephrologist on a regular basis, the treating rheumatologist has an obligation to look for renal disease and mitigate renal damage. If a patient has chronic, unexplained proteinuria and is no longer treating with a nephrologist, the treating rheumatologist is responsible for following, evaluating and determining the cause of the Plaintiff's proteinuria in addition to rheumatology disease.
- At the very least, in the absence of an obvious cause for a patient's proteinuria, the rheumatologist must order the proper testing (to include 24-hour urine tests and/or a UPEP test) to rule out certain causes of proteinuria, or refer the Plaintiff to a nephrologist for such testing.

- If a patient has been diagnosed with lymphadenopathy (i.e., enlarged lymph nodes), the treating rheumatologist has a duty to order the proper testing to include a lymph node biopsy.
- There are many appropriate medical care protocols which may apply to this case that may become relevant as this case proceeds and additional information is obtained.

6. I have reviewed the evidence submitted to me, and based upon my expertise, as set forth above, it is my opinion to a reasonable degree of medical certainty that Georgia Roane, M.D., and Rheumatology Associates, P.A., committed the following negligent, grossly negligent and/or reckless acts and/or omissions, which constituted a failure to comply with the appropriate standard of care:

- The Plaintiff, Virginia Marshall, who is currently 47 years old, was diagnosed with acute renal failure in 1999. At that time, the Plaintiff was hospitalized due to high fever, rigors and chills. While in the hospital, she was seen and evaluated by a rheumatologist, Dr. Carlisle Barfield. The Roper Hospital records indicate the Plaintiff had nonspecific symptoms (to include fever, chills and rigors) which is unusual for mixed connective tissue disorder or rheumatology disease. The hospital records state "rheumatoid factor was negative, ANA negative." During the Plaintiff's 1999 hospital stay, there were no specific findings of lupus or mixed connective tissue disorder.
- Dr. Georgia Roane, a rheumatologist with Rheumatology Associates, P.A., began treating the Plaintiff in 2000. At that time, the Plaintiff's SED rate was extremely high at 112-120, and Dr. Roane's records indicate she

continued to feel left and right cervical nodes on physical examination. In 2000, Dr. Roane diagnosed the Plaintiff with mixed or undifferentiated connective tissue disease based on her high SED rate and symptoms of pain and fatigue and began treating her for this disease.

- From 2000-2005, Dr. Roane continued to prescribe potent immunosuppressants, such as Immuran and CellCept, to treat suspected symptoms of mixed connective tissue disorder. In addition to the high SED rate and cervical nodes, the Plaintiff also had significantly elevated levels of protein in her urine during this time.
- From September 2004 through September 2005, the Plaintiff was also under the care of a nephrologist, Dr. Kenneth Dodds, for her proteinuria. During that time, Dr. Dodds noted that the Plaintiff had a history of "poorly characterized mixed connective tissue disorder."
- On April 29, 2005 and June 29, 2005, Dr. Roane continued the Plaintiff on CellCept for mixed connective tissue disease - 1000 mg in the morning and 1500 mg in the evening. Dr. Roane failed to properly diagnose the Plaintiff during this time as the prior diagnosis of mixed connective tissue disorder was never properly confirmed and was based on nonspecific symptoms. The fact that Dr. Roane continued to prescribe potent immunosuppressants to a patient with persistently high SED rates and poorly characterized mixed connective tissue disorder constitutes negligence. In addition, Dr. Roane's failure to recognize the misdiagnosis of mixed connective tissue disorder (specifically from April 2005 forward)

and consider other possibilities for the Plaintiff's symptoms constitutes a breach of the standard of care.

- After the Plaintiff stopped seeing the nephrologist in September 2005, Dr. Roane had an obligation to look for renal disease and mitigate renal damage. At that time, Dr. Roane failed to order the proper testing for the Plaintiff's proteinuria which would include 24 hour urine tests or a UPEP test. In addition, since the Plaintiff was no longer being followed by a nephrologist, Dr. Roane was responsible for following and evaluating the Plaintiff's proteinuria. This would include making a firm diagnosis and determining the cause of the Plaintiff's proteinuria. As such, Dr. Roane had a duty to continue to pursue the Plaintiff's high protein and order the proper testing. During this time, Dr. Roane made no changes to the treatment plan and continued the Plaintiff on medication (to include CellCept) without properly monitored her response to the medications. Furthermore, Dr. Roane failed to order additional testing to include 24-hour urine tests and/or a UPEP test to determine the cause of the Plaintiff's proteinuria. Failure of Dr. Roane to properly treat the Plaintiff's condition and order the appropriate testing constitutes negligence.
- Specifically, on September 29, 2005, Dr. Roane noted that the Plaintiff's urine revealed 4.2 grams of protein in 24 hours and that the year before she had 3.5 grams of protein. Dr. Roane continued the Plaintiff on her medications (to include CellCept), but failed to order any additional testing. Failure of Dr. Roane to recognize that the above increasing

protein levels could indicate cancerous protein and her failure to order or perform the proper testing, including a UPEP test, constitutes a breach of the standard of care.

- On April 5, 2006, Dr. Roane noted that the Plaintiff's SED rate was somewhat lower and continued the Plaintiff on CellCept, Plaquenil and Celebrex. At that time, Dr. Roane's diagnosis was "mixed connective tissue disease with the primary manifestation of proteinuria." Despite the increasingly high protein in the Plaintiff's urine during this time, Dr. Roane continued to prescribe the same medications as before. Instead of ordering the proper testing to determine the cause of the Plaintiff's elevated protein, Dr. Roane continued to misdiagnose mixed connective tissue disorder as the cause of the proteinuria and all other symptoms. Dr. Roane's failure to recognize the Plaintiff's cancerous symptoms and order additional testing constitutes negligence.
- During this time (specifically from April 2005 through October 2007), Dr. Roane failed to properly diagnose the Plaintiff. The Plaintiff's consistent symptoms of high fever, rigors, chills, and persistent lymphadenopathy were most likely signs of a malignant infection, meaning the Plaintiff was likely suffering from occult malignancy and/or lymphoma instead of the previously misdiagnosed mixed connective tissue disorder. Failure of Dr. Roane to recognize symptoms of a malignant infection and/or lymphoma constitutes negligence.
- The Plaintiff was misdiagnosed with unidentified mixed connective tissue disorder despite negative antibodies and atypical symptoms. Throughout

the course of her treatment (specifically from April 2005 through October 2007), Dr. Roane continued to treat the Plaintiff aggressively for mixed connective tissue disorder, a disorder which the Plaintiff did not have. Failure of Dr. Roane to properly diagnose and treat the Plaintiff's true medical condition and to continue aggressive treatment her for an illness she did not have constitutes negligence.

- In addition to the above symptoms, the Plaintiff's SED rate remained strikingly elevated (60-140 range) and did not really change. This should have suggested to Dr. Roane that there was a potential protein problem. If the SED rate continues to increase, but the patient appears to be improving clinically, that should also be a red flag that something else is going on. The Plaintiff's SED rate was consistently high despite medications, and while the potent medications caused the SED rate to decrease somewhat at times, it was obvious that the medications failed to treat the Plaintiff's underlying condition. Dr. Roane's failure to recognize that the Plaintiff's elevated SED rate and proteinuria could indicate cancer beginning in April 2005, and her failure to properly monitor the Plaintiff's response to medications, constitutes negligence.
- Instead of ordering additional testing, Dr. Roane kept the Plaintiff on potent immunosuppressants, such as Immuran and Cellcept, which did not effectively treat the Plaintiff's significantly elevated proteinuria or SED rate. These type of medications should be used to treat specific diseases and/or conditions, not just fatigue and joint pain. Dr. Roane was negligent in continuing to order the above potent immunosuppressants (specifically

from April 2005 through October 2007) to treat the Plaintiff's symptoms of fatigue and joint pain especially without determining the cause for such symptoms.

- Additionally, Dr. Roane noted throughout the medical records that the Plaintiff had lymphadenopathy (i.e., enlarged lymph nodes). Since the Plaintiff had persistent enlarged lymph nodes from April 2005 forward, Dr. Roane should have performed a biopsy of the lymph nodes especially when considering the Plaintiff's symptoms of unexplained fever, chills and rigors. Failure of Dr. Roane to order additional testing to include a lymph node biopsy constitutes negligence.
- Additionally, Dr. Roane continued to note that the Plaintiff had high protein in her urine – especially after September 2005 when the Plaintiff was no longer treating with a nephrologist. During this time, Dr. Roane was responsible for following and evaluating the Plaintiff's proteinuria. This would include making a firm diagnosis and determining the cause of the Plaintiff's proteinuria. At the very least, after September 2005, Dr. Roane had a duty to refer the Plaintiff to a nephrologist who could make a firm diagnosis. Failure of Dr. Roane to properly evaluate and diagnose the cause of the Plaintiff's proteinuria or refer her to a nephrologist (specifically after September 2005) constitutes negligence.
- On or about January-February 2010, a 24-hour urinalysis and a UPEP test was finally performed which revealed cancerous myeloma protein. In addition, a bone marrow biopsy revealed lymphoma. The Plaintiff was

subsequently diagnosed with lymphoplasmacytic lymphoma. This was the first time the Plaintiff was ever informed that she had cancer.

- Based on my review of the medical records, it is most likely that the Plaintiff's cancer was present in 2005 when she treated with Dr. Roane, and the cancer could have easily been identified by performing a UPEP test or a lymph node biopsy. Dr. Roane's failure to perform these tests constitutes negligence and a breach in the standard of care.
- With reasonable medical certainty, if Dr. Roane would have performed a UPEP test and/or lymph node biopsy as early as April 2005, the Plaintiff's cancer would have been detected and treated in 2005 – instead of six years later after the cancer had progressed.

7. These violations of the standard of care have proximately caused injuries and damages to the Plaintiff which may be summarized as:

- If Dr. Roane had correctly diagnosed the Plaintiff's condition and performed the proper testing beginning in 2005 to determine the cause of the Plaintiff's symptoms (to include but not be limited to her symptoms of lymphadenopathy, persistently high SED rates, and increasingly high urine protein), it is more likely than not that the Plaintiff's cancer would have been detected and treated at an earlier stage.
- It is more likely than not that the above negligent actions by the Defendants caused and is continuing to cause the Plaintiff to endure continuous and unnecessary pain and suffering and has led to a further decline in her medical condition.

- Additionally, it is more likely than not the above actions caused the Plaintiff to require and continue to receive medical treatment and incur additional medical expenses and costs.

Thomas M. Zizic M.D.
Thomas M. Zizic, M.D.

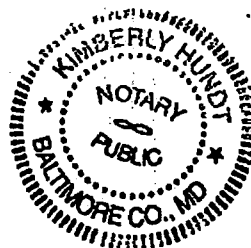
SWORN TO before me this

11 day of March, 20 11

Kimberly Hundt (L.S.)

Notary Public for Baltimore, MD

My commission expires: 9/22/13



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C. CARTER ELLIOTT, JR.
SEAN T. PHELAN*

LAUREN V. KNIGHT

*Also admitted to practice in NC & GA

March 4, 2014

VIA EMAIL & FEDERAL EXPRESS

The Honorable J. C. Nicholson, Jr.
100 Broad St, Suite 106
Charleston, SC 29401

RE: *Marshall, et al v Dodds, et al*
C/A Nos: 11-CP-10-00934

Dear Judge Nicholson:

Please allow this letter to follow up on the Summary Judgment Hearings held before you on March 3, 2014 in Charleston County. Please note that both Ed and I have now read over both cases relied upon by Defense Counsel relating to their arguments that they were entitled to Summary Judgment regarding both pending cases. The cases referred to in their memorandum and in their arguments are Harrison v Bevilacqua, 354 S.C. 129 (2003), 580 S.E.2d 109 and Kerr v Richland Memorial Hospital, 383 S.C. 146 (2009), 678 S.E.2d 809 (copies of which are attached for the Court's convenience). After having a chance to fully and completely review these cases we believe they are clearly distinguishable from our two cases. In Harrison, the Plaintiff was a diagnosed schizophrenic who alleged that he had been improperly involuntarily committed by a State run hospital for approximately 13 years. The main question addressed by the SC Supreme Court was whether or not the Court should adopt the continuous treatment rule (doctrine of continuing tort) – which basically stands for the proposition that the statute of limitations for medical malpractice would be tolled until treatment for the particular disease or condition involved was terminated. The Plaintiff/Petitioner argued that his causes of action did not accrue until the termination of his treatment – which was his discharge date. With regard to this issue the Court found that continuous treatment rule should not be judicially adopted. It is important to note that the plaintiff in the Harrison case sought to "toll" the statute of limitations until treatment had ended even though he was on notice that malpractice had occurred. This doctrine is a tolling doctrine which allows a plaintiff to extend the applicable statute of limitations. In the present case, the plaintiff is not trying to excuse a late filing or "toll" the statute. In these cases the Plaintiff (by and through her Complaint and experts) is only

attempting to pursue those claims that properly fall within the applicable statute of limitations and statute of repose.

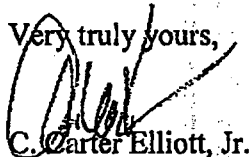
In the Kerr case, the Plaintiff Estate filed a medical malpractice action against the Richland Memorial Hospital alleging that in 1996 an excised mole was misdiagnosed as benign by a Pathologist. In 2001, the decedent learned the 1996 specimen (upon re exam) contained evidence of melanoma. This lead to the decedent's death in 2002 brought on by complications of cancer. Kerr's Estate brought suit in 2003 against the hospital – more than six years after the alleged misdiagnosis and/or negligent conduct. The Supreme Court again rejected the continuous treatment rule. In the Kerr case, (without a tolling argument) the Plaintiff's claims were found to be clearly outside the 6 year statute of repose. In the Kerr case, the only act of negligence was the initial misreading of the pathology slides by the pathologist. There were no allegations of separate acts of negligence within the 6 year window – as are alleged in the Marshall case.

With regard to the present cases, the Plaintiffs have not alleged or argued that they are entitled to any type of tolling – such as is described in the cases cited above. Additionally, the Plaintiffs have not alleged that their causes of action did not accrue until such time as their treatment ended with these Defendant Physicians. In the present civil actions filed by the Marshalls, the Plaintiffs have properly alleged numerous separate independent acts of negligence/gross negligence which occurred well within the 6 year window (prior to the filing of its actions). The experts for the Plaintiffs in both cases have given opinions (in their affidavits as well as in their depositions) that these separate and independent acts of negligence caused the Plaintiffs to incur damages. Even though defense counsel would surely like it to be so, the Court in Harrison and Kerr did not find that because there may have been some act of negligence which occurred beyond the 6 year time period – it somehow precludes a Plaintiff from bringing an action based upon separate independent acts of medical negligence which are within the 6 year time period.

Lastly, I have submitted the depositions of the Defendant doctors, as well as the Plaintiffs' experts who give opinions and went to great lengths to explain the independent actions of negligence which occurred well within the 6 year statute of repose. For the reasons stated above as well as those argued at the hearings – the Plaintiffs would respectfully request that the Defendants' Motions for Summary Judgment be denied.

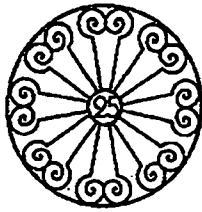
With kind personal regards, I am

Very truly yours,


C. Carter Elliott, Jr.

CCE/kam
enclosures

cc: J. Edward Bell, III, Esq. (via email only w/o enclosures)
H. Cooper Wilson, III, Esq. (via email only w/o enclosures)
Jack Gresh, Esq. (via email only w/o enclosures)
D. Jay Davis, Jr., Esq. (via email only w/o enclosures)



YCR LAW

Young Clement Rivers, LLP

Perry M. Buckner, IV
Attorney

Direct Dial: (843) 720-5406
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March 5, 2014

The Honorable J.C. Nicholson, Jr.
100 Broad Street, Suite 106
Charleston, SC 29401
(Via Email & U.S. Mail)

Re: Virginia L. Marshall and Todd W. Marshall vs. Georgia Roane, M.D. and
Rheumatology Associates, P.A.
Case No. 2011-CP-10-934
YCR File: 2466-20110384

Dear Judge Nicholson,

I am writing in response to Plaintiffs' correspondence to the Court dated March 4, 2014 concerning the summary judgment hearing which was held before you on Monday morning in the above captioned matter. Our firm represents Dr. Roane and her practice, Rheumatology Associates, P.A., and appeared on their behalf at the hearing.

Respectfully, I believe Plaintiffs' letter to the Court mischaracterizes the position taken by these Defendants at the hearing and unnecessarily confuses the legal issues presented. Therefore, I feel it is necessary to respond so as to avoid Plaintiffs' assertions going unanswered. I hope this letter can clarify the arguments which we have advanced and, where necessary, identify the distinctions between our position and those of the Co-Defendants, Dr. Kenneth Dodds and Charleston Nephrology.

This is a cancer misdiagnosis case. Plaintiffs' only liability expert (with regard to my clients) has testified that Dr. Roane failed to properly treat the Plaintiff and misdiagnosed the Plaintiff's cancer in February of 2002. Plaintiffs failed to commence this action until 2011. In a last ditch effort to revive their time-barred claim, Plaintiffs attempt to create a distinction which does not exist and complicate a straightforward argument to avoid summary judgment. Notably, Plaintiffs fail to cite to any legal authority that supports the arguments which they advance.

The statute of repose, as set forth in S.C. Code Ann § 15-3-545(A), requires the Plaintiffs to file an action within six years from the date of the first occurrence of a negligent act. The sole liability expert designated by the Plaintiffs to testify against Dr. Roane and her practice, Dr. Zizic, *stated that had Dr. Roane ordered proper testing be conducted in February of 2002, Plaintiffs*

condition would have been discovered. Plaintiffs did not file suit in this matter until 2011, some nine years after that first alleged negligent act. To be sure, Dr. Zizic is the sole witness in this case who can testify as to the date of the first negligent act as no other expert designated by the Plaintiffs has offered an opinion as to Dr. Roane (nor could they) and no other witness in this case is qualified. These are all undisputed facts.

Plaintiffs attempt to circumvent this testimony by now arguing that Dr. Zizic's testimony and his affidavit actually identify 2005 as the point of concern in this case. Conveniently, the 2005 visit referenced is the oldest treatment date among dozens throughout a nearly 8 year treatment period that still fits within the six year statute of repose period. However, Dr. Zizic's deposition testimony, without question, draws no distinction between the alleged failures in February of 2002 and those in 2005 going forward. What Plaintiff now suddenly identifies as "separate" and "independent" acts of negligence simply were not categorized as such by Dr. Zizic. In fact, a close examination of Dr. Zizic's testimony demonstrates precisely the opposite:

Q: Were there any other points along the time line of events that you have particular concerns? You've identified a couple, 2002, 2003. Were there any other points in time along that spectrum that you believe you're going to be particularly critical of?

A: Well, I think just like we take care of our patients with annual exams, physicals, and we're more appropriately doing that than their internists in patients with systemic rheumatic diseases such as an undifferentiated connective tissue disease. And so most rheumatologists will yearly do a more complete evaluation with laboratory studies, particularly when there's some features that are atypical and may not be fitting with our normal patients have. So I would say from 2004, 2005, 2006, 2007 *she should have had yearly exams looking at the laboratory studies we've been talking about.....* (emphasis added)

(See Deposition Excerpt of Dr. Zizic, Page 125, Lines 8-25, attached hereto as Exhibit A).

Importantly, these yearly exams which Dr. Zizic references are the same tests which he testified should have been conducted in 2002 and 2003:

Q: What would the re-workup [in February of 2002] include, in your opinion? What would need to be done to --you say rework the patient, what are we talking about?

A: Well, a whole complete antibody profile: ANA, anti-DNA, single-strand, double-strand, ENA, RNP, SM, RO, LA, p-ANCA, c-ANCA, and we can go on. But that's basically the antibodies I do. I would be looking at--I would get an SPEP, I would get a UPEP, because I've got proteinuria which I know, and I've got these low complements which I don't have explanation for. So I've got to go back through this.

Q: Do you have an opinion as to whether the SPEP or the UPEP would have revealed anything by this point [in February of 2002]?

A: I do.

Q: You think it would have?

A: I would. I do.

Q: Waldrenstrom's or something that –

A: Some abnormality that would lead you to do a bone marrow biopsy and go forward.

(See Deposition Excerpt of Dr. Zizic, Page 76, Lines 16-25—Page 77, Lines 1-11, attached hereto as Exhibit B). Dr. Zizic simply fails to articulate any discernible difference in Dr. Roane's treatment from 2002 to 2007 which supports Plaintiffs' arguments to this Court.

The fact that Plaintiffs' expert assigns fault as to Dr. Roane subsequent to 2002 does not mean Plaintiffs' claim is timely. This is exactly the scenario which South Carolina's judicial rejection of the continuous tort rule seeks to prevent. If Plaintiffs' argument was legally tenable, the statute of repose would be rendered meaningless and Plaintiffs' claims would be "revived" at every treatment date, particularly in a misdiagnosis case. Stated differently, if a condition is alleged to have been misdiagnosed in 2002, how could a 2005 misdiagnosis of the same condition be a "separate" and "independent" act?

This was the precise scenario presented in Howell v. Zottoli, 302 Ga. App. 477 (2010) in which the Georgia Court of Appeals granted summary judgment in favor of a defendant physician. Importantly, the South Carolina Supreme Court has cited to Georgia law when rejecting the continuous tort rule in the Harrison v. Bevilacqua 354 S.C. 129 (2003). In Howell, the plaintiff was treated over a five year span by the defendant physician but never was properly diagnosed with coronary artery disease. After five years of treatment, the plaintiff died of this very same condition that was never diagnosed. The plaintiff's estate filed the action outside the Georgia five year statute of repose if calculated from the first failure to diagnose but argued that the statute began to run anew upon subsequent misdiagnosis thereby rendering the action timely. The Court disagreed and stated that:

"although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition."

Howell, 302 Ga. App. at 479. A copy of the Howell opinion is enclosed.

What Plaintiffs allege is a "distinct event" in this case is nothing more than a continuation of the same course of treatment. Plaintiffs cannot avoid summary judgment by identifying different symptoms or protein levels that Plaintiff presented with at subsequent visits, emphasizing certain treatments, or by arguing that Plaintiff's condition worsened and there was therefore a distinct negligent act. The proper inquiry for examining a statute of repose issue is simply when the first act of negligence or misdiagnosis occurred. Because Plaintiff's only liability expert has represented that date was February of 2002, summary judgment is proper pursuant to the statute of repose.

Lastly, Plaintiffs' correspondence represents that Defendants primarily relied upon two South Carolina Supreme Court cases in arguing before the Court. Plaintiffs simply mistaken regarding my clients. The first case cited by Plaintiffs is Kerr v. Richland Memorial Hosp., 383

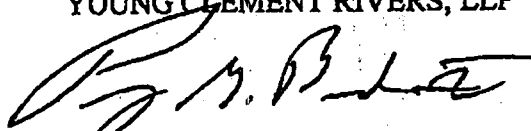
S.C. 146 (2009). This case was not raised by these Defendants at the hearing or in their brief filed with this Court. The second case referenced is Harrison case referenced above. While these Defendants did reference this case in their brief and would assert that it is legally relevant to the issues in this case, it was not raised as the primary or exclusive grounds for summary judgment. Notwithstanding this distinction, our arguments certainly were not limited to the Harrison case or the legal authority set therein as the brief filed with this Court cites to a multitude South Carolina cases applicable to this instant matter. Therefore, Plaintiffs' attempt to distinguish these two cases is not dispositive of the issues presented to this Court.

If the Court would prefer that the parties provide supplemental briefs or a proposed order for this matter, I would be happy to provide either.

With kindest regards, I am

Sincerely,

YOUNG CLEMENT RIVERS, LLP



Perry M. Buckner, IV
Attorney

PMB/

Enclosure(s): Deposition Excerpts of Dr. Zizic and Howell opinion

Cc: J. Edward Bell, III

C. Carter Elliott, Jr.

James B. Hood

HOWELL OPINION

302 Ga.App. 477
Court of Appeals of Georgia.

HOWELL

v.

ZOTTOLI.

No. A10A0003. | Feb. 24, 2010.

Synopsis

Background: Widow brought medical malpractice action against doctor following the death of her husband from coronary heart disease. The State Court, Chatham County, Ginsberg, J., entered summary judgment in favor of doctor. Widow appealed.

[Holding:] The Court of Appeals, Blackburn, P.J., held that statute of repose on claim arising out of the diagnosing and treating of patient's already existing cardiac disease and attendant vascular damage began to run on the date of doctor's initial misdiagnosis and failure to treat.

Affirmed.

Barnes, J., concurred specially and filed opinion.

Barnes, J., concurred in judgment only.

West Headnotes (3)

[1] Limitation of Actions

⇒ Negligence in performance of professional services

Although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening medical condition. (Per Blackburn, P.J., with one judge concurring separately and one judge concurring in judgment only.) West's Ga.Code Ann. § 9-3-71(b).

[2] Limitation of Actions

⇒ Negligence in performance of professional services

Limitation of Actions

⇒ Health care professionals in general

Statute of repose on medical malpractice action against doctor, arising out of the diagnosing and treating of patient's already existing cardiac disease and attendant vascular damage, began to run on the date of doctor's initial misdiagnosis and failure to treat; condition or injury of damage to vascular system, which worsened and eventually resulted in patient's demise, did not become "new" over the years, as would reset the running of the statute of repose. (Per Blackburn, P.J., with one judge concurring separately and one judge concurring in judgment only.) West's Ga.Code Ann. § 9-3-71(b).

[3] Limitation of Actions

⇒ Health care professionals in general

In order for the "new injury" or "new condition" exception to apply to reset the running of the statute of repose on medical malpractice claim, not only must there be evidence that the patient developed a "new injury" or "new condition," but he or she must also remain asymptomatic for a period of time following the misdiagnosis and mistreatment. (Per Blackburn, P.J., with one judge concurring separately and one judge concurring in judgment only.) West's Ga.Code Ann. § 9-3-71(b).

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Brennan & Wasden, Joseph P. Brennan, Savannah, for appellee.

Opinion

BLACKBURN, Presiding Judge.

*477 In this medical malpractice action, Vicki Howell (individually and as administratrix of the estate of her late husband) appeals the summary judgment granted to Dr. Lawrence Zottoli, arguing that the statute of repose¹ had not run on her claims against Dr. Zottoli. Because Dr. Zottoli's alleged misdiagnosis and mistreatment began in 1996, we agree with the trial court that the complaint filed seven years later was barred by the five-year statute of repose. Accordingly, we affirm.

Summary judgment is proper when there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. OCGA § 9-11-56(c). A de novo standard of review applies to an appeal from a grant of summary judgment, and we view the evidence, and all reasonable conclusions and inferences drawn from it, in the light most favorable to the nonmovant. *Matjoulis v. Integon Gen. Ins. Corp.*²

So viewed, the evidence shows that in October 1996, Dr. Zottoli treated Howell's late husband for complaints concerning blood in his urine and performed a "Trucker's" physical examination on him. In March 1997, Dr. Zottoli prescribed decedent the weight-loss medication Pheniramine, but decedent never returned for a follow-up appointment. Over the next several years until decedent's death, Dr. Zottoli provided decedent several referrals and prescriptions even though decedent did not come into the doctor's office for in-office visits.

*478 From decedent's first visit in 1996 until his demise in April 2001, he manifested several cardiovascular risk factors such as morbid obesity, smoking, high cholesterol, diabetes, high blood pressure, and a family history of coronary heart disease. Dr. Zottoli did not diagnose decedent as at high risk for coronary artery disease and did not counsel him on nor treat him for coronary artery disease.

The 39-year-old decedent died of coronary heart disease on April 13, 2001. On April 10, 2003, Howell sued Dr. Zottoli and others for medical malpractice, alleging that Dr. Zottoli failed to properly diagnose and treat the cardiovascular risk factors evident in decedent over the course of his care. An expert testified in an affidavit attached to the complaint and later in a deposition that Dr. Zottoli acted below the standard

of care by failing to diagnose and treat decedent's evident cardiovascular risk factors (through counseling, medication, and support) over the five years Dr. Zottoli served as decedent's physician. This same expert testified without dispute that decedent's smoking, which had continued for more than 16 years prior to his death, caused decedent to have vascular disease from the commencement of that smoking, and that the continuation of that smoking only worsened the disease. Howell amended her complaint to add an allegation that Dr. Zottoli failed to warn decedent of the perils of cardiovascular risk factors.

Dr. Zottoli moved for summary judgment, arguing that the five-year statute of repose set forth in OCGA § 9-3-71(b) barred Howell's claims. The trial court agreed and granted summary judgment to Dr. Zottoli, giving rise to this appeal.

OCGA § 9-3-71 provides in pertinent part:

(a) Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which an injury or death arising **566 from a negligent or wrongful act or omission occurred.

(b) Notwithstanding subsection (a) of this Code section, in no event may an action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred.

(c) Subsection (a) of this Code section is intended to create a two-year statute of limitations. Subsection (b) of this Code section is intended to create a five-year statute of ultimate repose and abrogation.

...

Interpreting this statute, the Supreme Court of Georgia has held:

Under Georgia law, an action for medical malpractice must *479 be brought within five years from the date on which the negligent or wrongful act or omission occurred. OCGA § 9-3-71(b). Unlike cases involving the medical malpractice statute of limitation, see OCGA § 9-3-71(a), our focus in this case is on the date or dates on which appellants may

have committed acts of professional negligence. The test for determining when OCGA § 9-3-71(b)'s period of repose begins is based on the determination of when the negligent act causing the injury occurred.

(Footnote omitted.) *Schramm v. Lyon*.³

[1] *Kaminer v. Canas*⁴ held that, in cases alleging misdiagnosis and mistreatment, the statute of repose begins to run on the date of the initial misdiagnosis and failure to treat where the condition of the disease existed on that date. In *Kaminer*, the patient's condition of AIDS was misdiagnosed and therefore not treated for years, even though the patient exhibited symptoms of the disease from shortly after his birth. Although this misdiagnosis and failure to treat occurred each time the patient reappeared for treatment from the defendant doctors during a seven-year period, *Kaminer* affirmed summary judgment in favor of the defendant doctors, holding that in cases of misdiagnosis and mistreatment, the statute of repose begins to run on the date the initial misdiagnosis occurred. *Id.* Thus, although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligent act cannot serve as the new starting point of the statute of repose where the negligent act is merely the repeated failure to diagnose and treat a continuing though worsening condition. *Id.*

Howell points to *Cleaveland v. Gannon*⁵ as an example of a case where the statute of repose began to run anew on the date of a later act of misdiagnosis by the physician. But *Cleaveland* restricted its holding to circumstances where the later negligent act related to misdiagnosing and mistreating a completely new condition or injury. *Id.* Thus, where the pre-existing treatable kidney cancer in *Cleaveland* had metastasized into an untreatable cancer and now affected new and different organs, this new condition or injury of metastasis allowed the court to conclude that the failure to diagnose this new condition or injury constituted a separate negligent act that began to run the statute of repose anew. It was the development of this new condition or injury that distinguished *Kaminer* from the limited exception applied in *Cleaveland*. See *480 *Cleaveland*, supra, 284 Ga. at 378(1), 667 S.E.2d 366 ("[t]here is a significant legal distinction between a patient's development of an entirely new medical condition, and his experiencing the proximate symptomatic consequences of the original misdiagnosis"); *Amu v. Barnes*⁶

("[t]he 'new injury' exception applies only 'in the most extreme circumstances'").

Howell also points to *Schramm*, supra, 285 Ga. at 73-74(1), 673 S.E.2d 241, as another example of an exception to the *Kaminer* rule (i.e., the rule that the running of the statute of repose starts on the date of the first misdiagnosis). *Schramm*, however, did not **567 involve a misdiagnosis, but instead the patient there alleged that the physician, after a patient's spleen was removed, failed to warn the patient of the possibility that that spleen's absence could result in a serious injury or condition known as OPSI. Thus, the "new injury" exception, which applies to cases of misdiagnosis as described in *Cleaveland*, did not apply. See *McCord v. Lee*⁷ ("the 'new injury' rule is limited to misdiagnosis cases involving a very discreet set of circumstances").

Moreover, the absence of the spleen was not a condition that in and of itself was causing damage or injury to the plaintiff in *Schramm*; thus, there was nothing for the physician to misdiagnose or mistreat. Rather, there was only the physician's failure to warn of a possible condition or injury that could result or occur in the future. This failure to warn of a possible or impending condition or injury constituted a new negligent act.

In reaching this conclusion, *Schramm* was careful to inform the bar that its holding was restricted to the particular facts of that case. *Schramm* emphasized this point by concluding with the statement: "Importantly, our holding in this case is not the adoption of the continuing treatment doctrine so as to allow for the tolling of the statute of repose and should not be interpreted as to impose upon physicians a continuing duty to warn patients of risks from an existing condition at each subsequent visit." Supra, 285 Ga. at 75(3), 673 S.E.2d 241. Thus, if the condition was existing and simply continuing from prior visits, a defendant physician bears no "continuing duty to warn patients of risks from [that] condition at each subsequent visit." *Id.* Because the vascular disease here was present in decedent from the beginning of his treatment by Dr. Zottoli, the concept of failing to warn of a non-existent condition that could occur in the future simply did not apply in any case.

[2] *481 Here, the only "new" condition or injury asserted by Howell was the death of the decedent. But no subsequent negligent act occurred after the development of this new condition, for the patient was already dead and no longer receiving medical services. Rather, as testified to by Howell's

own expert, the undisputed evidence showed that the cardiac disease and attendant vascular damage had occurred and existed when the decedent began smoking cigarettes, which condition and injury continued uninterrupted from the time Dr. Zottoli first diagnosed and treated him. The condition or injury of damage to his vascular system did not become "new" over the years; rather, it simply worsened and eventually resulted in his demise, as in *Kaminer*. Because the condition or injury was already existing, the rule regarding diagnosing and treating the condition applied, not the rule regarding warning the decedent about a condition in the future. Thus, the statute of repose began to run from the date of the first misdiagnosis and mistreatment.

[3] Moreover, in order for the "new injury" or "new condition" exception to apply, not only must there be evidence that the patient developed a "new injury" or "new condition," but he or she must also remain asymptomatic for a period of time following the misdiagnosis and mistreatment. *Amu*, supra, 283 Ga. at 552, 662 S.E.2d 113. Here, as alleged by Howell and as confirmed by her expert in his testimony, the condition of Howell's husband's cardiac risk factors and the attendant damage to his vascular system continued over the course of Dr. Zottoli's treatment of decedent. It simply worsened over time until it resulted in decedent's demise.

Accordingly, the statute of repose here did not begin to run anew from a negligent act that occurred after the development of a new condition or injury, but, as in *Kaminer*, ran from the initial date of misdiagnosis and failure to treat. Since this initial misdiagnosis and failure to treat occurred in 1996, the filing of the complaint some seven years later was barred by the five-year statute of repose in OCGA § 9-3-71(b). The trial court did not err in granting summary judgment to Dr. Zottoli.

Judgment affirmed.

****568 BARNES, J., concurs specially.**

BERNES, J., concurs in judgment only.

BARNES, Judge, concurring specially.

I agree with the majority that the trial court properly granted summary judgment to the defendant doctor in this medical malpractice case, based on the statute of repose, but I concur specially as I do not agree with all that is said. We need not decide that Mr. Howell had an "injury"-vascular disease caused by years of smoking-when he first saw Dr. Zottoli, and

need not consider whether the doctor's subsequent attenuated contacts with Howell caused "new *482 injuries." Instead, based on the expert's testimony that Zottoli breached the standard of care when he first saw Howell by failing to diagnose, treat, and warn Howell about his cardiovascular risk factors, the statute of repose began running from that initial visit. The doctor's continued failure to diagnose, treat, and warn Howell of his risk factors was simply continued negligent treatment for the same medical condition. Additionally, the record does not indicate that treatment protocols changed in the interim, a factor the Supreme Court of Georgia considered in *Schramm v. Lyon*, 285 Ga. 72, 673 S.E.2d 241 (2009) in determining that subsequent negligent acts began new periods of repose. While Howell may indeed have had vascular disease when he first saw Zottoli, that condition did not arise from Zottoli's negligence. Howell's risk factors by themselves were not injuries for which he could have sued Zottoli; the injury resulting from Zottoli's failure to diagnose, treat, and warn occurred when Howell suffered a fatal heart attack. But the statute of repose ran five years after Zottoli's initial negligence and Howell's suit was not filed within that time period.

"The statute of repose imposes an absolute limit on the time within which an action may be brought. Because the statute of repose is unrelated to the accrual of the cause of action, it runs from the date on which the negligent or wrongful act or omission occurred or was discovered." (Citation and punctuation omitted.) *Christian v. Atha*, 267 Ga.App. 186, 187, 598 S.E.2d 895 (2004); see also *Bush v. Sreeram*, 298 Ga.App. 68, 70(3), 679 S.E.2d 87 (2009).

The majority's analysis of recent Supreme Court of Georgia medical malpractice cases involving the statutes of repose and limitation is thoughtful and scholarly. The distinctions between some of those cases are not easy to apply to new fact patterns. Compare *Kaminer v. Canas*, 282 Ga. 830, 834(1), 653 S.E.2d 691 (2007) (statute of repose began running when plaintiff's doctors first failed to diagnose and treat pediatric AIDS); *Amu v. Barnes*, 283 Ga. 549, 551, 662 S.E.2d 113 (2008) (new statute of limitation began running when plaintiff's treatable colon condition developed into untreatable metastatic cancer, although two years passed after doctor's initial failure to diagnose); *Cleaveland v. Gannon*, 284 Ga. 376, 377(1), 667 S.E.2d 366 (2008) (statute of limitation began when plaintiff's treatable kidney cancer developed into untreatable metastatic cancer); and *Schramm v. Lyon*, supra, 285 Ga. 72, 673 S.E.2d 241 (new statute

of repose began running upon each failure to warn post-splenectomy plaintiff of infection risk).

As former Chief Justice Sears noted in her concurrences in *Amu*, 283 Ga. 554, 662 S.E.2d 113 and *Cleaveland*, 284 Ga. at 383, 667 S.E.2d 366, "no meaningful distinction" exists between those two cases and *Kamliner* except that the first two cases involved men with cancer and *Kamliner* involved *483 a child with AIDS. Fortunately, this court need not sort

through this confusion here because the defendant's negligent act occurred more than five years before suit was filed, and thus the statute of repose applies.

For these reasons, I respectfully concur specially.

Parallel Citations

691 S.E.2d 564, 10 FCDR 583

Footnotes

- 1 OCGA § 9-3-71(b).
- 2 *Majoulis v. Integon Gen. Ins. Corp.*, 226 Ga.App. 459(1), 486 S.E.2d 684 (1997).
- 3 *Schramm v. Lyon*, 285 Ga. 72, 73(1), 673 S.E.2d 241 (2009).
- 4 *Kamliner v. Canas*, 282 Ga. 830, 837-838(3), 653 S.E.2d 691 (2007).
- 5 *Cleaveland v. Gannon*, 284 Ga. 376, 378-379(1), 667 S.E.2d 366 (2008).
- 6 *Amu v. Barnes*, 283 Ga. 549, 552, 662 S.E.2d 113 (2008).
- 7 *McCord v. Lee*, 286 Ga. 179, 182, 684 S.E.2d 658 (2009).

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March 7, 2014

VIA EMAIL & FIRST CLASS MAIL
The Honorable J. C. Nicholson, Jr.
100 Broad St, Suite 106
Charleston, SC 29401

RE: *Marshall, et al v Dodds, et al*
C/A Nos: 11-CP-10-00934

Dear Judge Nicholson:

Please allow this letter to follow up on the additional information sent to you by Defense Counsel on March 5, 2014. I find it interesting that at the hearing Defense Counsel basically relied upon the two (2) cases cited in my letter to you dated March 4, 2014. After we pointed out the fact that these cases were distinguishable from the facts of the Marshall case and did not seem to apply – Defense Counsel then came up with additional cases to now include a Georgia case – *Howell v Zottoli*, 302 Ga. App. 477 (2010). In *Howell*, the evidence showed that in October of 1996, Dr. Zottoli examined and treated the decedent for complaints concerning blood in his urine. Over the next several years Dr. Zottoli provided decedent several referrals and prescriptions – but during this time the decedent never came back into the doctor's office for in office visits. Dr. Zottoli did not diagnose decedent as high risk for coronary artery disease and did not counsel him on nor treat him for coronary artery disease. The decedent later died of coronary heart disease on April 13, 2001.

Even though this is a Georgia case, and seemingly should not serve as precedent to this South Carolina case – we believe the Marshall cases are distinguishable from this case as well. In *Marshall*, there was no evidence of high protein levels until June of 2003. Thereafter, Dr. Roane prescribed certain medications to try and treat the high protein levels as well as a high sed rate. After not seeing a response to the medications Dr. Roane then referred the Plaintiff to Dr. Dodds in September of 2014. The main purpose of the referral was to see if Dr. Dodds could successfully treat the high protein levels. Dr. Dodds then placed the Plaintiff on the prescription drug Diovan. The Plaintiff's expert, Dr. Luke, testified that it generally takes a month or two to see whether or not a patient is responding to this type of medication as a treatment for these types of conditions. (see page 143 of Deposition). On February 7, 2005, Dr. Dodds performs a 24 hour urine test which reflected extremely high protein levels. It is specifically at this time that Dr.

Luke opines that Dr. Dodds should have recognized that the Diovan was indeed not having an effect. However, at this time Dr. Dodds failed to make a change in her medication and told her to follow up in another 6 months for a follow up 24 hour urine protein test. In his affidavit Dr. Luke testified that Dr. Dodds continuing to prescribe Diovan without properly monitoring the Plaintiff's response to the medications constituted negligence. Furthermore, Dr. Luke testified that the failure of Dr. Dodds to change the treatment plan in light of the continuous high protein count was further evidence of negligence. (see Luke affidavit page 5 and 6). On September 12, 2005 the Plaintiff's 24 hour urine test revealed 4.2 grams of protein – which was significantly higher than it was in September of 2004 or February of 2005. At this time Dr. Dodds failed to order additional testing to try and account for the significant increase in protein levels. Again, he failed to properly recognize the fact that the newly prescribed Diovan was not having the desired effect – which was further evidence of negligence. Dr. Luke based his opinions primarily on the fact that the new medication was not working and the fact the protein levels were now the highest they had ever been. Additionally, at this time neither Dr. Roane nor Dr. Dodds warned the Plaintiff that the underlying medications prescribed by Dr. Roane – placed her at risk of developing cancer.

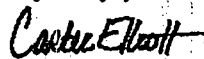
Mrs. Marshall continued to see Dr. Roane throughout this time period by and through in person office visits from 2005 to 2007. Additionally, Dr. Roane had obtained the office notes from Dr. Dodds and was fully aware that he had placed Mrs. Marshall on additional prescription medications and that the protein levels had failed to come down. Her notes also reflect that she was aware that the protein levels in the urine had increased to the highest levels they had ever been. Therefore, Dr. Roane should have known at this time – that a new action needed to be taken. Dr. Roane should have ordered additional testing or (at a minimum) referred the Plaintiff to another specialist. (see affidavit of Dr. Zizic).

Clearly, the separate and distinct acts of negligence (focused on by the Plaintiffs' experts) are directed at the time period beginning in February of 2005. Additionally, this is the time period when it was most likely the cancer/lymphoma would have been detectable had the proper tests been ordered. Additionally, from 2005-2010 the cancerous tumor continued to grow in size and the Plaintiff's overall health continued to deteriorate. Therefore, it is during this time period when the defendants consciously failed to act as they were trained. This would be the evidence of gross negligence the Plaintiffs would need in order to pursue punitive damages.

Therefore based on the above the Plaintiff would again respectfully request that the Defendants' summary judgment motions be denied.

With kind personal regards, I am

Very truly yours,



C. Carter Elliott, Jr.

CCE/kan
enclosures
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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Case No. 2011-CP-10-0934

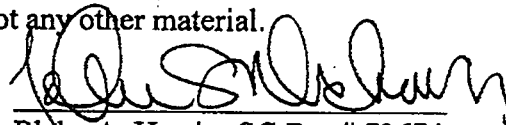
Virginia L. Marshall and
Todd W. Marshall, ... Appellants,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A., ... Respondents.

CERTIFICATE OF COUNSEL

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.



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April 14, 2015

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Case No. 2011-CP-10-0934

Virginia L. Marshall and
Todd W. Marshall, ... Appellants,

v.

Kenneth A. Dodds, M.D., Charleston
Nephrology Associates, LLC, Georgia
Roane, M.D., and Rheumatology
Associates, P.A., ... Respondents.

PROOF OF SERVICE

The undersigned hereby certifies that on the date indicated below she served counsel
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