

THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

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S.C. SUPREME COURT

Appeal from Charleston County
Court of Common Pleas

R. Markley Dennis, Jr., Circuit Court Judge

Circuit Court Cases No. 2012-CP-10-2867 and 2011-CP-10-8313

Opinion No. 5535 (S.C. Ct. App. filed February 7, 2018)
Appellate Case No. 2015-001463

Clair Craver Johnson, Respondent,

v.

John Roberts, M.D., Petitioner.

And

Clair Craver Johnson, Respondent,

v.

Medical University of South Carolina, Petitioner.

JOINT APPENDIX VOLUME 2 OF 2

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¹ Includes cover letter advising that suggestion for rehearing en banc has been rejected

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

RECEIVED

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

MAR 14 2016

SC Court of Appeals

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

RECORD ON APPEAL
Volume II of II

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

CLAIR CRAVER JOHNSON,

Plaintiff,

vs.

Case No. 2012-CP-10-2867

JOHN ROBERTS, M.D.,

Defendant.

CLAIR CRAVER JOHNSON,

Plaintiff,

vs.

Case No. 2011-CP-10-8318

MEDICAL UNIVERSITY OF SOUTH CAROLINA,

Defendant.

DEPOSITION OF HAROLD B. BURSZTAJN, M.D.

Cambridge, Massachusetts

Tuesday, October 29, 2013

11:14 a.m.

MAGNA
LEGAL SERVICES

Page 2

1 Deposition of Harold B. Bursztajn, M.D., held at:
2 Harvard University Science Center
3 1 Oxford Street
4 Cambridge, Massachusetts 02138
5
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7

8 Pursuant to agreement, before Victoria S.
9 Reade, Professional Reporter and Notary Public in
10 and for the Commonwealth of Massachusetts
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1 P R O C E E D I N G S

2 MR. EARLY: Doctor, you understand
3 you're still under oath?

4 THE WITNESS: Yes.

5 DIRECT EXAMINATION BY MR. EARLY:

6 Q. Dr. Bursztajn again, Will Early
7 representing MUSC. I am here in Mount Pleasant,
8 South Carolina and you're in either Cambridge or
9 Boston still; is that correct?

10 A. Yes. You should come up, see the Red
11 Sox.

12 Q. Doctor, since I think we last spoke,
13 today is October 30th, I think it was either
14 sometime in July or August when we stopped your
15 deposition.

16 Have you had any discussion with
17 anyone regarding your testimony or this case
18 since that time?

19 A. No.

20 Q. Have you ever reviewed any additional
21 material since we last convened for your
22 deposition?

23 A. Well, I continued to review the
24 literature and then I sent you a specific piece

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1 of law and an order from the South Carolina
2 Department of Mental Health that I focused on and
3 then I just went back over the case file in
4 detail.

5 Q. I understand.

6 A. I'm sorry, also my own deposition, of
7 course, a transcript of my deposition.

8 Q. You did review your transcription?

9 A. Yes, I did. Yes.

10 Q. And believe when we last and I was
11 looking at some of that last night and into this
12 morning, that as far as the liability, and I am
13 going to go through your testing here shortly,
14 but as far as the liability portion, you had
15 indicated to me I think that you had told me all
16 of the areas in which you believed that the
17 Medical University of South Carolina deviated in
18 the standard of care in their treatment of the
19 plaintiff in case already, have you not?

20 A. I believe I have.

21 Q. And if anything, again, comes up as I
22 stated last time between now and trial and you
23 feel you have another area where you'd like to
24 elaborate, would you please let Mr. Ravenel know

1 that so that he can contact me?

2 A. I will.

3 Q. Thank you, sir. And let's look at, if
4 you will, for lack of a better word, your
5 testing, Dr. Bursztajn.

6 Before we go into that, it's my
7 understanding based upon your testimony last time
8 that the areas or ways that you believe Miss
9 Johnson has suffered as a result of what you
10 believe to be malpractice in this case are that
11 she has post-traumatic stress disorder and memory
12 loss; is that a fair statement?

13 A. Well, she has memory loss and brain
14 damage as well as post-traumatic stress disorder,
15 yes.

16 Q. And so are you going to opine that she
17 has any vision problems as a result of
18 electroconvulsive therapy?

19 A. No specific visual problems as a
20 result of ECT, no, that's not my opinion.

21 Q. And as far as you used the word brain
22 damage, can you qualify that and be any more
23 specific than the broad term brain damage?

24 A. Well, when you have permanent fixed

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1 brain loss, when you have the loss of a variety
2 of executive functions which is permanent, that's
3 brain damage.

4 You don't have loss of brain function
5 which is permanent and fixed without having brain
6 damage. Psychiatry is not brainless.

7 Q. Is there something specific or any
8 more narrow that you can make it for or me or you
9 just use the word brain damage?

10 A. I think that covers it.

11 Q. And the basis of that diagnosis is
12 anything other than your test of her or is it
13 anything else?

14 A. It's the reports of her family about
15 the changes which occurred over time. It's her
16 own complaints found in the medical records about
17 her memory problems, the changes in memory and
18 executive function that are evidenced over time,
19 and there are corroborated both by her parents
20 and her brother, and by review of her history.

21 That history indicates that before
22 2003 she had been able to even in the midst of
23 the mental illness that she does have, which is
24 bipolar illness, and even subsequent to a

1 youthful period of drug and alcohol use she was
2 able to go ahead and complete college, she was
3 able to have a job and to function like a social
4 human being, and now she doesn't have the memory,
5 doesn't have the autobiographical memory, doesn't
6 have the ability to integrate memorizes, doesn't
7 have the executive functions which depend on the
8 ability to integrate memories that are necessary
9 for her to hold a job, for her to function as a
10 relatively independent social human being.

11 Q. Do you base your opinion with regards
12 to the brain damage based anything to do with any
13 CT scans or any other imaging?

14 A. The CT scans are consistent, the
15 changes with the CT scan are consistent with
16 brain damage, but they don't form the foundation
17 for my opinion.

18 Her history and her presentation and
19 the medical records, the collaborative
20 information, those are foundational stones for my
21 opinion.

22 Q. Dr. Bursztajn, I know you have done a
23 lot of testing. I think I have all those tests.
24 Mr. Ravenel provided those to us.

Page 10

1 Is there a document where you
2 summarize the testing itself that we can go
3 through, and if so, can you point it to me?

4 A. Yes. If you look at my report of
5 April 1st 2011 and specifically if you look at,
6 it's Page 10, psychological testing and
7 self-reporting instruments, it's 494 from the way
8 it's marked.

9 Q. Give me just a second to make sure
10 I've got it so we can go through it. I didn't
11 bring yours in a Bates number sequential fashion
12 so can you tell me the title of the document one
13 more time, the first one?

14 A. Yes. The title of it is my April 1st
15 2011 report. It says draft on it.

16 Q. Got it. And you had indicated another
17 document outlined your opinions with regard to
18 her testing, what other document did you say?

19 A. No. That's in the document on Page 10
20 of the document if you look at Page 10.

21 Q. Okay.

22 A. And it begins subsection B as it
23 Boston.

24 Q. Okay. I guess the previous section if



1 you go back to Page 8 talks about your
2 examination and observations and then would
3 Subsection B be the results of the tests
4 themselves?

5 A. Of the tests and the self-report
6 instruments, yes.

7 Q. All right. What is PAI, Personality
8 Assessment Inventory, can you tell me what that
9 is?

10 A. A personality assessment inventory is
11 a standardized test where the respondent's
12 answers are compared to a large sample of people
13 to be able to go ahead and formulate, first of
14 all, whether they were faking, exaggerating or
15 malingering their reported symptomatology.

16 Secondly, to see what other underlying
17 major mental illness or other forms of suffering
18 the person may be experiencing.

19 The test itself even though I
20 administered it, I sent away to be blindly
21 compared to a computer algorithm to a very large
22 sample of people.

23 So this is a way of checking to make
24 sure that just because I am retained by one side

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1 my interpretation does not, therefore, is not
2 therefore biased.

3 So it's compared to a large group of
4 people and to allow the possibility of faking,
5 exaggerating or malingering and also to
6 characterize what forms of suffering the patient
7 may be experiencing in the mental illness
8 arena.

9 Q. What, if anything, did the PAI test
10 show that you performed on Ms. Johnson?

11 A. Well, the findings and I am looking
12 now on Page 11, actually the bottom of Page 10 to
13 Page 11, she answered in a reasonably forthright
14 manner and did not present an unrealistic or
15 inaccurate impression that was either more
16 negative or more positive than the clinical
17 picture would warrant.

18 Therefore, and this is vital, she was
19 not faking, exaggerating or malingering as far as
20 her reports of her symptomatology and
21 impairments.

22 Q. How do you know that? Just in -- give
23 me the basis of that, what do you compare it to,
24 how did you make that determination?

1 A. Well, first of all, I did not make
2 this determination. This determination was made
3 by -- it's consistent with my own determination
4 but the determination I just read to you was not
5 made by me, it was made by a computer protocol
6 which compared her responses to the responses of
7 a large number of people some of whom were
8 faking, malingering and exaggerating.

9 And her responses are not those of
10 someone who is faking, exaggerating or
11 malingering symptomatology.

12 They were also consistent with my own
13 observations during the examination, and they
14 were consistent with her pattern of self-reports
15 which unlike the self-reports of people who fake
16 or exaggerate symptomatology tend to be nuanced
17 and focused and not basically consistent with any
18 pattern of faking, exaggerating or malingering.

19 Similarly, if anything during my
20 examination when I was observing her she had more
21 impairments than she was actually was able to
22 communicate when she was talking about those
23 herself.

24 But basically the impairments which I



1 observed during my examination were consistent
2 with the impairments that she reported in the
3 self-report instruments both which are the NFI
4 and also her own cognitive history checklists
5 that she proceeded to fill out and also are
6 consistent with reports of others including those
7 of her parents.

8 So when we put all this together we
9 have at least three different ways of checking to
10 make sure that she's not faking, exaggerating or
11 malingering.

12 The testing -- actually, four
13 different ways: The testing, the self-report
14 instruments, my observations, the observations of
15 collaborative witnesses, and then on top of that
16 we have a fifth way which is the medical record
17 itself which no where notes that she is faking,
18 exaggerating or malingering, so she's not.

19 Q. Other than the malingering you also
20 indicated the PAI showed whether or not she would
21 be suffering from some mental illness; is that
22 right?

23 A. Yes. It gives a differential
24 diagnosis to consider, and the diagnostic

1 considerations it raised were a chronic
2 depressive disorder ruling out a major depressive
3 disorder.

4 There was a question to rule out,
5 which can be ruled out in her case, of a
6 personality disorder not otherwise specified.

7 And that was based on the fact that in
8 her youth she used drugs and alcohol, which would
9 be consistent with her having dissocial features,
10 although, again, overall that particular
11 differential is much lower, and it's much more
12 consistent with the kind of profile in terms of
13 the co-efficient fit which occurs in the
14 post-traumatic spectrum and also in bipolar
15 disorder.

16 Q. Do you believe she had both the
17 chronic depressive disorder and the personality
18 disorder prior to being treated at MUSC?

19 A. I believe, first of all, that she did
20 not have a personality disorder, and she doesn't
21 have a personality disorder at this point.

22 What she does have is a post-traumatic
23 disorder, post-traumatic stress disorder in the
24 context of a bipolar disorder.

1 Prior to receiving involuntary ECT at
2 MUSC, I don't believe that she had a
3 post-traumatic component to her disorder, and I
4 don't believe that she had the, although she may
5 have had a vulnerability to brain damage, there
6 was not the kind of fundamental impairment of
7 memory executive function which she has today
8 which is consistent with having brain damage from
9 ECT.

10 Q. I want to take these one by one,
11 Dr. Bursztajn.

12 Are you saying that your decisions
13 post-traumatic stress disorder PIA test or is it
14 some other test?

15 A. It's not based simply on this test,
16 but this test is consistent with my diagnosis of
17 post-traumatic stress disorder, her natural
18 history, my observations and my examination and
19 the reports of people who have known her over
20 time.

21 Q. You don't believe she has a
22 personality disorder even at this time,
23 correct?

24 A. I don't believe she has a personality

1 disorder. What she has is a chronic
2 post-traumatic stress disorder, brain damage and
3 bipolar disorder.

4 Q. And her chronic depressive disorder, I
5 believe you used that term earlier, or bipolar
6 disorder predated any treatment at MUSC, you
7 agree with that?

8 A. Her bipolar disorder predated it,
9 however, it was episodic rather than -- it was
10 episodic and it repeated itself, but there was
11 not a chronic depressive component in between the
12 major depressive episodes and the manic episodes.

13 Now there is a chronic a depressive
14 component which is consistent with a kind of
15 demobilization that I see when patients have
16 post-traumatic stress disorder.

17 Q. I am not sure I am following you. Chronic
18 depressive disorder, you don't agree that she had
19 that prior to 2003?

20 A. I don't believe that she had a chronic
21 persistent post-traumatic complication which is
22 chronic demobilization and depression prior to
23 the involuntary ECT in 2003 which went through to
24 2005 and the ECT itself continued through to

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1 2008, no, I don't think so.

2 Q. The next page, I am looking Page 12
3 deals with your self-reporting instruments?

4 A. Yes.

5 Q. Tell me just in lay terms what that
6 is?

7 A. Well, it's a variety of different
8 check lists including the Davidson Trauma Scale,
9 and Behavioral Functional Inventory, the
10 Dissociative Experience Scale and five different
11 cognitive symptom checklists, one for attention,
12 one for memory, one for visual processes, one for
13 receptive languages, one for expressive language
14 and one for executive functions.

15 Q. I am going through those tests, but
16 can you tell me broadly what, if anything, those
17 self-reporting instruments show in your
18 opinion?

19 A. Yes. On the Davidson Trauma Scale,
20 her avoidance and numbing is much higher than the
21 intrusion.

22 That's, again, consistent with someone
23 whose been both traumatized and has memory loss.

24 People who don't have memory loss who



1 have been traumatized have much more intrusion
2 and less of an avoidance numbing response.

3 On the Neurobehavioral functional
4 Inventory she listed some impairments, however,
5 overall she rated her impairments only as being
6 slightly more severe than her mother did but
7 slightly less severe than her friend, Anna Maria
8 did and much less severe than her father did.

9 So overall she sees herself as being
10 less impaired than the people how know her and
11 love here, which, again, is inconsistent with
12 someone who is faking or exaggerating or
13 malingering or simply making a case.

14 Where she reported problems they were
15 mainly in areas of vision which were primarily
16 related to her chronic dystrophy not related to
17 the ECT but with one or two exceptions of
18 integration, but also memory.

19 She also reported a few up obsessions.
20 She did not list any indicators which would be
21 consistent with ongoing disturbance such as
22 epilepsy, so we know that's not the cause of her
23 disorder.

24 She tended to minimize the extend to

1 which said had dissociation but the exceptions
2 were interested because they are were primarily
3 in the area of memory and having no memory from
4 important events in her life and finding that she
5 had done or created things for which she had no
6 memory.

7 Again, this is not someone who
8 randomly is just trying to exaggerate here. It
9 was interesting when there were more specific
10 questions she did report specific deficits in all
11 the areas covered by cognitive symptom checklist,
12 again, consistent with someone who if anything
13 minimizing the amount of deficits she has.

14 When you ask more specific questions,
15 you get more reliable answers. So we can through
16 each of these such as attention and concentration
17 if you just give me a moment, I can look at
18 those.

19 Q. If you can while you're doing that,
20 Doctor, just tell me which test you're pointing
21 to so I can look at it with you, if you would.

22 A. Okay, will do. So I am looking now at
23 this cognitive symptom checklists and we'll begin
24 the, let's see, the first one is

1 attention/concentration.

2 So we can begin with

3 attention/concentration, are you with me?

4 Q. Yes, I am.

5 A. Okay..

6 Q. And just so I understand, this is part
7 of the Davidson Trauma Scale?

8 A. This is separate. These five
9 self-report structured questionnaires are
10 separate from all of those. That's constitutes
11 what's called cognitive symptom checklists and
12 the first one we have is the
13 attention/concentration one, but there is five of
14 them.

15 Q. Okay. What, if anything, does the CSC
16 attention/concentration checklist that -- well,
17 first of all, did she fill this form out
18 herself?

19 A. Yes, she did.

20 Q. So these would be subjective answers
21 that she gave based upon these questions,
22 correct?

23 A. Yes, but, again, objective to the
24 extent that they were corroborated by my own



1 observations as well as the observations of those
2 people who were closest to her.

3 So they were not simply her subjective
4 answers, but they were also interobjective which
5 makes them much more objective than simply
6 individually subjective.

7 Q. I understand. So, for example, on
8 Page 2 she indicated that she is not experiencing
9 any panic or fear on the date when you tested her
10 which would have been January 31st of 2011; is
11 that what that's saying essentially?

12 A. That is what that is saying, and
13 again, that would be consistent with minimization
14 because when she was talking about the ECT which
15 I saw as a good deal of someone who is very
16 frightened almost horrified.

17 So she tends to minimize how
18 frightened she really is rather than exaggerate
19 her how frightened she really is.

20 It isn't an inconsistency, but it's an
21 inconsistency between the direction of
22 minimization rather than exaggeration.

23 Q. She testified that didn't remember the
24 involuntary ECT treatments, correct?

1 A. Precisely, but when you ask her to try
2 and remember, that's when she gets very
3 frightened and that's what she begins to -- so
4 when she tries to remember, when we try and get
5 into details, that's when she begins to get very
6 hyperaroused and fidgety, but she doesn't see
7 that herself.

8 She will also alternate and then she
9 will go into a numbing state, someone who is
10 basically spaced out disassociated and she says I
11 just don't remember, but what you see first is
12 the fear which she herself overlooks, but you can
13 certainly see it when you try to question her
14 about it.

15 Q. I stopped you, but go ahead and tell
16 me if you would what, if anything, the
17 attention/concentration component of this CSC
18 shows, if anything?

19 A. Yes. She has a great deal of
20 difficulty focusing and she does get easily
21 distracted by any loud noises, which, again, is
22 both consistent with a post-traumatic component
23 it's also consistent with people who have been
24 shell shocked or brain damaged in a variety of

Page 24

1 ways.

2 Moving on to Page 3, again, she in
3 terms of sustained concentration she does have
4 difficultly staying on task and being focused.
5 She very easily will space out.

6 Moving onto the next page now focusing
7 on Number 9 and Number 10, she says that she does
8 not have difficulty shifting concentration from
9 one important thing to other things, and by my
10 observation she did have difficultly making
11 shifts of information, not all the way throughout
12 but when she was feeling frightened.

13 She certainly has difficulty keeping
14 track of more than one thing at a time in a
15 fundamental way, although, again, I think she
16 does to some extent tend to minimum that based on
17 my observations and based on the observations of
18 other people.

19 Q. And Doctor, is this -- I am sorry, you
20 had not finished with your answer, had you?

21 A. Well, I was going to ask you if you
22 wanted me to move on to the executive functions
23 which is the next chapter or we can stay with
24 this one, it's up to you.

1 Q. Well, I do have a few more questions
2 about this particular test.

3 Is this test or a similar test given
4 to patients or people in the assistance of
5 diagnosing folks with attention deficit
6 disorder?

7 A. It can be. It can be given to people
8 who have attention deficit disorder,
9 post-traumatic stress disorder and any other
10 disorders, brain damage or any other disorders of
11 attention and concentration. It's a general
12 instrument rather than an exclusive instrument.

13 Q. Were the findings of this particular
14 this attention/concentration checklist that
15 Ms. Johnson gave you on January 312011 consistent
16 with a person with ADHD?

17 A. In and of itself possibly but not
18 likely because people who have ADHD will, for
19 example, will tend to check off -- it's less
20 spotty.

21 For example, they will go ahead and
22 tend to check off focusing on the test when in a
23 large area or staying focused in places where
24 there are many sights and sounds, but it can be.

1 But itself it's not likely, but it can
2 be. What makes it unlikely is the overall
3 pattern, the other components of both this
4 instrument and the other facts that we have at
5 hand.

6 So it is consistent with some forms of
7 ADHD, possibly but not likely but possibly.
8 Again, it's not consistent when taken in
9 context.

10 Q. Let's move on to the executive
11 function portion of the test. Is that also
12 something that she did on her own in answering
13 those questions?

14 A. Yes.

15 Q. What, if anything, is executive
16 function just for a lay understanding is how is
17 that different from the attention portion of the
18 CSC that you just discussed?

19 A. Grossly speaking and forgive me for
20 being so general, the attention portion, the
21 attention/concentration portion focuses on focus
22 itself, that's what it's about.

23 Executive function are about judgment
24 and decision making. Now, that's a general

1 description, but a fair one.

2 Is that clear? Am I communicating
3 that clearly?

4 Q. Yes, sir, I think I understand that.
5 I was trying to look at Page 13 of your report in
6 conjunction with the executive function test and
7 can you tell me what, if anything, the executive
8 function subjective data that Ms. Johnson gave
9 you on January 31st 2011 shows, if anything?

10 A. Well, the findings that she reports
11 are first of all, inconsistent with someone who
12 is exaggerating or faking or malingering because
13 they're quite selective.

14 If anything they're less than what
15 I've observed and what her family and friends
16 have observed.

17 At the same time they are consistent
18 with some problems that she has in her reaction
19 time. She has major problems in initiating and
20 following through, so that's a deep area of
21 weakness.

22 I believe has she more problems in
23 self-correction even though she didn't check any
24 problems with self-correction. I observed

1 problems with self-correction when I was
2 examining her.

3 Again, she's checked off some problems
4 in mental flexibility. I believe those problems
5 tend to be more pervasive than the ones she
6 simply checked off, at least from what I observed
7 and from what other people have said about her.

8 She does have problems with planning.
9 She is aware of major problems in sequencing and
10 completing other tasks, an activity in sequence.

11 She has problems in problem solving.
12 If you give her a problem of any complexity she
13 will not know where to look for information. She
14 is quite disorganized so organizationally she is
15 not able to go ahead and organize and put things
16 together.

17 She has problems in reasoning. For
18 example, I observed and she checked off she could
19 not apply a general rule to a specific case, to a
20 specific example and by the token she couldn't go
21 in the other direction, go from a few specific
22 cases to a more general rule, so she has problems
23 going up and down from the particular to the
24 general and the from the general to the

1 particular.

2 She tends to focus only on one part of
3 a problem. If there is an elephant, she will go
4 ahead and see its trunk and call it a snake
5 basically so she has problems focusing on the
6 part as opposed to being able to see it in
7 context to be able to see it as a whole.

8 So together that makes it very
9 difficult for her to engage in any kind of
10 complex problem solving where you can't lose the
11 forest through the trees, so to speak.

12 Q. Is there anything else about the
13 executive function test that you have opinions on
14 that you haven't just stated to me?

15 A. I think that's basically covers it.
16 Again, having gone through each one in
17 particular, but they were consistent with my
18 observations.

19 Q. And just move onto the language
20 portion of this CSC.

21 A. I am sorry, I interrupted you. Please
22 go on.

23 Q. Well, if you wanted to finish one of
24 your answers, please do.

1 A. I was just going to say when you said
2 moving on to the language portion I would say
3 that overall except with expressive language she
4 is much more intact linguistically, so she sounds
5 better than she really is and that's evident in
6 the language portion.

7 So what we have is someone who has had
8 frontal lobe damage and some parietal lobe damage
9 basically.

10 Q. What was the last one?

11 A. Parietal, frontal and parietal lobe
12 damage, but basically her language function
13 compared to certainly compared to her executive
14 function and her attention is more intact.

15 So this is a picture of a patient who
16 can talk a good game to some extent and she may
17 appear to much more functional than she really
18 is.

19 Q. What is the frontal lobe affect, and
20 that my abe a lot of things, but can you tell me
21 what it affects?

22 A. Well, it primarily affects executive
23 functions and it also integrates so that together
24 way the parietal temporal lobe it -- even though

1 the parietal temporal lobe is more focused on
2 memorizes, the frontal lobe translates memories
3 into decisions.

4 Q. The language test, is there anything
5 about the language test that forms the basis of
6 any of your opinions in this case, and
7 specifically I am referring to the one that she
8 did herself?

9 A. Again, it's consistent with someone
10 who is no faking, exaggerating or malingering her
11 symptoms of brain damage.

12 Q. Let's move onto to, I guess the next
13 would be the memory test?

14 A. Yes.

15 Q. And it looks to me on the first page
16 that she didn't check any problems with her
17 memory on those first two areas; do you agree
18 with that?

19 A. Yes.

20 Q. And do you believe she's not telling
21 the truth when she says she's not having problems
22 with any of these areas?

23 A. Well, I think she's trying her best to
24 tell the truth, but if you notice, for example,

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1 in Number 2 about cooking, difficultly
2 remembering while cooking, she says she doesn't
3 cook.

4 If you don't cook, you don't have
5 difficulties remembering you're cooking, right?

6 So she's tried to adapt to her
7 disability and impairment by avoiding those areas
8 where she is disabled.

9 So again, it's an underestimate based
10 on the fact that she is trying to cope with her
11 deficits.

12 Q. But also in fairness she has no
13 problems regularly shopping for groceries or
14 buying items on her grocery list, correct?

15 A. Again, that's what she says which from
16 what, again, have seen in other areas may be an
17 underestimate because she tends to move in the
18 direction of underestimating her deficits rather
19 than overestimating them or exaggerating her
20 deficits. She's trying to cope as best as she
21 can by avoiding those activities where she's
22 impaired.

23 Q. Moving on to Page 2, Dr. Bursztajn, I
24 guess just for the sake of this next question the

1 following three pages has all of the memory test
2 what, if anything, does her subjective answers
3 show in you and does this affect your opinion in
4 any way?

5 A. Well, she does report, although she
6 may be underreporting, significant memory
7 deficits such as routines of daily living, money
8 management, spacial relationships.

9 It seems like she is doing her best to
10 cope with these deficits, but I think to some
11 extent these certainly are not consistent with
12 faking, exaggerating or malingering.

13 They are consistent with someone who
14 is trying to adapt to her deficits and maybe
15 overlooking some of her memory deficit at the
16 same time.

17 Q. Let's go to the visual processes of
18 the CSC.

19 A. Yes.

20 Q. You are aware she has been diagnosed
21 with cone rod dystrophy by the Stromhei
22 (ph)Clinic?

23 A. Yes.

24 Q. And are you aware that cone rod

1 dystrophy can be caused by medications taken
2 over time?

3 A. Yes.

4 Q. And you're aware that Ms. Johnson has,
5 in fact, had mental health medications prescribed
6 to her as far back as her teens?

7 A. Yes.

8 Q. And what, if anything, does this
9 visual processes checklist or how does it bear on
10 your opinions in anyway in this case?

11 A. Well, what's interesting about it is
12 obviously the cone rod dystrophy can complicate
13 analyzing this particular section, but what I
14 found interesting is if you look at Number 8,
15 mental imagery.

16 Q. Yes.

17 A. Now, mental imagery is not dependent
18 on cones or rods. It's not depending on the
19 peripheral visual system.

20 It's depending on central processes of
21 integration and to the extent that connections
22 have been disrupted for her between her frontal
23 lobes and parietal lobes with the rest of the
24 brain and the occipital lobes she reports a major

1 deficit in her mental imagery.

2 Now, that's not the result of cone rod
3 dystrophy. So I think certainly there and also
4 that and Number 10, organization, would be the
5 result of the brain damage that she suffered from
6 ECT rather than cone rod dystrophy.

7 Q. Why is that portion in the visual
8 process exam checklist?

9 A. Because mental imagery is a kind of
10 visualization, but it is an internal
11 visualization as opposed to an external
12 visualization.

13 The same is true of organizing. You
14 close your eyes and you remember something,
15 right, you remember something pleasant, you
16 remember someone that you love, but when she
17 closes her eyes her memory is disrupted she
18 cannot remember and she cannot visualize someone
19 that she loves or someone that loves her or a
20 pleasant experience in her life.

21 The problem with this, you see, is
22 that it points to fundamental disruption of what
23 I call and what's called autobiographical memory.

24 If you can't imagine, if you can't

1 remember enough to imagine, that's a significant
2 deficit especially for someone who has already
3 has bipolar disorder because for someone, and
4 it's huge complication in the treatment of
5 someone with bipolar disorder because someone who
6 has bipolar disorder needs to remember who loves
7 her, who she loves, and if she can't remember
8 enough to be able to visualize them, then she is
9 going to get overwhelmed by emotions and becomes
10 hypersensitive to stress.

11 Am I explaining it in a way that is or
12 am I just making it confusing?

13 Q. No, you're answering fine. Are you
14 aware of the extent of her vision problems as we
15 sit here today?

16 A. I am not aware of the exact extent of
17 her vision problems, but I'm assuming she has
18 some pretty substantial vision problems.

19 Q. Would you agree with me that
20 substantial vision problems apart from blindness
21 can contribute to stress?

22 A. It can contribute to stress. You're
23 making a very good point, Will, it by itself can
24 contribute to stress, but you see, the way we

1 handle stress -- if I feel stressed out, I think
2 of a few of my favorite things and then I don't
3 feel so bad.

4 You start to imagine a few of my
5 favorite people, a few of my favorite
6 relationships. I think of the Red Sox game last
7 night and then I get less stressed out, right?

8 I can imagine that, you can imagine
9 that, but for her that ability to imagine as a
10 way of buffering stress and detoxifying stress is
11 severely limited at this point.

12 Q. Well, and not to make light of the
13 situation, did you read her deposition when she
14 told me in response to a question that she was
15 both crazy and blind?

16 A. Yes. But you see how she is judging
17 herself? It's almost like she is not visualizing
18 herself as being more than just crazy and blind
19 but being also a human being who has had a life.

20 Her mother loved her dearly. Her
21 father loves her in his own way. Her brother
22 loves her, but you see how she reduced herself in
23 that? That's a very harsh judgment that she is
24 making of herself.

1 Q. And I certainly wasn't making light of
2 it.

3 A. I know you weren't.

4 Q. Both of these two things could cause
5 stress. Crazy is a broad term that people use in
6 lay form, but she's had mental health issues for
7 many years and now she's got severe vision
8 problems and both of those can contribute to
9 stress, correct?

10 A. Absolutely they will, but, you see,
11 that's why she needs to have a reservoir of
12 mental imagery and access to that reservoir of
13 mental imagery which is called an
14 autobiographical memory as a way of detoxifying
15 that stress and buffering that stress.

16 As she gets older it's a very grim
17 prognosis for her because the older all kinds of
18 things come up and we begin to have all kinds of
19 health problems which themselves are stressful,
20 well, gee, it helps me to remember the good times
21 I had with my daughter when if I am facing a
22 health problem, for example, because it's a way
23 of buffering stress and trying to modulate one's
24 response to stress.

1 She doesn't have that any more and
2 especially given her mental illness and given her
3 suffering she absolutely needs that.

4 In fact, the reason I am going on is
5 there are some implications for psychotherapy for
6 her, there should be a focus for therapy, help
7 her find ways to work around this lack of mental
8 imagery, this lack of autobiographical memory
9 that she suffers from. That's going to be very
10 important for her.

11 Q. Well, Doctor, how is her coping
12 mechanism prior to getting ECT and dealing with,
13 I know she didn't have the extent of the visual
14 problems, but how was her coping mechanism in
15 dealing with these mania and depressive issues
16 and conditions that she had prior to getting
17 ECT?

18 A. On one hand she could get overwhelmed
19 by intense feelings of helplessness,
20 hopelessness, demobilization and then she could
21 respond by bouncing back and becoming very
22 depressed and then very manic.

23 On the other hand she was always very
24 resilient. She was always able to bounce back

1 from these episodes. So she had resiliency
2 before and she doesn't have residency now and
3 without resiliency you can't do effective
4 coping.

5 Q. Well, Doctor, to be fair when you say
6 she was resilient she was involuntarily
7 hospitalized multiple times prior to getting ECT
8 at MUSC, and in fact, had involuntary forced
9 medications on multiple occasions prior to going
10 to MUCS and you're saying that is resilient in
11 dealing with these mental health issue that she
12 had?

13 A. She was resilient because she was able
14 to bounce back each time. At no point during any
15 of those hospitalizations, and we talked about
16 this before during our first meeting, Will, at no
17 point was it involuntary ECT necessary or
18 considered to be necessary.

19 So she was always able to go ahead
20 with medication even if it was involuntary for a
21 short period of time she was able to bounce back
22 and pick up her life again.

23 Look, last night I was on the phone
24 with a patient of mine who had had ECT at one

1 point in his life, although it was voluntary.

2 He was becoming psychotic again. I
3 think it's because his father was becoming very
4 fragile and we talked on the phone and we agreed
5 that he would increase his medication.

6 Now, this is a man who had been
7 hospitalized seven times before I ever met him.
8 He was hospitalized once over the 28 years I've
9 worked with him, but you know what, this guy has
10 two careers, a meaningful life, has kids who love
11 him, has an ex-wife who may have ambivalent
12 feelings about him but she they're good friends
13 basically.

14 So it's possible for people like Clair
15 to go ahead and have seven hospitalizations, even
16 to have one course of ECT or two courses of ECT
17 on a limited basis especially if it's voluntary
18 and then it's possible for them to go ahead and
19 age gracefully and have a meaningful life as they
20 age.

21 This person will not wind up in a
22 nursing home. He has his own home, he has
23 friends, he's well-recognized in his field.

24 There was no reason why Clair with

1 appropriate treatment if she had not been brain
2 damaged would not have the same prognosis
3 eventually.

4 Sometimes you have a tremulous youth
5 and middle age but then you have a graceful old
6 age. With good therapy you should be able to do
7 that.

8 Q. And sometimes you don't, correct?

9 A. Sometimes you don't, but if you look
10 at the details enough, and I do second opinion
11 consultations it's because either someone has
12 missed something or not only have they missed
13 something, but they haven't checked back and
14 realized they've missed it.

15 There have been times I've missed
16 things with patients, but I go back and try and
17 see, oh, gee, what did I miss that this person
18 needed to be hospitalized and when I figured out
19 what I missed they're much less likely to be
20 hospitalized.

21 This man was hospitalized once during
22 the time I saw because I had missed something.
23 He came out of the hospital. We figured out what
24 I had missed that he was communicating to me and

1 he hasn't been hospitalized since then.

2 Q. Doctor, I am just trying to get to
3 your opinions so I can turn it over to my
4 colleague.

5 We have talked about the memory issues
6 are there any more tests that substantiate your
7 opinion that Clair Johnson has memory issues
8 resulting from ECT?

9 A. Well, again, in terms of the
10 self-reports that she gives, if we look at the
11 dissociative experience scale.

12 Q. I have got it and I am looking at it.

13 A. She denies that she dissociates except
14 in those area where memory is clearly at work.
15 So in Number 25, Number 26, Number 32 and Number
16 33 -- well, those are more intrusive.

17 If you look at 25 and 26 some people
18 find evidence that they have done some things
19 that they do not remember doing.

20 Some people find their writing,
21 drawing or notes among their belongings which
22 they must have done, but they cannot remember
23 doing, that's, again, consistent with a
24 fundamental disruption of memory.

1 Q. Anything else specifically about this
2 DES that bears on your opinion with regards to
3 memory?

4 A. Not specifically as far as memory
5 itself is concerned, but again, it's in
6 context.

7 Q. I am just trying to cover this because
8 I am going to ask you about PTSD in a second.

9 The next thing I have is the Davidson
10 Trauma Scale that tended, to me at least, to go
11 towards the PTSD diagnosis, is that memory or
12 not?

13 A. That tends to go to PTSD, the PTSD
14 diagnosis, although it's post-traumatic stress
15 disorder which is complicated by her memory
16 deficits.

17 I have seen this often with veterans
18 who have had shell shock like in Iraq, for
19 example, and there you have both a damaged brain
20 and damaged memory both you also have a
21 post-traumatic stress component. You can have
22 both at the same time.

23 Q. Have you told me all the ways you
24 believe or the basis for your opinion that Clair

1 Johnson suffers from memory deficits as a result
2 of electroconvulsive therapy?

3 A. I hope so.

4 Q. Let's shift gears then and talk about
5 your diagnosis of post-traumatic stress disorder.

6 Did you use the Diagnostic Manual to
7 come up with that diagnosis?

8 A. Well, as you may know the diagnostic
9 Manual is not something that's used by
10 experienced clinicians for forensic purposes.

11 In fact, there is a warning against
12 using it that way. It's meant to be a training
13 manual and a research manual.

14 Q. What did you use, if any, concept,
15 theories, basis for determining that Clair
16 Johnson has post-trauma stress disorder as a
17 result of electroconvulsive therapy?

18 A. Over 30 years of clinical experience,
19 forensic experience, my general knowledge of the
20 literature, having treated people with
21 post-traumatic stress disorder, having evaluated
22 people who have had ECT, having evaluated people
23 who have had post-traumatic stress disorder
24 everything that I know and I have learned and I

1 teach and I practice.

2 Q. What criteria do you use when you
3 diagnose someone with post-traumatic stress
4 disorder whether it be from ECT or like you said,
5 a war veteran, what criteria or what elements
6 does a patient have to meet for you to consider
7 them to have post-traumatic stress disorder?

8 A. Have they experienced helplessness, or
9 horror in the face of an or series of events
10 which anyone would reasonably find traumatic.

11 Do they have symptoms of hyperarousal?
12 Do they have symptoms of avoiding or numbing?

13 Do they show any physiologic evidence
14 of hyperarousal or is there intrusion relative to
15 events which one would find to be traumatic, how
16 long have these symptoms lasted?

17 Are these symptoms substantial enough
18 to contribute to a major impairment which has
19 lasted for a good amount of time.

20 Q. And in your opinion Clair Johnson
21 meets all of those criteria?

22 A. It's my opinion which I hold to a
23 reasonable degree of medical certainty that Miss
24 Johnson's suffering includes suffering in the

1 post-traumatic stress disorder spectrum relative
2 to the over 80 ECTs that she received most of
3 which were clearing involuntary.

4 And as a whole all of which were
5 coerced even in the face of her complaints about
6 her memory deficits and the availability of
7 reasonable alternatives for treatment of her
8 bipolar disorder.

9 Q. How about the ones that she
10 voluntarily consented to, do you think those are
11 traumatic enough events to warrant this
12 diagnosis?

13 MR. RAVENEL: Objection to the form of.
14 the question.

15 A. Although she did sign some consent
16 forms, there was a lack of voluntariness because
17 the alternative from her perspective and given
18 everything that I seen in reviewing the medical
19 records was that if she did not agree to having
20 additional ECT treatments they would be
21 administered on an involuntary basis.

22 Where there is coercion and there is
23 guidelines such as NICE guidelines from the
24 British National Health Service, if you tell a

1 patient that unless you agree to having ECT we
2 will go ahead and get an order to give you ECT
3 involuntarily.

4 That's not considered to be voluntary
5 ECT by any stretch of the imagination by anyone's
6 accepted standard.

7 Again, I would refer you to the NICE
8 guidelines of the British National Health Service
9 which specifically addresses this issue.

10 So I think it's misleading to say that
11 she voluntarily consented to ECT after an
12 extended period of involuntary ECT treatment with
13 the threat of involuntary ECT treatment hanging
14 over her head.

15 Q. When you saw that she had the threat
16 of involuntary ECT treatment hanging over her
17 head, did Dr. Faust ever indicate that he
18 threatened to involuntarily hospitalize her if
19 she did not have voluntary ECT treatment?

20 A. Again, although there was no explicit
21 threat -- if you can give me a couple of seconds
22 here, let me see if I can refer to something
23 specific. Okay. If we look at Bates stamped
24 01088.

1 Q. I probably don't have that with me.
2 Can you just tell me what it is, what the
3 document is.

4 A. Sure. It's a discharge document from
5 December 21, 2006.

6 Q. Discharge document?

7 A. Yes, Institute of Psychiatry Discharge
8 Summary.

9 Q. Okay. Tell me what you're looking at.

10 A. Hospital course. It's Page 1122 also
11 if that's of any help.

12 Q. Go ahead and read to me what you're
13 referring to.

14 A. "Patient underwent three ECT
15 treatments, a forced medication and ECT protocol
16 was obtained by patient's father, and then it
17 says, but patient agreed to all treatments
18 voluntarily".

19 Well, if you're holding an involuntary
20 protocol and saying well, are you going to agree
21 to in voluntarily or do we have to go
22 involuntary, that's no choice.

23 That's such a violations of human
24 rights and just the basic practice of psychiatry.

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1 Again, look at NICE, the National Health Systems,
2 it cautions explicitly against it.

3 So if you say to someone we can do it
4 on an involuntary basis because we already have
5 this first treatment protocol or we can do it on
6 a voluntary basis if you consent to it. That's
7 no choice. That's a choiceless choice.

8 It's exactly the kind of choiceless
9 choice the variety of psychiatrists such as
10 Robert J. Lifton have described in people who
11 have suffered in complex post-traumatic stress
12 disorder.

13 When you give people a choiceless
14 choice like that that's no voluntary, Will.

15 Q. And that's what you believe based upon
16 your review of the medical record what happened
17 reading Dr. Weinstein's note?

18 A. Reading the totality of the record,
19 speaking with Clair, reviewing the totality of
20 the depositions, she was forced, she was given a
21 choiceless choice basically.

22 I have no question about that, Will.
23 Now, it may have been unintentional, but that was
24 it and that's way below the standard of care.

1 Q. And you haven't reviewed anything from
2 Dr. Weinstein himself like a deposition or
3 affidavit or anything like that?

4 A. I have just reviewed the totality of
5 the medical records and the totality of the
6 depositions.

7 Again, it's all consistent with this
8 description, Will. If you tell me there is
9 something inconsistent with it I have missed, I'd
10 be glad to consider it, but it's a choiceless
11 choice which we certainly treat people for, but
12 we don't give me -- we treat people who have been
13 traumatized by choiceless choices.

14 You can't say to someone we'll do it
15 the easy way or the hard way, which way is it
16 going to be. That's no choice.

17 Q. I understand if that's what you're
18 reading in that medical record. I am interested
19 in this post-traumatic stress disorder diagnosis.

20 Is there anything that we haven't
21 talked about that you have used in formulating
22 your opinion that Clair Johnson suffered from
23 PTSD resulting from ECT?

24 A. I think we have we have touched on my

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1 basis and they are all in my draft of April 1st
2 of 2011. We can go into more detail if you want,
3 but I think we have given a fair summary.

4 Q. In fairness to my colleague I've been
5 going about an hour, and I may have some follow
6 up in regards to the testing itself depending on
7 how long Jim goes, but can we take about a five
8 minute break and then resume?

9 A. Thank you, Will. It's a plan.

10 (Thereupon there was a short recess
11 taken.)

12 CROSS-EXAMINATION BY MR. SCOTT:

13 Q. Dr. Bursztajn, as you know I represent
14 John Roberts. I am going to try and
15 compartmentalize this case to the degree that we
16 can. I don't want to talk about MUSC. We've
17 talked about them enough.

18 Let's move to Dr. Roberts and I want
19 to ask you if you can to outline any each and
20 every criticisms that you have against
21 Dr. Roberts. If you have none, that's wonderful,
22 we'll stop.

23 If you do I'd like to start in a
24 bullet point fashion the criticisms you plan on

1 testifying against Roberts and then we'll discuss
2 each of those in some level of detail.

3 A. Okay, Jim, that's a plan and in
4 keeping with that I will be referring to my April
5 1, 2011 draft report.

6 First of all, Dr. Roberts should have
7 been aware that Miss Johnson showed significant
8 indications of a preexisting vulnerability to
9 cognitive impairment which is itself a foresee
10 risk of ECT.

11 He was her primary treating
12 psychiatrist on an outpatient basis. He had the
13 best overview of her history.

14 He should have when the question of
15 ECT was brought up made it clear that she was a
16 high risk ECT candidate at best and that
17 alternative treatments should be considered
18 first.

19 Q. Anything else?

20 A. Yes. Number 2, Dr. Roberts should
21 have informed as her primary psychiatrist should
22 have informed Miss Johnson and her family that
23 ECT was not an inevitable choice of treatment and
24 given the fact that it was high risk that she was

1 a high risk patient and that the treatment was
2 going to be involuntary that it was
3 contraindicated.

4 Moreover, Dr. Roberts as the ECT and
5 the involuntary ECT treatment went on should have
6 informed Miss Johnson and her family that a high
7 number of ECTs going up to over 80 was
8 contraindicated given her complaints of memory
9 loss and her preexisting vulnerability.

10 We have a patient who has a
11 preexisting vulnerability where treatment is
12 being recommended on an involuntary basis and
13 where alternatives exist and there is a failure
14 to monitor the foreseeable complications of ECT
15 especially bilateral ECT.

16 Moreover, there is at best an
17 inconsistent and at worst an ineffective response
18 to ECT. His actions as her primary treating
19 psychiatrist were below the standard of care
20 which can be found in the British National Health
21 Service NICE guidelines which focus on the fact
22 that alternatives need to be considered and
23 especially with a patient who is at high risk and
24 where there is a large volume of ECT and the

1 patient is complaining of impairment.

2 Alternatively he should have offered
3 Ms. Johnson and her family alternative treatments
4 to ECT especially once she began to complain of
5 memory impairments.

6 He should have informed Miss Johnson
7 and her family that there was going to be to the
8 extent her competence was compromised there was a
9 need to have a guardian ad litem who is fully
10 informed and fully involved in making decisions
11 for her, and the guardian ad litem should be
12 someone other than the person she was having
13 conflictual relationships which focused on her
14 husband from whom she was separated and
15 eventually who divorced her.

16 He did not in his treatment even
17 though she was complaining about conflicts of
18 interest ever explore with Clair how stressful
19 those conflicts of interest were for her and how
20 those conflicts of interest could have been
21 circumvented by having a non-conflictual
22 guardian.

23 He did not consider reasonable
24 medication choices as an alternative to ECT and

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1 it's true she had had other medications in the
2 past, but, for example, Lamictal was not
3 considered, although she some response to
4 depolarize, those were not instituted.

5 There was no indication that Dr.
6 Roberts ever gave Miss Johnson the opportunity to
7 benefit from a comprehensive program of
8 psychotherapy which she especially needed not
9 only in view of her bipolar illness but
10 subsequently due to her memory deficits and the
11 trauma of involuntary ECT.

12 Dr. Roberts failed to monitor the
13 foreseeable risk of cognitive impairments
14 resulting from long-term bilateral ECT and when
15 she did complain of such impairment there was an
16 insufficient response.

17 Dr. Roberts also failed to explore
18 with Miss Johnson and thereby decrease the stress
19 of the impact of involuntary ECT, the impact of
20 being given a choiceless choices and how
21 traumatic it was for her and would foreseeably
22 continue to be for her without appropriate
23 explorations.

24 Q. Is that it?

1 A. Yes.

2 Q. Thank you. I will go over all of them
3 actually in a little bit.

4 It sounds like to me that some of
5 these may overlap with one another and maybe we
6 can condense the list a little but we'll bridge
7 that as we get to it I guess.

8 Let me ask you we discussed some of
9 your I guess your role as an expert how much time
10 you had put into the case when we last met, how
11 much time have you put into the case since that
12 last testimony in July?

13 A. Oh, I would say at this point well
14 over an additional 30 hours or so.

15 Q. I am going to ask you some general
16 questions. You have probably seen some of these
17 questions from Dr. Bregen's deposition.

18 I am just going to run through some
19 and see if we can agree or disagree.

20 Do you agree that Clair Johnson had a
21 well documented history of non-compliance with
22 her medications over the course of her life?

23 A. She did have a well documented history
24 of having a difficult time adhering to a

1 medication regime throughout the history of her
2 illness.

3 Q. Do you agree that when one is
4 non-compliant with medications it makes it more
5 difficult for the treating psychiatrist to judge
6 the effectiveness of the medications?

7 A. When there is a difficulty in
8 adherence the treating psychiatrist needs to make
9 that much more of an effort to help the patient
10 become adherent, and even in the absence of
11 adherence to go ahead and exercise reasonable
12 professional judgement as to the effectiveness of
13 the medications that are being prescribed.

14 Moreover, when there is a difficulty
15 of adherence, it is the duty of the treating
16 psychiatrist to explore alternatives which a
17 patient may have less difficulty adhering to such
18 as, for example, injectable anti-psychotic
19 medication as opposed to a medication that's
20 taken daily by mouth, a long-term injectable
21 medication, a medication that a patient can
22 receive only once a month by injection as opposed
23 to the patient needing to take it every day.

24 And if the patient is feeling

1 overwhelmed by stress, they may forget to take it
2 or just not be able to take it or refuse to take
3 it without insight as to why they are refusing to
4 take it.

5 So throughout my 30 years of clinical
6 practice and teaching and writing I have
7 emphasized that when there is difficulty with
8 adherence to the medication regimen that's when
9 you really need a psychiatrist, otherwise you
10 could just have a primary care physician
11 prescribe the pill and that's it.

12 But that's why you need a psychiatrist
13 to explore what's the reason for the difficulty,
14 how can we make it easier, how can we get around
15 the difficulty of adherence that you question
16 quite wisely those points.

17 Q. Well, my question was rather simply
18 and that was simply do you agree that it makes
19 more of a challenge for a psychiatrist to judge
20 the effectiveness of medication when the patient
21 is non-compliant with the medication therapy; do
22 you agree with that in general?

23 A. I agree that it's both more of a
24 challenge on the one hand, but also I qualified

1 it by saying it's more of a duty of the physician
2 to proceed in a careful manner to explore why the
3 difficulty in adherence and what alternative --
4 how can we help the patient become more adherent
5 to the medication regime that I am prescribing.

6 You have more of a challenge so you
7 have more of a duty. That's why we refer
8 patients to psychiatrists rather than primary
9 care physicians.

10 Patients who have major metal illness
11 generally do have some difficulty in adherence
12 and very often we do treat it.

13 Q. The evidence in this case suggests
14 that Dr. Roberts, in fact, was doing that with
15 the Lamictal, right, when Miss Johnson presented
16 today him and he became aware that she had
17 trouble with compliance with the Lamictal he went
18 to another medication in hopes of trying to find
19 a simpler regimen that she could more easily
20 follow, correct?

21 A. He did try that, but what he failed to
22 do was go ahead and explore what her reasons were
23 for difficulty in adhering to the Lamictal
24 regimen and he failed to suggest therapeutic

1 interventions which might have made it easier for
2 her, which would have made it easier for her to
3 adhere.

4 Her lack of adherence should have been
5 a major treatment focus. What's the problem that
6 she's not taking the medications, that's a
7 serious.

8 The question that you're asking right
9 now, Jim, is a serious questions that Dr. Roberts
10 should have focused on fundamentally and provided
11 some treatment for.

12 Q. Do you not agree that the records
13 suggest that Dr. Roberts was actively trying to
14 tweak and intervene with various and sundry
15 medications that he could find that that would be
16 of maximal benefit for Miss. Johnson?

17 A. I agree that he was trying to tweak
18 medications, but it he wasn't providing here with
19 sufficient psychotherapy to help her become
20 adherent, and he wasn't instituting alternatives
21 such as, for example, once a month injectable
22 medication on an ongoing basis which would have
23 made adherence easier.

24 So he was overlooking alternatives

1 which any reasonable and prudent psychiatrist
2 such as comprehensive psychotherapy and an
3 injectable medication regime would have
4 considered at this prior to the recommendation
5 that the patient and her family proceed with
6 involuntary convulsive treatment.

7 Q. Are you testifying that Dr. Roberts
8 breached the standard of care by not attempting
9 to utilize injectable medication as an
10 alternative form of treatment?

11 A. By not presenting it as an alternative
12 to electroconvulsive therapy to the patient, her
13 family and her guardians.

14 Q. What medications do you contend should
15 have been injected into Miss Johnson by Dr.
16 Roberts?

17 A. Dr. Roberts could have recommended
18 given her difficulty she could be on an
19 injectable anti-psychotic medication, any
20 injectable, and those injections can be spaced
21 out from every two weeks to every month.

22 Q. And is that a new criticisms to add to
23 the list that you believe Dr. Roberts failed to
24 offer injectable medication?

1 A. No. It's covered under the fact that
2 electroconvulsive therapy was not an inevitable
3 choice of treatment which is Number 2 and Number
4 6, it's questionable whether reasonable
5 medication choices were considered as
6 alternatives to ECT so it's consistent with those
7 two.

8 Q. All right. Do you agree that Miss
9 Johnson was managed by different medical
10 providers prior to be being treated by
11 Dr. Roberts with little success for her mental
12 health?

13 A. She was being treated by other mental
14 health providers with limited success, however,
15 they were successful enough to avoid involuntary
16 ECT and brain damage they did not make matters
17 worse.

18 Q. Are you contending that they had her
19 mental health disorders under good control prior
20 to her being seen by Dr. Roberts?

21 A. Jim, under limited control. It's not
22 satisfactory, not good enough for sure and there
23 was room for improvement, but there wasn't the
24 kind of deterioration which occurred subsequent

1 to Dr. Roberts psychiatric treatment management
2 of Miss Johnson's illness.

3 She came to him with one illness and
4 by the time she left she had three.

5 Q. You do understand that Dr. Roberts did
6 not refer the patient -- you're not contending
7 that Dr. Roberts referred the patient for ECT
8 therapy, are you?

9 A. I am not saying that he formally
10 referred her for electroconvulsive therapy,
11 however, he was her primary treating psychiatrist
12 he was aware that that was the recommendation.

13 He could have intervened at any point
14 and certainly when she came back to him
15 complaining of memory deficits.

16 He could have advised her against
17 receiving further electroconvulsive therapy. He
18 also could have advised the clinicians who were
19 administering that, advised her parents, advised
20 the guardian ad litem.

21 A course of ECT beyond a course of 6
22 to 12 ECTs was really counter-indicated. He
23 could have also advised her and her family that
24 she was at a high risk for complications of ECT.

1 especially when she began to complain of memory
2 loss and those complications included the
3 possibility of the memory loss becoming permanent
4 and as a result of brain damage from ECT.

5 He could have also advised her and her
6 family about the fact that involuntary ECT is an
7 extreme measure which has also complications of
8 its own which should only be considered after
9 you've tried everything else and nothing else
10 worked basically.

11 Again, I would refer you to the NICE
12 guidelines of the British National Health Service
13 for what I think is a fair statement of when
14 electroconvulsive therapy should be used and also
15 a warning about the dangers and complications of
16 involuntary electroconvulsive therapy.

17 Q. You question the validity of the
18 bipolar disorder diagnosis that had been made in
19 the '80s, I believe?

20 A. No, I do not question the validity of
21 the bipolar diagnosis. However, in light of the
22 diagnosis prescribing Wellbutrin to her,
23 prescribing stimulants to her, which other
24 clinicians did as well, but here is her primary

1 psychiatrist, he should not have done that
2 because that can certainly make bipolar disorder
3 worse and can trip a depressed person into a
4 manic episode.

5 I know he had reservations about
6 prescribing that and he, in fact, advised her
7 against it, but he continued to prescribe it to
8 her.

9 Q. Is this a new opinion, Doctor?

10 A. No. This is well within the opinions
11 which I have already stated and are contained in
12 my draft report.

13 Q. Well, let's talk about this then. You
14 agree that the bipolar disorder was valid,
15 correct, that diagnosis?

16 A. Yes, that's what she came to him with
17 as well as a history when she was much younger of
18 having some head injury and some drug and alcohol
19 abuse.

20 Q. And this issue of the head injury that
21 I have heard so much about, you agree with me
22 that her own family testified that there weren't
23 aware of any hospitalizations that were
24 associated with any head trauma as a child or a

1 teenager, correct?

2 A. Yes.

3 Q. You don't have any idea what level of
4 head injury she might have suffered as a
5 youngster other than the fact that she apparently
6 reported that she hit her head several times when
7 she was young, correct?

8 A. It's noted in the medical records on
9 several occasions. I have not had access to --
10 it's her reports are very consistent on this.

11 Q. It's noted in the medical records that
12 she subjectively reported a rather vague report
13 of having suffered head injuries, that's what
14 you're referring to?

15 A. I am referring to that, yes.

16 Q. All right. But you're not testifying
17 that she suffered a brain injury as a child or a
18 teenager based on everything that you know at
19 this point, correct?

20 A. I don't think that there was any level
21 of brain injury which would cause a substantial
22 level of impairment prior to her receiving the
23 electroconvulsive therapies, the involuntary ECT
24 that she did in 2003, that's right.

1 But she was vulnerable. She was at
2 risk for it both by the history and also by the
3 CT scan which noted some cerebral atrophy in 2002
4 so we have someone who is clearly vulnerable?

5 Q. You agree that cerebral atrophy that
6 was reported to be more advanced for her stated
7 age was most probably related to alcohol and/or
8 drug abuse?

9 A. That's certainly a reasonable
10 possibility, but again, there was no functional
11 impairment, and I think that's very important.
12 What atrophy there was relatively mild.

13 Q. What do you base it on -- I am sorry.
14 Go ahead.

15 A. Well, what atrophy that is reported is
16 relatively mild and minimal and there were no
17 reports of the kind of pervasive memory
18 impairments that she had subsequent to ECT.

19 I am going to just read you the 2002
20 report, give me one second. Looking now at Bates
21 Number 02951.

22 Q. Just tell me what it is, Doctor.

23 A. It's the report of the CT of the head
24 from 2002, from December of 2002, December 12,

1 2002.

2 Q. Yes, sir.

3 A. And basically when it shows is some
4 prominence of cortical sulci which may reflect
5 atrophy, but it's relatively mild and certainly
6 substance abuse could be one potential cause of
7 that.

8 Again, what we see is a very mild form
9 of brain atrophy with, a form of brain atrophy
10 which is not correlated with any functional
11 impairment.

12 We don't have any evidence here of
13 preexisting fixed brain injury which is impairing
14 function. What we have is some data that is
15 consistent with the fact that she has a history
16 of substance and alcohol abuse, given her history
17 of head injuries is vulnerable to a repeated
18 massive cause of bilateral electroconvulsive
19 treatment.

20 Q. The results of that CT scan do not
21 make ECT therapy contraindicated; you agree with
22 that?

23 A. No, I would say that the results of
24 the CT scan when taken with her history of drug

1 and alcohol abuse, her prior history, the history
2 of head injuries make it relative
3 contraindication.

4 Again, she should have been advised,
5 her family should have been advised that she
6 would be at higher risk for cognitive
7 complications than most patients from bilateral
8 ECT especially massive volumes of bilateral ECT,
9 an overdose of bilateral ECT which she eventually
10 suffered from, over 80 ECTs.

11 Q. You're not opining that the CT scan
12 results from 2013 ordered by Dr. Bragen, the
13 other expert in this case diagnosed any
14 appreciable brain damage resulting from ECT, are
15 you?

16 A. It's my opinion that the subsequent
17 functional impairments are consistent with the
18 progression which otherwise one would not see
19 under the circumstances and those functional
20 impairments are due to the massive doses of ECT
21 that she received on an involuntary basis. It's
22 the volume of ECT that she received.

23 Is the progression between the two CTs
24 scans consistent with that, yes, it is. Do I

1 base my opinion on those two CT scans, is that
2 the foundation of my opinion, no, it's not.

3 The foundation is her natural history
4 and the degree of impairment from before the
5 massive volume of ECT to subsequent.

6 Q. I think I understand your opinion, but
7 I want to be clear about this. You have
8 explained before her cognitive dysfunction and
9 why you think that's related to ECT, but you are
10 not going to opine that the results of that CT
11 scan from May of 2013 are proof of brain injury
12 from the ECT therapy, are you?

13 A. The results of the CT are consistent
14 with ECT related injury, but they're not
15 foundational to my opinion.

16 Q. All right. I understand they're
17 consistent with, but they're not diagnostic of
18 ECT related brain injury, correct?

19 A. Not by itself, no. However, in the
20 context of the fact pattern, yes.

21 By themselves if you just look at the
22 CT scans you can't just say this is due to ECT,
23 not by itself, of course.

24 Q. Well, to be fair it's also consistent

1 with deterioration of the brain over ten years
2 that already had advanced atrophy, did it not?

3 A. She did not have advanced atrophy.
4 She had some evidence of atrophy due to prominent
5 sulci, but she did not have advanced atrophy
6 consistent with functional impairment and she had
7 no functional impairment in 2002.

8 There was no estimate of functional
9 impairment in 2002 prior to the ECTs. If there
10 is, then please let me know.

11 Q. I think you're talking about one thing
12 and I am talking about another.

13 I am simply asking if you intend to
14 testify that the CT scan ordered by Dr. Brangen,
15 the other expert in this case is diagnostic of or
16 can lead one to conclude that she has suffered a
17 brain injury due to the result of the CT scan,
18 there is as is suggested a slight increased
19 atrophy from ten years prior or whatever the
20 verbiage is in that radiographic study?

21 A. Jim, by itself it's not diagnostic,
22 but it is indicative and consistent with a
23 diagnosis of brain damage due to massive ECT.

24 Q. Are you testifying that if you took

1 the ECT therapy out of this case that the CT scan
2 results from May of 2013 would not be consistent
3 with the CT scan of 2002 based on the way the
4 body ages an atrophy occurs?

5 A. It would be unusual, again, anything
6 is possible, but it would certainly be unusual
7 and I am testifying to the functional impairments
8 that we see are not consistent with the way the
9 normal brain ages or even the vulnerable brain
10 ages because.

11 Q. Do you agree that her bipolar disorder
12 or let's say her overall mental health illness, I
13 guess her mental illness could be reasonably
14 characterized as severe when she first came to
15 see Dr. Roberts?

16 A. She had severe episodes of her bipolar
17 illness both in terms of mania and depression.

18 Q. Do you agree that her disease process,
19 her mental health or her mental disease was
20 chronic in nature before she was ever seen by
21 Dr. Roberts?

22 A. It was episodic and recurrent,
23 however, she also had periods of time where she
24 was able to function in a relatively normal

1 manner.

2 Q. Do you agree that it's reasonable for
3 a psychiatrist as I used the term tweaked before,
4 to try and change or tweak medications with a
5 patient in order to find the best regimen for
6 that particular patient?

7 A. Medication monitoring can include
8 changes and what medications the patient is
9 taking in order to be able to minimize the risk
10 and maximize the benefits for the patient and
11 also to help the patient adhere to the
12 recommended medication regimen.

13 This includes, however, having a
14 meaningful psychotherapeutic relationship which
15 focuses on what difficulty the patient is
16 encountering and sticking to that medications
17 regimen which seems to have the best benefit for
18 the patient.

19 Q. Are you contending that Dr. Roberts
20 had no meaningful psychotherapy with Clair
21 Johnson during their doctor/patient
22 relationship?

23 A. From what I can tell, it was
24 ineffective. It wasn't focused on the traumatic

1 issues of memory loss subsequent to involuntary
2 ECT and the high volume of ECT.

3 He also prescribed to her even though
4 he advised against it stimulated which were
5 counter-indicated given her bipolar disorder and
6 he knew better but he continued to prescribe
7 those.

8 So yes, I think there was a failure as
9 far as any comprehensive psychotherapy plan which
10 you need to have, I would need to have if I was
11 treating her.

12 You need to have a plan that the
13 patient agrees to and shares with you. That's
14 part of what psychotherapy is with a bipolar
15 patient.

16 You have to help the patient learn to
17 help you help them, and if they cannot do so,
18 then you have to figure out why not with the
19 patient and with the patient's family and people
20 who love the patient.

21 Q. Do you agree in general that ECT has
22 therapeutic benefits for many patient across
23 America?

24 A. Electroconvulsive therapy when

1 appropriately prescribed and appropriately
2 administered to an informed patient can have
3 therapeutic benefits for patients, yes.

4 Q. Do you agree that antidepressants can
5 have therapeutic benefits for patients?

6 A. Yes, for selected patients who are
7 appropriately informed of the benefits and risks
8 they can, yes.

9 Q. You, in fact, have prescribed many
10 patients with antidepressants over your 30 plus
11 year career, yes?

12 A. And I continue to do so, Jim, yes.

13 Q. And you treat patients that at times
14 actively undergo ECT therapy as part of their
15 therapeutic regime?

16 A. Yes. As I mentioned, I was on the
17 phone with a patient last night who has undergone
18 ECT.

19 I hope we have now been able to go
20 ahead and help him enough that we can avoid
21 future hospitalizations and the need for
22 electroconvulsive therapy, but yes.

23 Q. Do you agree that the consensus in
24 your field or in the literature is that the vast

1 majority of memory loss associated with ECT
2 therapy is felt to be short term in nature?

3 A. There is some controversy about that,
4 Jim. The simple answer is it really depends on
5 the dosage of ECT.

6 There is a consensus that if the
7 dosage is high enough over a long enough period
8 of time and especially if it's bilateral in a
9 high risk patient it's likely to result in
10 permanent rather than transitory loss..

11 In a patient who is at very low risk
12 especially with unilateral placement for a
13 limited number, between six and 12 ECT
14 administrations, then in that instance you have
15 the case that you described which is that with
16 memory loss it is relatively short term.

17 So it depends. You have two groups of
18 patients, low risk patients, small volume of ECT
19 and high risk patients and high volume of ECT and
20 with bilateral ECT being in that category as
21 well.

22 So it's a biphasic curve in terms of
23 short term versus long term. These days since
24 most patients receiving short courses of ECT and

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1 generally it's unilateral, then with memory loss
2 it is, in fact, transitory as opposed to
3 permanent.

4 Q. Do you have any citation for the
5 literature to support that notion that the
6 studies are broken into two categories, short
7 term ECT versus long term ECT and the resulting
8 memory deficit from each that's expected, do you
9 have any authority for that?

10 A. Off the top of my head I can't name
11 specific references, I would encourage you to
12 obtain a full copy of the NICE guidelines, those
13 are the National Health Service Guidelines.

14 They do include references which
15 basically are consistent with my opinion that
16 long term high volume ECT is much more likely to
17 result in permanent brain damage and permanent
18 memory loss than short term unilateral low volume
19 ECT. Those references are there.

20 If you look at the document, you can
21 simply find them. I certainly have read them. I
22 looked at those references pro se.

23 Q. Let me ask you this: The mere fact
24 that someone might complain of some aspect of

1 memory loss during ECT does not necessarily mean
2 the ECT should be stopped at that point because
3 frankly short term memory loss is not terribly
4 unexpected, correct?

5 A. If someone complains of memory loss
6 doing a low volume ECT, at the very least you
7 proceed to go ahead and monitor them very
8 carefully including administering formal
9 neuropathological testing to make sure that the
10 memory loss doesn't get worse before you
11 administer additional ECT.

12 You also begin to look at alternatives
13 to continuing a protracted high volume ECT course
14 at that point in time.

15 If you're going to continue ECT you
16 have to monitor them very carefully to make sure
17 that short term memory loss isn't a long-term
18 fixed memory loss.

19 Q. But the mere fact that someone may
20 complain of some memory loss is not in and of
21 itself a basis to stop ECT therapy particularly
22 when someone believes they're getting benefit
23 from the therapy?

24 A. It's not an absolute red light, but

1 it's certainly an orange light to go ahead an
2 institute additional monitoring including formal
3 neuropathological testing and to look at
4 alternatives to continuing with electroconvulsive
5 therapy at that point and make sure the patient
6 regains their memory.

7 Q. Did you not find that Dr. Roberts in
8 his notes after he notes some memory loss that he
9 follows up over the weeks and months and some
10 form of monitoring the memory to see if its
11 improving?

12 A. Not adequately and not according to
13 standard of care that I practice.

14 Q. Which requires what?

15 A. Would require at the very least some
16 referring Clair to a neuropathologist so we can
17 get a baseline set of tests or neuropathological
18 function and then to be able to see whether she
19 is improving from that. That's not being done.

20 He doesn't even do a mini mental
21 status exam in a formal way that I can see. But,
22 again, you would need more than that for someone
23 given the fact that she's complaining of memory
24 loss and she's at higher risk.

1 You would need formal
2 neuropathological testing at that point to show
3 what her baseline is and what recovery of memory
4 function she actually has rather than what
5 recovery she hopes she will have and you hope she
6 will have.

7 He based basically without that the
8 orange light becomes a red light and to continue
9 ECT under those conditions you're moving from an
10 orange light to a red light and then you are in
11 violation of what I consider to be the standard
12 of care.

13 Q. Even if he feels the memory is
14 improving?

15 A. It's not up to his feeling. You need
16 to have a formal baseline at that point. You
17 have a patient who is clearly complaining of
18 memory loss.

19 I may feel she is improving, but how
20 do I know that my observations may not be
21 observations at the moment as opposed to
22 observations of her average function.

23 How do I know she's not putting on her
24 game face or her best face for me. So you really

1 need to get neuropathologic testing done at this
2 point and you really need to consider alternative
3 forms of treatment that she can be adherent to
4 and still focusing on exploring what the
5 difficulty has been in adhering to non-ECT forms
6 treatment.

7 Most people with bipolar disorder are
8 able to get by without ECT. It's not inevitable
9 and most people who have failed multiple
10 medication regimens can get by with either no ECT
11 or at the most six to 12 ECTs, not over 80.

12 Q. ECT was a reasonable option to explore
13 in this case, correct?

14 A. It was a reasonable option to explore
15 but only in the context of recognizing that she
16 was at higher risk for complications and then
17 subsequently carefully monitoring her and
18 presenting her with meaningful alternatives to
19 over 80 ECTs.

20 What was reasonable between six and 12
21 stops being reasonable at 80. It's an overdose
22 in a high risk patient.

23 Q. Do you agree or disagree that the
24 standard of care in psychiatry allows bipolar

1 patients to be treated with antidepressants and
2 mood stabilizers so long as they're carefully
3 monitored while on this medication?

4 A. Yes, so long as they're carefully
5 monitored and they're carefully educated about
6 the risks and benefits so they can be carefully
7 monitored.

8 Q. You agree that there were indications
9 of a good response to the ECT therapy when it was
10 instituted?

11 A. There were mixed indications as to
12 what the response was. It was questionable as to
13 how good the response actually was.

14 Q. Do you agree as a general matter that
15 there is no standard of care limiting the
16 duration of maintenance ECT?

17 A. There is, again, I am referring to the
18 National Health Service of Britain, the NICE
19 guidelines, once you go beyond six to 12 ECTs you
20 have to be very careful about maintenance ECT,
21 extraordinarily careful and you need to go ahead
22 and make sure whatever consent there is
23 absolutely voluntary.

24 Certainly 80 bilateral ECTs for

1 someone who is complaining of memory loss is
2 below any standard of care that I am familiar
3 with.

4 Q. I understand what you're saying, but
5 my question is a general question that there is
6 no standard of care as to any certain number of
7 maintenance ECT treatment one can undergo, there
8 is nothing that says you have to stop at 12 or 15
9 of anything of that nature?

10 A. There is no absolute number that one
11 can refer to, but it's a little like radiation
12 treatment for cancer.

13 Generally a little can be of help, but
14 once you get beyond a certain point you kill the
15 patient so I feel once you get up to 80.

16 So it's foreseeable with a patient who
17 is vulnerable and complaining of memory loss
18 throughout there is going to be brain injury and
19 brain damage.

20 Certainly the standard of care that
21 I am familiar with as a general rule of practice
22 would not indicate over 80 ECT treatments to a
23 patient who is vulnerable and complaining of
24 memory damage as Miss Johnson was and still is.

1 Q. You agree with the following two
2 sentences: Brain imaging in 2002 showed some
3 brain atrophy more advanced than would be
4 expected for her age.

5 This finding by itself does not
6 definitively show vulnerability to brain damage
7 to ECT".

8 Do you agree with those statements?

9 A. Well, not by itself but in the context
10 of her overall history, of substance and alcohol
11 abuse, the trauma history, then that's different.
12 Context matters here. History matters.

13 Q. I understand. I am just asking if you
14 agree that the imaging from '02 shows some brain
15 atrophy -- you agree that Lamictal has not been
16 proven effective in reducing Miss Johnson's
17 symptomatology?

18 A. Lamictal seems to have been or seems
19 to be of some limited effectiveness. Is it
20 totally effective, no.

21 Q. Do you agree that evaluating the
22 effects of medications in Miss Johnson's case was
23 a challenge for the treating physicians given her
24 labile condition, irregular compliance, chronic

1 dissatisfaction and exaggerated complaints?

2 A. Well, I am not sure of the exaggerated
3 complaints, but I can tell you what you've just
4 described about one-third of my bipolar patients.

5 So it's very standard. That's what
6 you expect as a psychiatrist. That's why they
7 come to you as a psychiatrist and not having the
8 family physician manage your medication because
9 you don't need a psychiatrist to just write
10 prescriptions, right.

11 Q. Did you write the November 1, 2010
12 initial analysis of merit that you sent to
13 Mr. Ravenel, did you author that?

14 A. - Yes.

15 Q. What I just read to you, does that not
16 sound familiar?

17 A. Can I go ahead and take a look at
18 that?

19 Q. Sure.

20 A. For some reason I only have the cover
21 letter for it. I don't see the actual analysis
22 of merit.

23 MR. EARLY: Dr. Bursztajn, if that's
24 what I sent you, which I think you're referring



1 to in the notebook, it's separated by cover
2 letter, but if you flip back about five, six,
3 seven tabs you'll see another analysis, 11/1/10
4 that Jim is referring to.

5 Q. I am reading from Page 4, Paragraph F
6 of your report. All these questions I am getting
7 from your report.

8 A. I appreciate that. Let me find the
9 report so I can place your questions in context
10 so let me go ahead and find it. No, I am still
11 not finding it. Okay. November 1, 2010, I found
12 it. Can you tell me again what page you're
13 looking at.

14 Q. Yes, Page 4, Paragraph F.

15 A. Okay. And.

16 Q. The sentence starts in the middle of
17 the paragraph and it starts with admittedly.

18 A. Okay. Okay.

19 Q. I was just asking if you agree with
20 your own sentence that says admittedly evaluating
21 the effects of medications in Miss Johnson's case
22 was a challenge given her labile condition and
23 irregular compliance, chronic dissatisfaction and
24 exaggerated complaints together with the fact

1 that the medications were prescribed with her in
2 complex and changing combinations with potential
3 interaction effects?

4 A. I do agree with that, and as I go on
5 to say, however, with the foreseeable risks of
6 ECT medication management merited most serious
7 consideration.

8 It would have been reasonable and
9 prudent to give careful consideration to the
10 context in which medications were prescribed and
11 monitored which might have addressed by
12 psychotherapy.

13 In other words, this is the kind of
14 challenge that I regularly face as a psychiatrist
15 when you consult or treat a patient who has had a
16 series of recurrent episodes of depression and
17 mania.

18 So yes, I agree with it, but this is
19 why I chose to be a psychiatrist so I could go
20 ahead and treat those challenging patients as
21 opposed to simply being a medication dispenser.

22 Q. Okay. You agree that the maintenance
23 ECT was decided on in a family meeting in October
24 of 2005 at MUSC included her parents and

1 outpatient and inpatient clinicians as well as
2 the patient?

3 A. There was such a meeting, yes.

4 Q. And as rule such shared decision
5 making amongst the patient, family and physicians
6 increasing the chance of making a wise decision
7 that will benefit the patient?

8 A. It does to the extent that such shared
9 decision making is informed.

10 When it's uninformed, it's no longer
11 shared decision making. And it was uninformed in
12 this instance because the family was not informed
13 that she was at high risk and that special
14 precautions would need to be taken given the fact
15 that she was at high risk and that alternative
16 given the fact that she was at high risk,
17 alternatives should have been given precedence.

18 Q. All right. Let's talk about those
19 high risk for a minute.

20 I know you mentioned this before, but
21 just outline by bullet point. I see it in your
22 report, but tell me again what these high risks
23 are for adverse outcome related to ECT.

24 A. A preexisting history of substance

1 abuse or a preexisting history of brain trauma, a
2 patient who begins to complain of memory loss, a
3 high volume of ECT, bilateral ECT versus
4 unilateral ECT.

5 Q. Well, let me start with that last one.
6 Bilateral ECT is approved by the APA, correct?

7 A. Well, the APA has issued reports which
8 certainly have included bilateral ECT and some
9 clinicians do use bilateral ECT, but generally
10 it's avoided in high risk patients.

11 Unilateral ECT is considered an
12 alternative to try before you go to bilateral
13 ECT. There is a sequence here.

14 Just because something is possible
15 doesn't mean that it's indicated or the standard
16 of care.

17 Is it something that people use? Yes.
18 Can it be used in low risk patients
19 appropriately? Yes.

20 Was Miss Johnson a low risk patient?
21 No, especially after she began to complain of
22 memory loss.

23 Q. Well, let's stick with our outline
24 that you gave us here.

1 So we've got bilateral ECT and I think
2 somewhere in there you acknowledged that
3 bilateral ECT is within the standard of care,
4 correct? It's used all across America today,
5 correct?

6 A. It's used appropriately with low risk
7 patients, yes.

8 Q. Now, high volume of ECT, now, the
9 question was when they had this family meeting
10 why was she at heightened risk?

11 Nobody knew what the number of ECT
12 treatments were going to be at the time they met
13 to discuss the possibility of maintenance ECT,
14 correct?

15 A. Yes.

16 Q. Now, the complaint of memory loss when
17 they met with the clinicians and the family to
18 talk about maintenance ECT, there was no ongoing
19 complaint of memory loss, correct?

20 A. During which meeting now?

21 Q. The whole premise of the question was
22 the initial family meeting to discuss maintenance
23 ECT, October of '05, and my question was for you
24 to bullet point each and every factor that made

1 her a high risk?

2 A. By October of '05 there was already
3 data from the 2003 hospitalization that she had
4 been complaining of memory loss, so it's
5 misleading to say that there had been no history
6 of memory loss by 2005. There had been, Jim.

7 Q. So as early as '03 your contention is
8 there was evidence of a sustained or a long-term
9 memory loss?

10 A. There was evidence that she had
11 complained of memory loss and that memory loss
12 was even monitored prior to 2005.

13 There was no neuropsychological
14 testing done. Without adequate monitoring we
15 have the Hippocratic oath and the Hippocratic
16 oath says primum non nocere, first of all, do no
17 harm.

18 Without the proper monitoring since
19 she had complaints of memory loss, you have to
20 assume that it's there or test and show that it's
21 not there. You can't simply go ahead and go by
22 your feelings whatever your feelings may be.

23 Q. Well, point to me in the -- I am not
24 disputing that there is this evidence, but I want

1 you to point to me in the chart when exactly it
2 is from 2003 that you're going to rely on to
3 support the position that she was already
4 suffering from memory loss.

5 A. Well, let me see what I have here.
6 Okay. Let's begin. If we look at the medical
7 record itself from MUSC it's December 9th of
8 2003.

9 Q. Go ahead. I don't know that I have
10 the MUSC chart handy, but go ahead and tell me
11 what you have.

12 A. On the one hand the patient herself,
13 Clair, expresses an interest in continuing the
14 Geodon which is a potent anti-psychotic on an
15 inpatient/outpatient basis.

16 On the other hand, she's agitated
17 about continuing with any additional ECT and then
18 we note on her discharge summary which is
19 dictated by Dr. Richard Holt he notes that she
20 continues to at the time of discharge the patient
21 still had some residual effects from ECT such as
22 affective flattening, mild memory and
23 concentration deficits.

24 That's in 2003 in the discharge

1 summary. Let's continue here. Now, I am moving
2 on to Dr. Roberts' notes.

3 Q. Do they have Bates numbers on them?

4 A. They do, so let me find you the first
5 one here. Bates Number 00209.

6 Q. Just give me the date of the note when
7 you're ready.

8 A. This is actually subsequent to 2005,
9 so this is in 2006 that she's complaining of
10 memory deficits in Dr. Roberts' notes. 2004 even
11 though she has been discharged with memory
12 impairments in 2003, on Bates 00055 Dr. Roberts
13 failed to note any assessment of memory.

14 There was no formal -- so what's
15 missing here -- she was discharged in 2003 with
16 memory impairments and there is a failure by
17 Dr. Roberts to provide a systematic assessment of
18 memory improvement from discharge on.

19 So it's a bit like Sherlock Holmes,
20 she's discharged with memory impairments.

21 Dr. Roberts is not doing any
22 systematic memory assessment that we can see from
23 his notes here.

24 So by 2005 I think it's a reasonable

1 inference to accept her family's understanding
2 that she still was having some memory
3 impairments.

4 Q. All right. Doctor, let me see if we
5 can agree on something or not.

6 Do you agree that after pretty much
7 any regimen of ECT therapy you expect to see the
8 results that you described from a discharge
9 summary, that would be the mild effects, the
10 flattened effects, the mild memory loss, that's
11 not unexpected, is it?

12 A. It is not unexpected for a low risk
13 patient, but it's certainly a reason to monitor
14 even a lost risk patient and a high risk patient
15 such as Clair, it's certainly reason to go ahead
16 an initiate referral for formal neuropathological
17 assessment and testing.

18 Q. So essentially what you're saying is
19 that every patient after a round of ECT if they
20 complained of mild deficits such as you described
21 the standard of care requires formal neurological
22 assessment for memory impairment?

23 A. The standard of care for every high
24 risk patient who complains of memory loss

1 subsequent to a course of ECT before initiating
2 another course of ECT is to go ahead and get some
3 memory testing done, some neuropsychological
4 testing, sure.

5 Q. What was the date of that discharge?

6 A. It was 2003.

7 Q. What the month, do you remember?
8 December?

9 A. I believe it was.

10 Q. It's been suggested that it may be
11 December 23rd, does that sound right?

12 A. It sounds right because there was a
13 follow up with Dr. John Roberts on the bottom on
14 Monday the 29th at 4 p.m. so there to the extent
15 there was a follow up on December 29th '03, that
16 sound right to me, Jim.

17 Q. Well, I am going to turn your
18 attention back to Dr. Roberts' notes and I don't
19 have the Bates labels, but I have got the dates
20 up in the left-hand corner, I can help you with
21 that.

22 A. I don't have all of Dr. Roberts' notes
23 here so I would need to see the actual note.

24 Q. All right. So you don't really know

1 if she was even checking on her memory or not
2 after that discharge, do you?

3 A. No, I do know. I've read those notes
4 thoroughly and basically there was an inadequate
5 attention was being paid to checking memory and
6 there was never any referral for any
7 metapsychological testing that's being done even
8 while additional ECT is being considered and
9 subsequently recommended to the family as being
10 the best alternative, in fact, from what I can
11 tell, the only alternative.

12 Q. Right, and you told me a minute ago
13 after she was discharged with those memory
14 complaints that Dr. Roberts didn't do any
15 evaluation to see if her memory was improving or
16 worsening or anything, that's what you told me,
17 correct?

18 A. What I told you is he did not do any
19 appropriate intervention as it merited for a high
20 risk patient who subsequent to ECT is complaining
21 of memory loss.

22 Q. High risk based on those bullet points
23 that you described for me earlier, correct?

24 A. Based on my overall assessment and as

1 communicated and the points which I have
2 enumerated for you.

3 Q. Now, where were going here, I want to
4 get us back on track is I was asking you about
5 each of these bullet points that qualified her as
6 high risk and one of them that we were talking
7 about was complaints of memory loss, and I think
8 unless you have got something else the sum total
9 of what you've been able to point to me was the
10 on the discharge summary December of '03 there
11 was some mild effects described by the treating
12 physician that included flat affect and some
13 memory loss, is that everything you have?

14 A. That's what I have to illustrate.
15 However, again, there were other complaints of
16 her having memory loss which I don't have in
17 front of me to illustrate for you.

18 But, again, if you need I will
19 certainly go ahead and identify each and every
20 one of them when I have the complete record in
21 front of me to illustrate.

22 Q. Well, I don't know how to respond to
23 that. If you're not prepared to tell me each
24 basis for your believe that she had existing and

1 ongoing memory problems related to ECT in 2003, I
2 am not sure I'll ask you the question.

3 A. I have given you the basis. The
4 discharge summary and the lack of appropriate
5 subsequent follow up and the fact that she was at
6 high risk to begin with.

7 Q. Well, this seems a bit circular
8 because you're saying she was at high risk to
9 begin with, but the basis for you're saying she
10 was high risk was these memory problems so I am
11 just trying to figure out --

12 A. No, not, you're getting confused now,
13 Jim. She was at high risk because of the fact
14 that she had a history of drug and alcohol abuse,
15 she had a history of head trauma.

16 There was a CT scan which at least
17 showed at least showed some mild atrophy and
18 subsequent to her initial ECT course she did have
19 memory loss on top of all that.

20 So you have to put -- it's a
21 constellation of factors which make her at high
22 risk, not any one single factor. You have to
23 think of constellations of risk factors, Jim, not
24 just any one single risk factor.

1 Q. The brain trauma that you're talking
2 about, I think we've beaten this to death, that
3 is this issue about her self-reporting that she
4 hit her head when she was doing gymnastics as a
5 teenager or something to that effect?

6 A. Well, there were specific reports in
7 the medical record which predates the ECT her
8 reporting that she had head trauma. There was
9 also a substantiated history of drug and alcohol
10 use.

11 Q. And just explain to me briefly how the
12 drug and alcohol abuse and her history puts her
13 at high risk for ECT?

14 A. Drug and alcohol use creates a
15 vulnerability to the brain being damaged to the
16 extent that it reduces the brain reserves.

17 Q. So you believe that the drug and
18 alcohol use did cause brain damage?

19 A. No, I believe the drug and alcohol use
20 did not produce any functional damage, but it did
21 reduce her reserve capacity and made her more
22 vulnerable to the ECT therapy producing permanent
23 brain damage which has reduced her ability to
24 function in this world, in this life.

1 Q. Do you agree that the 2002 brain
2 atrophy did not definitively show vulnerability
3 to brain damage from ECT, you agree with that
4 statement?

5 A. In the context of the constellation of
6 factors which I have enumerated it is certainly
7 consistent with a vulnerability to a high volume
8 of ECT.

9 Q. Now, you brought this issue up about
10 the Wellbutrin and the Concerta, the stimulant
11 medication so I need to ask you a couple of
12 questions about that. That's not anywhere in
13 your report that I could find, am I wrong about
14 that?

15 A. It's under Number 2 and Number 6, I
16 believe, of the draft report. I indicate
17 although I don't name those medications
18 specifically, I do indicate a failure to consider
19 reasonable alternative medications which in this
20 instance means not prescribing Wellbutrin and not
21 prescribing Concerta.

22 Q. Well, you don't dispute that she had
23 periods of depression between her manic episodes,
24 do you?

1 A. She did have periods of depression
2 between her manic episodes, however, as soon
3 as -- there was alternatives to Wellbutrin and
4 Concerta as far as the treatment of depression is
5 concerned, for example, intensive psychotherapy,
6 cognitive therapy for depression, group therapy,
7 referring her to a day hospital even.

8 There was a variety of alternatives
9 when you have a bipolar patient who may be
10 exquisitely sensitive to having their depression
11 turn into mania with a stimulant like Wellbutrin.

12 Q. Are you testifying that it was the
13 stimulant medication that caused her manic
14 episodes?

15 A. It certainly did not cause all her
16 manic episodes because once they were established
17 they had a life of their own to some extent, but
18 they simply placed her at higher risk for having
19 a rapid cycling, having more episodes and having
20 those episodes be more intense and having her
21 suffering become more intense.

22 They should not have continued to
23 prescribe them to her. Alternative means to
24 treat her depression needed to be implemented in

1 a comprehensive manner.

2 Q. Well, the records, do they not bare
3 out that Dr. Roberts tried many different forms
4 of medication therapy over the years for
5 Miss Johnson?

6 A. He tried many different forms of
7 medication for her, but he never initiated from
8 what I can tell a comprehensive psychotherapy
9 program, referring her for group therapy,
10 referring her for social occupational therapy.

11 There is a variety of non-mania
12 precipitating measures one can put into place for
13 a bipolar patient such as Miss Johnson who seems
14 to be sensitive to stimulants and Wellbutrin.

15 Q. You have noted in the chart where
16 Dr. Roberts indicates that as a part of his
17 evaluation that they had processed Miss Johnson's
18 feeling and explored options, you seem to note at
19 various visits that Miss Johnson had with
20 Dr. Roberts, correct?

21 A. And it seems to have all the
22 characteristics of it lacks detail and has all
23 the characteristics of being a pro forma note
24 rather than a comprehensive description of what

1 was being done and what the plan was.

2 Q. I understand you're not happy with the
3 length of the note, but you do admit that that is
4 capturing some type of therapy, that he was
5 working with her more than just a medication
6 regimen, that there was some psychotherapy
7 ongoing?

8 A. As I read those notes they seem to me
9 to be more place holders rather than an
10 indication of an active comprehensive
11 psychotherapy plan focusing on how to help her
12 reduce the level of impairment she was suffering
13 from which was foreseeably demobilizing and
14 foreseeably precipitating first her depression
15 and then mania.

16 He also did not focus with her from
17 what I can tell in his notes or in his deposition
18 on what difficulty she had adhering to the
19 various medication regimens that he was trying.
20 Why was she having such a difficult time with
21 that.

22 Q. Are you contending that Dr. Roberts
23 was not working with her from a psychotherapeutic
24 perspective -- or you called it a place holder, I

1 am not sure what that means.

2 A. What I am saying is the notes
3 themselves seem more like place holders in the
4 sense that they seem pro forma. There was no
5 detail in them.

6 There was no description of any
7 meaningful psychotherapeutic focus or plan and
8 what progress is being made and with a patient
9 who is at as high a risk as Clair Johnson one
10 needs to have an explicit plan for psychotherapy.
11 There was no indication of any referral for group
12 therapy.

13 There is no indication for a referral
14 for occupational therapy. I don't see any
15 psychotherapy plan here what I see is medication
16 prescribing but not the practice of psychiatry.

17 Q. All right. Well, would part of a
18 reasonable psychotherapeutic plan for Clair
19 Johnson include assessing how the patient has
20 been doing from a subjective report from the
21 patient asking how she has been doing, would that
22 be one part of?

23 A. That would be one part of ongoing
24 monitoring, but one needs to supplement that with

1 a more compressive monitoring and a more
2 comprehensive treatment plan.

3 Q. I am just trying to gets through this,
4 but go ahead.

5 A. , Please go on.

6 Q. Is another part of a reasonable plan
7 include allowing the patient to talk and express
8 her feelings of what's going on and how she is
9 doing?

10 A. It can be in the context of a
11 comprehensive treatment plan, yes.

12 Q. Is one part of the plan to assess the
13 medication regimen to see if the patient is
14 compliant and what types of benefits or adverse
15 reactions they might be getting from the
16 medication?

17 A. Patient adherence is something that
18 does need to be assessed and any difficulties
19 which are revealed in the patient adhering to the
20 medications need to be explored and resolved in
21 order for successful treatment to proceed so by
22 itself it's a necessary step, but itself it's not
23 a sufficient step.

24 Q. Is one part of a reasonable

1 psychotherapeutic plan for Clair Johnson
2 assessing her sleep pattern and her appetite and
3 energy?

4 A. Again, necessary by not sufficient.

5 Q. By itself you mean?

6 A. Precisely, but itself but also in the
7 context of everything else that I've seen
8 documented and what Dr. Roberts testified to it
9 was below the standard of care as I understand
10 it.

11 Q. What about as part of a reasonable
12 psychotherapeutic plan for Clair Johnson would it
13 include assessing suicidal or homicidal
14 ideations?

15 A. Again, necessary but not sufficient.

16 Q. How about redirecting her focus to
17 positive aspects of her life, is that part of a
18 reasonable psychotherapeutic plan?

19 A. Maybe, maybe not because simply
20 redirecting her focus to positive aspects of her
21 life without allowing her to do the grief work
22 that she needed to do mourn the loss of her
23 hopes, of her memory and of her marriage would
24 inadequate.

1 If you simply say to a patient, just
2 don't think about it, look at the bright side of
3 life, this is a patient who has lost her memory
4 and a patient who has lost her husband and has
5 basically lost an opportunity at a meaningful
6 life to just say think about the positive stuff,
7 that's actually going to be counter-therapeutic
8 and counter-indicated.

9 Q. Doctor, you say that as if to suggest
10 that's actually what Dr. Roberts and we both know
11 that's not what he did, correct?

12 A. I don't know that. You may know that.
13 Dr. Roberts may know that. If he does, he has
14 not expressed it in his deposition and he's not
15 expressed it in his notes.

16 Q. Well, did you get from his deposition
17 the impression that he was the type of therapist
18 that would just merely suggest think about
19 something happy and move on?

20 A. Well, again, my impression was that he
21 did not do meaningful grief work with her that
22 needed to be done in the context of her very
23 serious losses. There was a deep failure here,
24 Jim.

1 Q. Okay.

2 A. This woman needed to have a safe place
3 to grieve her losses, not redirected to simply
4 what's positive.

5 Q. So allowing Miss Johnson to talk about
6 the stressors in her life and to express how
7 she's been doing and if necessary let her rant
8 and rave a little bit, is that not part of what
9 you're talking about?

10 A. No. Meaningful grieving is not simply
11 ranting and raving and talking about the
12 stressors in your life, no, Jim, that's not the
13 same.

14 And if Dr. Roberts was under the
15 impression that what you're saying is the same,
16 then that would be a departure from the standard
17 of care.

18 Q. Dr. B, I am asking these questions,
19 not Dr. Roberts and I am not a doctor, but you
20 agree that Clair Johnson was predisposed to do a
21 lot of ranting and raving in a lot of different
22 circumstances of her life, right?

23 A. I think Clair Johnson was deeply upset
24 and when she was deeply upset and when she was

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1 deeply sad it was easier for her to be mad than
2 sad.

3 And what you need to do for a patient
4 for whom it's easier to be mad than sad is to
5 help them be in a safe place where it's okay to
6 be sad an okay to grieve.

7 Q. And he didn't do that, Dr. Roberts did
8 not do that?

9 A. He did not provide her with such a
10 save environment especially in view of her
11 opposition to continue with ECT and his support
12 of continued involuntary electroconvulsive
13 therapy, her coerced electroconvulsive therapy as
14 it was she was already quite frightened and quite
15 sad and to coerce her into having involuntary
16 high volume ECT undermined the chance of any
17 meaningful therapeutic alliance between the two
18 of them.

19 Q. Are you testifying that Dr. Roberts
20 coerced her into involuntary ECT therapy?

21 A. To the extent that Dr. Roberts did not
22 himself address the fact that there were
23 alternatives to ECT that it wasn't simply a
24 matter of gee, well, if you don't agree to this



1 then we'll tell your father and we'll convince
2 him to agree to this.

3 That undermines the therapeutic
4 alliance between the two of them. Dr. Roberts
5 failed to do what is standard for any good
6 meaningful psychotherapy with a patient who is
7 suffering from major mental illness to A, create
8 a therapeutic alliance and B, address those
9 factors which may be underlying the therapeutic
10 alliance such as coerced electroconvulsive
11 therapy and the unresolved grief that this
12 patient was experiencing.

13 Q. What do you mean by therapeutic
14 alliance?

15 A. A therapeutic alliance involves the
16 therapist creating a safe enough environment for
17 the patient and removing any obstructions from
18 the patient's path to be able to trust the
19 therapist, and if the patient herself is
20 expressing a refusal for electroconvulsive
21 therapy absent, then you have go ahead that see
22 what that refusal is about.

23 And if you recommend involuntary ECT
24 and then don't explore with the patient what is

1 meant to have recommended or to have agreed do
2 the recommendation of involuntary
3 electroconvulsive therapy or have not objected to
4 involuntary electroconvulsive therapy for your
5 patient, then you will not have a therapeutic
6 alliance.

7 The patient expects their physician to
8 protect them and protect their autonomy and
9 involuntary electroconvulsive therapy does not
10 protect the patient's autonomy, and it's not
11 something which unexplored and by itself will
12 lead to a therapeutic alliance.

13 Once it occurs, then the primary
14 psychiatrist needs to explore with the patient
15 what the meaning of the involuntary
16 electroconvulsive therapy is to the patient and
17 whether or not the patient sees the therapist as
18 being against her rather than with her as far as
19 her wishes and aspirations are concerned and her
20 best interest it concerned.

21 The patient has to trust her
22 psychiatrist, and if her psychiatrist is not
23 addressing with the patient what foreseeable
24 areas of mistrust there may be, then the

1 therapist isn't doing their job.

2 They're not helping to create a
3 therapeutic alliance. If you don't trust me and
4 we don't talk about it, you will continue not to
5 trust me. You may continue not to trust me
6 anyway, but that's another matter.

7 Q. You got the impression from this case
8 that she didn't trust Dr. Roberts? Did you read
9 her deposition?

10 A. I did. I think she initially trusted
11 him blindly almost and the problem was as the ECT
12 continued Dr. Roberts did not step in and say
13 wait a minute, we need to find another
14 alternative here.

15 That was undermined in a foreseeable
16 manner to the point where it's now difficult to
17 trust any treating clinician, although she still
18 tries to, as I understand.

19 Q. Did you read in her deposition that
20 she loved Dr. Roberts?

21 A. I am sure she did. And you see, when
22 someone who you love betrays you, then you feel
23 that much more hurt and that much more
24 disappointed and you trust the person much less.

1 You don't love me, so you don't trust
2 me and that's okay, right, but if you love
3 someone and then they seem to be violating your
4 trust like in a boundary violation, then that
5 violation of trust is that much greater.

6 Let's face it, involuntary ECT is a
7 form of boundary crossing. I can become a
8 boundary violation when the patient or the
9 patient's guardian isn't informed of that.

10 Q. Where are you getting the notion that
11 Dr. Roberts violated her trust and that she was
12 so devastated because of his violation of trust,
13 where is that coming from?

14 A. It's coming from my both talking with
15 her, my observing the fact that she does love
16 Dr. Roberts and yet she could not express any
17 negative feelings about him relative to the fact
18 that he was standing by and allowing involuntary
19 ECT to be the only alternative that she was being
20 offered.

21 Q. So Miss Johnson told you that
22 Dr. Roberts violated their relationship, their
23 trust?

24 A. Miss Johnson told me that she was

1 bewildered by Dr. Roberts not protecting her from
2 involuntary electroconvulsive therapy. She just
3 didn't understand.

4 Q. Is that in your notes?

5 A. It's not in my notes, but certainly
6 part of my examination of her.

7 Q. You produced several articles in this
8 case; is that right?

9 A. I have referenced several articles in
10 this case, yes.

11 Q. You may not have produced them, I
12 apologize. My impression was that you produced,
13 for example, there is something called
14 "Neuropsychiatric Practice and Opinion",
15 "Neuropsychiatric Considerations and the Use of
16 ECT", Andrew Crystal and Edward Coffee, maybe I
17 just pulled these because you reference them, I
18 don't know.

19 A. I believe you pulled them because I
20 referenced them.

21 Q. Okay. And why did you reference those
22 various articles that I pulled? Did you find
23 them to be useful in your opinion or what was
24 that?

1 A. They form the overall background of
2 what knowledge there exists and did exists about
3 involuntary massive electroconvulsive therapy.

4 I would have to look at each specific
5 reference to tell you how each one is relevant to
6 the overall theme, but they are part of a
7 background of knowledge that's easily
8 available.

9 Q. You know either Andrew Crystal or
10 Edward Coffee?

11 A. I do not.

12 Q. Do you agree that at present ECT is
13 recognized as the most effective treatment for
14 serious major depression and that it's been shown
15 to be efficacious in mania and certain types of
16 schizophrenia?

17 A. It can be. It depends, again, on what
18 level of risk the patient is and what benefits
19 the patient has.

20 Q. You agree that the available evidence
21 suggests that ECT does not cause damage to the
22 brain?

23 A. I do not agree with that. I think
24 that's only true for low risk patients but not.

1 for high risk patients.

2 You have to divide up your patient
3 pools between low risk for brain damaged patients
4 and high risk for brain damaged patients.

5 Q. Do you agree that there is evidence
6 that ECT sometimes is associated with a temporary
7 retrograde and anterograde amnesia predominantly
8 affecting several weeks preceding and following
9 the ECT CT course?

10 A. There is such evidence and for high
11 risk patients there is also evidence that such
12 amnesia is not temporary but permanent.

13 Q. If you have or produce or plan to go
14 research any literature to support what you just
15 said, I need that produced before trial, okay?

16 A. Okay.

17 Q. You agree that maintenance ECT has
18 been successfully and safely used as prophylactic
19 therapy in individuals?

20 A. Yes, in appropriately selected and
21 monitored low risk individuals at appropriate
22 volumes.

23 Q. The article that you reference in your
24 reports, are those reasonable articles if one

1 wants to learn about ECT and the various
2 advantages and disadvantages of ECT therapy?

3 A. They include articles which have some
4 reasonable information in it, some unreasonable
5 information and some misleading information. Any
6 article which I myself write probably has the
7 same.

8 Q. So you've cited articles to support
9 your opinions that have unreasonable information
10 in them?

11 A. No article that I know from top to
12 bottom has reasonable information. It has some
13 information that becomes outdated, some
14 information that simply may be misstated and some
15 information which is valuable and helpful. We
16 don't have any articles like the Bible, Jim.

17 Q. Is that a yes to my question?

18 A. It's a qualified yes which is that any
19 article has information that's helpful and
20 information that's mistaken and information
21 that's not helpful. It has all of that. You
22 have to read mindfully, not mindlessly.

23 Q. Let me ask you this: Do you agree
24 with the following that ECT is indicated when one

1 of the following exists: Number 1, medical or
 2 psychiatric need for a rapid definitive response;
 3 Number 2, there is a history of prior episodes of
 4 the same condition that responded to ECT but not
 5 other available therapies; Number 3, in the
 6 present episode the patient has been intolerant
 7 or failed to respond to other available therapies
 8 or Number 4, the patient prefers ECT over the
 9 alternatives; do you agree with that?

10 A. In general for low risk patients,
 11 yes.

12 Q. Do you agree that there are no
 13 absolute contraindications for ECT therapy?

14 A. Again, there are no absolutes in
 15 medicine, but there is what a reasonable and
 16 prudent physician would do and certainly a
 17 prudent physician would not go ahead and give the
 18 high volume of involuntary ECT to a vulnerable
 19 patient like Miss Johnson.

20 You don't go over 80 with a patient
 21 who is as vulnerable as she is on an involuntary
 22 basis.

23 Q. Do you agree that the literature
 24 suggests that there may be a greater risk

1 associated with ECT in conjunction with the brain
2 injury if the brain injury occurs close in time
3 to the ECT therapy rather than remote?

4 A. It depends on the nature of the brain
5 injury per se. Again, the probably with
6 statistics is it doesn't distinguish among
7 different kinds of injuries.

8 Some injuries if they occur close to
9 can make the patient more vulnerable but that
10 doesn't mean that an injury that has occurred ten
11 or 15 years previously doesn't make the patient
12 vulnerable. It still does.

13 Q. But we don't know the nature of her
14 brain injury, correct?

15 A. I think we don't know the specific
16 brain injury, but it is consistent with drug and
17 alcohol use and possibly with some brain trauma
18 as well.

19 Q. Who is Fink?

20 A. He is someone who advocates the use of
21 electroconvulsive therapy and a very
22 controversial figure in American psychiatry and
23 psychiatry in general. Some people think he's a
24 fink, other people think not.

1 Q. Bear with me earn. I think some
2 things have been covered by Will at the first
3 deposition so bear with me.

4 A. Take your time, Jim.

5 Q. Is it fair to say based on the numbers
6 we've been talking about that you've earned over
7 \$100,000 on this case thus far?

8 A. I don't think it's been over that.

9 Q. Getting close, I think we were at 80
10 something the last time we deposed you.

11 A. I am not sure what the amount is, but
12 anyway I would say 80 something would be a guess
13 on my part.

14 Again, I don't keep track of that
15 myself. But will be sure to have my office send
16 you via Mr. Ravenel any billing statements that
17 we have or he can send them to you directly.

18 Q. Let me take a break. I do have some
19 more questions, but I want to take a five minute
20 break.

21 A. Please feel free, Jim.

22 (Thereupon, there was a short recess
23 taken.)

24 Q. Dr. B, I am going to try and run

1 through the bullet points that we started with.

2 I think we have covered several of
3 them. You're welcome to say what you need to
4 say, but part of this process is simply going to
5 be to confirm your opinion and if we have talked
6 about it I'll just ask if there is anything more
7 you need to say about it and if we haven't then
8 we'll explore it, does that make sense?

9 A. Okay, Jim. Please proceed.

10 Q. The first one I had was this issue
11 about Miss Johnson being vulnerable or being at
12 high risk and Dr. Roberts needing to be aware
13 that she was at high risk and making her aware of
14 that, is that an accurate summary of your first
15 criticism?

16 A. That's fair, Jim, yes.

17 Q. And I believe we have talked at length
18 about why she was at high risk and your feelings
19 on what that meant for her that she was at high
20 risk, have we covered your opinions on the aspect
21 of her being at high risk with the ECT therapy?

22 A. Yes. Again, what needs to happen is a
23 dynamic risk assessment.

24 She was at high risk to begin with and

1 as time went on and they were more and more ECTs
2 she became at even higher risk.

3 Q. All right. Do you agree that she had
4 not had adequate success in the years prior to
5 ECT with medication therapy; you agree with
6 that?

7 A. She only had limited success and there
8 were areas where she would get recurrent episodes
9 of depression and mania so by success we mean was
10 she able to totally prevent or was her treating
11 clinician able to treat the depression and mania
12 and the answer is no.

13 When you're treating someone with an
14 episodic recurrent illness you sometimes need to
15 go ahead and get them through that phase of their
16 illness so that they can go ahead eventually and
17 reach a plateau and hopefully eventually recover
18 or at least stabilize and stop having these kinds
19 of episodes.

20 Q. But you agree that her response to the
21 various and sundry medication therapies was less
22 than you would hope for as a treating
23 clinician?

24 A. Yes, absolutely, Jim.

1 Q. Now, you mentioned that ECT was not an
2 inevitable choice for treatment and then you
3 mentioned that it was, my notes trail off, and
4 then you indicate it was contraindicated, are you
5 opining that ECT was absolutely contraindicated
6 in this case?

7 A. Initially it was not absolutely
8 contraindicated, but if it was going to be given
9 and needed to be given in a limited manner with
10 extremely careful monitoring, again, unilaterally
11 to begin with in a manner which was informed and
12 what was contraindicated was involuntary ECT for
13 this particular patient who would be particularly
14 sensitive to the involuntary coerced nature of
15 ECT.

16 Q. Why did it have to be unilateral?
17 Bilateral is standard of care, is it not?

18 A. Bilateral ECT for manic patients who
19 are at low risk is certainly something which can
20 be given.

21 However, unilateral ECT for patients
22 who are at high risk is less likely to go ahead
23 and produce memory damage.

24 Now, if unilateral ECT fails and there

1 is no memory damage, you certainly can proceed to
2 bilateral ECT, but you need to do it in a
3 sequence rather than jumping right away to
4 bilateral involuntary ECT.

5 Q. Do you consider yourself an expert in
6 ECT therapy?

7 A. I consider myself, I practice
8 psychiatry which included expertise in evaluating
9 patients as candidates for ECT and the kind of
10 ECT administration that any particular patient
11 would, in fact, have it be optimal for.

12 I don't administer at this point ECT
13 myself, but I certainly have consulted on
14 patients who have undergone ECT or who are
15 candidates to undergo ECT to see whether or not
16 they're appropriate candidates and whether
17 appropriate informed consent has been obtained,
18 and I do consider what other potential treatment
19 options for the patients I treat.

20 Q. You mentioned as one of the bullet
21 points as involuntary treatment went on the
22 number of treatments was a contraindication given
23 her vulnerabilities and her memory loss, and I
24 think we've talked about that.

1 You're talking about the number of
2 maintenance ECT and the fact that she complained
3 of memory loss over time, is that what you're
4 talking about?

5 A. Yes, and the fact, again, that they
6 were initiated and maintained on an involuntary
7 basis or subsequently on a coerced basis.

8 Q. And can you agree with me that
9 Dr. Roberts does document, does chart, if you
10 will, observations of memory but your position is
11 that is not sufficient, he needed to do
12 neurocognitive testing to test the memory is what
13 you told earlier; is that correct?

14 A. He needed to do neurocognitive
15 testing. He needed to go ahead and at the very
16 least do some formal mini mental status testing
17 which he didn't do.

18 He really needed more than that. He
19 needed to refer her for neuropsychological
20 testing and follow her with neuropsychological
21 testing.

22 Q. Are there any circumstances where an
23 outpatient clinician such as yourself or
24 Dr. Roberts can note some subjective memory loss

1 and monitor it to see if it improves over time
2 and be within the standard of care when someone
3 has ongoing ECT therapy?

4 A. Not when someone has ongoing ECT
5 therapy because ECT therapy, especially in a high
6 risk patient, can foreseeably lead to permanent
7 memory loss and brain damage, which is manifested
8 as permanent memory loss and also loss of other
9 brain function such as executive functions.

10 Q. Dr. B, it seems to me a large aspect
11 of your opinion hinges on your position that she
12 was a high risk patient; is that a fair
13 characterization?

14 A. Not just that she was a high risk
15 patient but also that this was involuntary
16 treatment and there was a high volume of
17 treatment, 80.

18 Again, if you look at the NICE
19 guidelines, I think those are fair guidelines.
20 They're written by the British National Health
21 Service, which is no dog in the fight here.

22 You have to be extraordinarily careful
23 with a higher volume especially when it's coerced
24 or involuntary ECT.

1 So she was at high risk to begin with
2 and by virtue of the fact that this was a high
3 volume and involuntary it became overwhelming.

4 I try and look at any fact that is
5 presented to me from both sides because I consult
6 as much for defense attorneys as I do for
7 plaintiff's attorney, I consult to other
8 clinicians, and I just don't see given how her
9 initial level of risk, how her risk increased,
10 that this was coerced and involuntary why such a
11 low level of monitoring and such a pro forma
12 level of informed consent.

13 Just having people sign consent forms
14 rather than it being a process. I know that's
15 something which people wanted to have happen, it
16 just didn't happen here from what I can tell.

17 Q. Let me ask you this: Is it fair to
18 say that over the last ten years that you have
19 earned over a million dollars off expert fees?

20 A. I would imagine so.

21 Q. The next one on my outline is
22 alternatives need to be considered, should have
23 offered alternative treatment to ECT. I think we
24 have discussed this.

1 Can you just as briefly as you can
2 tell me what alternatives you're talking about, I
3 think you told me about psychotherapy?

4 A. A comprehensive program of
5 psychotherapy focusing on issues around a
6 therapeutic alliance, difficulty in her adherence
7 to medication, grief and unresolved grieve,
8 issues around her memory loss including
9 potentially group psychotherapy, occupational
10 therapy, medication management such as
11 intramuscular long lasting neuroleptic medication
12 such as Prolixin, for example, potentially trying
13 to add to that a clonopin regimen that she could
14 stick to and adhere to or some other kind of
15 benzos, mood stabilizer, Lamictal in this context
16 could be more beneficial than it actually was if
17 it was done in a proper psychotherapeutic and
18 overall medications management context.

19 Q. But you agree with me that she had had
20 prior to ECT psychotherapy and medication
21 management not only by Dr. Roberts but by several
22 other treating clinicians as we described earlier
23 or characterized earlier with limited success?

24 A. It was with limited success, however,

1 it was successful enough to prevented an extended
2 course of high dose involuntary ECT, so it was at
3 least of limited success but of much less harm,
4 again, primum non nocere, you do no harm as a
5 physician.

6 Q. You next said in this bullet point
7 list that Dr. Roberts should have advised the
8 patient for the need for a guardian ad litem?

9 A. Yes, either that for perhaps have the
10 patient create a living will document where she
11 could go ahead and specify what her treatment
12 should be should she become incapacitated like
13 being psychotic given the conflicts of interest
14 that existed with her husband who was both
15 separating from her eventually divorced her, the
16 fact that there was an institution involved where
17 her husband's brother-in-law was the chair of the
18 board of trustees.

19 She needed to have an independent
20 well-informed decision maker as her guardian ad
21 litem.

22 Q. What --

23 A. She herself complained actually during
24 her first hospitalization of conflicts of

1 interest so she herself had brought this up.

2 This should have been validated and an
3 alternative should have been provided to her with
4 a non-conflicted guardian ad litem who could
5 reasonably weight risks, benefits and
6 alternatives including the risk of her proceeding
7 with treatment in a situation which was filled
8 with conflicts of interest that she herself was
9 complaining about.

10 Q. What's your position on what Miss
11 Johnson was complaining about Dr. Roberts
12 relative to the ECT treatment?

13 A. I am not sure I understand your
14 question.

15 Q. What do you contend Miss Johnson was
16 telling Dr. Roberts about the ECT therapy as she
17 was undergoing it?

18 Do you contend that she was telling
19 him, hey, they're over here brutalizing me giving
20 me involuntary treatment, I don't want to go
21 back, please help me?

22 What do you contend she was telling
23 him or that he was aware of in that regard?

24 A. He was aware in his meetings with her

1 that she did not want the ECT treatment. He
2 should have had access to the medical record and
3 the discharge summary from the hospital as a
4 treating psychiatrist where she speaks about
5 conflicts of interest at MUSC and how suspicious
6 she is of that given her husband's position and
7 her husband's brother-in-law's position as chair
8 of the board of trustees there.

9 He should have explored with her the
10 alternative of having any additional
11 hospitalizations occur outside of the MUSC system
12 given her complaints during the hospitalization
13 about potential conflicts of interest.

14 He should have explored with her
15 alternatives to electroconvulsive therapy given
16 her complaints about electroconvulsive therapy?

17 Dr. Roberts could have certainly asked
18 for the medical record as well as I was able to
19 ask for it with Miss Johnson's consent. She
20 never refused him access to the MUSC medical
21 record at least as far as what I know and I can
22 tell.

23 Q. You say there was no evidence that
24 Dr. Roberts gave her the opportunity to benefit

1 from psychotherapy, what is that based on?

2 A. The lack of any documentation, of any
3 comprehensive plan of psychotherapy which
4 includes grief work and a focus on the
5 therapeutic alliance as well as Dr. Roberts' own
6 testimony what he is describing is at best
7 superficial and at worst just close to nothing
8 basically to the extent that she's being simply
9 redirected to look at what's positive in her
10 life.

11 Q. What do you base that on? Is that
12 based on the question I asked you earlier about
13 redirection or is there something you're actually
14 referring to in the chart about that?

15 A. No, just referring to the question you
16 had asked me previously, however, in reading
17 Dr. Roberts' deposition I don't see any evidence
18 that he provided her with any meaningful grief
19 work, any specific exploration of what factors
20 made it so difficult for her to adhere to her
21 medication regime. Similarly in reading his
22 notes I just don't see that at all.

23 I don't see any referral for group
24 psychotherapy. I don't see any referral for

1 occupational therapy.

2 It's not only a failed treatment plan,
3 it's a below the standard of care treatment
4 plan.

5 Q. Was Miss Johnson a candidate for group
6 psychotherapy given her condition?

7 A. Once her condition had stabilized
8 certainly introducing her to a group, yes. I
9 have had patients who have had manic depressive
10 episodes in group therapy.

11 I've practiced group psychotherapy and
12 such patients can do very well because they don't
13 feel so alone, so helpless, so hopeless.

14 She was also a candidate for ongoing
15 family therapy. When there was separation from
16 her husband she should have been told about it.

17 She shouldn't have been the last
18 person to know about it when she was
19 hospitalized.

20 To the extent that she was the last
21 person to know about it when she was
22 hospitalized, Dr. Roberts when she became an
23 outpatient had those records, he could have
24 addressed those issues with her, which is

1 certainly a focus for mistrust.

2 Q. You next told me that failed to
3 monitor her cognitive impairments, I think we've
4 talked about that, correct?

5 A. Yes.

6 Q. And then we talked about the
7 Wellbutrin and Conerta issues, correct?

8 A. Correct.

9 Q. Have you diagnosed her with
10 post-traumatic stress disorder?

11 A. Again, she suffers from impairments in
12 the post-traumatic stress disorder spectrum. I
13 understand it to be a spectrum rather than simply
14 a category. The category simply refers to a
15 group of patients.

16 Her suffering is in the spectrum, so
17 yes, she does suffer in the post-traumatic stress
18 disorder spectrum secondary to the brain damage
19 which was done and the memory loss that she's had
20 and the involuntary nature of the ECT itself.

21 Q. So you have diagnosed her with
22 post-traumatic stress disorder, correct?

23 A. I have diagnosed her as suffering in
24 the post-traumatic stress disorder spectrum.

1 Q. Has any clinician before you diagnosed
2 her with post-traumatic stress disorder?

3 A. There has been no attempt made to
4 either rule in or rule out post-traumatic stress
5 disorder.

6 The focus has been on her bipolar
7 disorder rather than on the consequences of her
8 ECT as far as I can tell.

9 Q. Can some of the mental impairments
10 that come with a severe bipolar disorder patient
11 overlap into the realm of the criteria that is
12 utilized to diagnose PTSD?

13 A. Of course there can be some overlap,
14 but elephant's trunks and snakes feel the same,
15 but elephants and snakes are different.

16 Q. Are you suggesting that there is not
17 the potential for some overlap in the testing
18 that you administered that some of those answers
19 may merely reflect her mental disease from the
20 bipolar disorder rather than a PTSD?

21 A. Some of the may but all of them
22 cannot.

23 Q. Does bipolar disease progress over
24 time or can it progress over time?

1 A. It can be progressive. It can also go
2 ahead and reach a plateau and also people can
3 stabilize and simply be maintained with a program
4 of psychotherapy and psychotherapy medication so
5 that it doesn't continue to recur.

6 It can be a progressive disorder with
7 recurrence recurring more and more frequently
8 especially in the face of loss, or it can be a
9 disorder which is recurrent but eventually
10 becomes more of a vulnerability than an ongoing
11 impairment.

12 Q. The PAI test that you spoke of earlier
13 you agree that that is a subjective report from
14 the patient?

15 A. No. It's takes subjective from the
16 patient and compares them objectively against a
17 group of patients and compares them blindly
18 without any knowledge of their being any
19 litigation or anything else about the patient's
20 condition.

21 It's an objective measure of whether
22 or not the patient is faking, exaggerating or
23 malingering and the simple answer is she is not
24 by that test or any other measure that I have.

1 seen.

2 Q. And these tests are to be effectively
3 utilized on a patient who suffers from brain
4 damage?

5 A. They can, it depends on the extent of
6 brain damage as to how effectively they can be
7 utilized the extent the patient has brain damage,
8 but they simply can be used with patients who
9 have some degree of brain damage.

10 Q. How would you characterize Clair
11 Johnson's brain damage?

12 A. In terms of the impact that it has on
13 her life, it's been catastrophic especially in
14 view of the fact that she suffers from the trauma
15 of coerced ECT over the course of five years,
16 involuntary ECT over the course of five years and
17 she suffers from bipolar illness.

18 And she also has suffered from a
19 variety of losses where her autobiographical
20 memory would be very helpful.

21 On the other hand she is someone who
22 has had resiliency, although her resiliency was
23 largely exhausted by the trauma of atrogenesis
24 namely the foreseeable side effects of a

1 treatment that was counter-indicated to being
2 with, nonetheless, she tries her best.

3 She's able to bounce back at least for
4 periods of time. So I think relative to where
5 she was before the ECT, it's been major. On the
6 other hand, she does not yet require
7 institutionalization.

8 Q. So she's had catastrophic brain injury
9 but you think that she's functional to perform a
10 PAI test and get results that are reliable out of
11 it?

12 A. Yes.

13 Q. The PAI is not diagnostic of PTSD,
14 correct?

15 A. In and of itself it is not diagnostic
16 of classic post-traumatic stress disorder.

17 Q. And how do you diagnose someone with
18 post-traumatic stress disorder when they tell you
19 that they don't remember the trauma that's
20 inciting the PTSD?

21 A. Because even if they don't remember,
22 they tell you they don't remember, you can
23 observe their physiological responses.

24 They can become fidgety. They can

1 become numb. They can space out the way she did.
2 Their pupils can become dilated which is
3 consistent with arousal.

4 She also herself on the Davidson
5 questionnaire does report some intrusive elements
6 and foreseeably anyone who has lost a good part
7 of their memory and their brain function due to
8 something which they did not consent to is going
9 to be traumatized by it.

10 You wouldn't be human if you weren't
11 traumatized by it and especially if you were to
12 begin with have a vulnerability to having a
13 bipolar condition.

14 Q. Even if you don't remember?

15 A. You may not remember it, but your body
16 remembers it. You may not be aware of it, but
17 you still see people's physical reactions and
18 still see where they are avoiding trying to talk
19 about it.

20 Q. Was part of your evaluation for
21 physiological responses to certain stimuli?

22 A. Part of my evaluation was to observe
23 her and observe her demeanor, which is what I
24 usually do with patients to see what their

1 responses were as far as who their demeanor
2 changed as we talked about various areas of her
3 experience, and this is a particularly
4 distressing area of her experience.

5 Q. Did you record anywhere in your
6 reports her physiological responses?

7 A. No, but I did mention that this was
8 consistent with my observation.

9 Well, I should say actually -- let me
10 just take a look here. If you look at Page 8,
11 Number 3.

12 Q. From what report, your most recent
13 one?

14 A. This will be April 1st, 2011 and it
15 says examination/observations. Number 3, Miss
16 Johnson observed difficulty in maintaining
17 attention and concentration so as to present a
18 coherency collection of facts and ideas was
19 especially pronounced when she spoke about the
20 period in which she was subjected to ECT without
21 meaningful consent.

22 This selective impairment
23 unaccompanied by signs of faking, malingering or
24 exaggerating is consistent with all the

1 indications in the records that both the ECT
2 itself and its forces administration over an
3 extended period of time constituted a significant
4 traumatic experience for Miss Johnson involving
5 feelings of helplessness and terror.

6 Such traumatic emotional experience
7 will foreseeably compound the physiological
8 effects of ECT in causing cognitive impairment.

9 Q. So you would talk to her about the
10 time period that she was getting ECT and she
11 would not remember it?

12 A. It's more than just not remember it,
13 she would become scattered and disorganized and
14 very anxious and observably so around that time.

15 She would become hyperaroused and
16 space out and become numb. She had a variety of
17 responses that I expect when someone has been
18 traumatized and avoiding talking about something
19 which she cannot quite put into true words but
20 they nonetheless are feeling the trauma.

21 Q. Is that not consistent with her
22 underlying demeanor from her disease process?

23 A. Not by itself because her demeanor was
24 more composed when she was talking about her

1 memory impairment themselves or about other areas
2 of her life which are conflictual and stressful
3 did not produced the same kind of numbing,
4 spacing out and hyperarousal that was produced
5 when I put up the issue of what was it like for
6 her to receive involuntary ECT.

7 Q. Any other aspect of your physiological
8 evaluation to support this diagnosis of PTSD
9 other than what's contained in Paragraph 3 on
10 Page 8 of your report?

11 A. That's the gist of it.

12 Q. So it was your physiological
13 assessment and the Davidson checklist, are those
14 the components of your post-traumatic stress
15 disorder diagnosis?

16 A. The overall fact and the totality of
17 the information which I have reviewed and
18 analyzed and have spent time reviewing and
19 analyzing.

20 Q. Did the Davidson trauma scale have any
21 validity scales built in?

22 A. It does have some validity scales
23 built in if we look at the Davidson trauma scale.
24 But basically what's most consistent her.

1 avoidance numbing score is twice as high as her
2 intrusion score and her hyperarousal score which
3 is consistent with someone who has a dissociative
4 response to trauma and also has gotten and has
5 difficulty maintaining conscious awareness of the
6 trauma.

7 And if you look at her responses and
8 the nature of her responses and that plus the
9 NFI, those would be consistent with someone who
10 suffers impairments in the post-traumatic
11 spectrum.

12 Q. Part of this assessment included her
13 trauma being the cone rod dystrophy?

14 A. Yes, we did talk about that and
15 discuss it and she was able to go ahead and
16 maintain an appropriate level of attention,
17 concentration and demeanor when discussing this
18 particular health problem that she also has.

19 Q. Did you not that find that some of her
20 responses in the Davidson Trauma Scale are
21 inconsistent with the others?

22 A. Can you be more specific perhaps. I
23 am not sure what you mean by inconsistent with
24 the others.

1 Q. Let's just take the first five
2 questions. Is four the maximum score?

3 A. Four is the maximum score in terms of
4 frequency.

5 Q. So look at those five, you don't have
6 to read them outloud. There are three of them
7 that she scores zero on and two of them she
8 scores four on.

9 And I am a lay person, but it looks to
10 me like these overlap with each other for
11 consistency sake, sometimes they repeat the
12 questions slightly different ways, is that not
13 the case here?

14 A. No because, in fact, people who would
15 score every one of them as being four I would be
16 very suspicious of as faking, exaggerating or
17 malingerling, no.

18 It's one thing to have had some
19 painful images and memories of the event, but
20 sometimes people just don't dream, especially
21 people who have been somewhat brain damaged or
22 don't have dreams related to that event.

23 People may have painful memories or
24 thoughts, but they not feel as if the event is

1 recurrent.

2 On the other hand, it makes sense that
3 they would be upset if they're reminded of
4 something especially if there is a memory deficit
5 onto of the PTSD.

6 In terms of being physically upset,
7 people are very often not aware of being
8 physically upset although you can observe.

9 Sometimes I will look at people and I
10 know their heart is racing and they never say to
11 me my heart is racing because they just block it
12 out.

13 If you have someone, Jim, who gives
14 you all fours on these, then it would raise a red
15 flag for me that they are, in fact, faking,
16 exaggerating or malingering.

17 This is much more consistent with
18 someone who is doing her best to cope with the
19 distress that she feels.

20 Q. Were the validity scale scored in this
21 case?

22 A. The validity scales were added up in
23 this case, yes.

24 Q. And where are they?

1 A. Go to Page 3 on this, on the DTS.

2 Q. Okay. Just give us the results,
3 please.

4 A. It's more likely that she has
5 post-traumatic stress disorder rather than not
6 post-traumatic stress disorder.

7 Q. Say that another way. What do the
8 validity scales tell us? Is there an indication
9 of some fawning or exaggeration or not?

10 A. No.

11 Q. So she is basically scored with no
12 indication of any inaccuracies or invalidates or
13 whatever the terms of art is?

14 A. I think the only inaccuracies that
15 might be there could be easily understood in
16 terms of her memory loss.

17 Q. And this is a 17 question exam that's
18 filled out by the patient, she reads the question
19 and then fills out her answer on a scale of zero
20 to four, that's how this is administered,
21 correct?

22 A. That is how this is administered, yes.
23 Again, when you have someone with memory loss,
24 the validity scales in and of themselves can be

1 somewhat misleading.

2 That's why you have to rely on the PAI
3 which is more robust as far as the possibility of
4 exaggeration, faking or malingering is
5 concerned.

6 Q. Is it your testimony that her bipolar
7 illness could not cause -- I am not going to go
8 through each test because we have done that, but
9 is it your position that bipolar disorder
10 especially to the degree that she had as we know
11 even before ECT therapy could not account for
12 some of the responses, either bipolar disorder,
13 depression, and/or ADHD could not account for the
14 responses that we have on the executive function,
15 the language, the memory and these various other
16 checklists that she went through?

17 A. A few, yes, some maybe, but absolutely
18 not the total.

19 Q. Can bipolar patients such as with the
20 executive function, would it be unusual for a
21 bipolar patient with her degree of illness have
22 problems with sequencing and problems with follow
23 through and things of the like, would that be a
24 surprise to have her score or report those

1 deficiencies?

2 A. During the active phase it would be no
3 surprise, however, during a non-active phase of
4 the illness this would be unusual.

5 Q. Well, I understand that, but all she
6 did was a checklist, in other words, this was no
7 true testing.

8 You gave her a checklist questionnaire
9 where she checked if she had problems with these
10 issues; isn't that right?

11 A. No because what you are overlooking is
12 that this was part of a battery where, in fact,
13 she also received a PAI, which did not show her
14 to be actively manic or she wouldn't have been
15 able to attend.

16 During my own observations she was not
17 actively manic at the time. She wasn't actively
18 manic, Jim, so the symptoms that she was
19 reporting experiencing at the time cannot be
20 attributed to mania.

21 Q. So it's your position that the
22 checklist questionnaire was specifically asking
23 her if she was having problems at the very moment
24 with these various issues as opposed to a recent

1 history of those issues?

2 A. I was asking her when she was
3 functioning the way she was functioning when I
4 saw her what was her experience, and I made it
5 clear that I was not speaking about an acute
6 manic episode or a major depressive episode, but
7 when she was functioning the way she was
8 functioning when I saw her.

9 Q. Did you report, you may have, and I am
10 just overlooking, but did report anywhere where
11 she specifically expressed to you thoughts or
12 feelings regarding the involuntary ECT that
13 you've been talking about?

14 A. Aside from all these checklists which
15 are non-specific, did you actually record
16 something where she told you specifically about
17 the ECT therapy?

18 A. As I noted previously in the paragraph
19 which I read to you, she became very disorganized
20 and very frightened when trying to go ahead and
21 talk about it when we tried to talk about it.

22 Q. Anything other than that paragraph
23 where you recorded that she specifically
24 expressed to you the stress, the trauma, the

1 outrage or anything of the like that she has
2 undergone as a result of the ECT therapy?

3 A. More precisely the fear, the loss.
4 Again, she communicated that she evoked that.

5 I could observe her demeanor change
6 when she was trying to talk about it and could
7 not talk about it.

8 The trauma even at this stage is
9 largely unspeakable for her but because it's
10 unspeakable it doesn't mean she's not suffering.
11 The two are not the same.

12 Q. All I am asking is if you recorded
13 that specifically anywhere in all of these notes,
14 reports of anything of the like other than that
15 paragraph that you have referred me to?

16 A. That paragraph summarized the gist of
17 my observations from my examination.

18 Q. So is the answer to my question no?

19 A. Which question is that?

20 Q. Have you recorded anywhere else in any
21 of your notes or reports or anywhere else her
22 expression to you of her fear, anxiety,
23 overwhelming sense of doom or loss or whatever
24 associated with this involuntary ECT, did you

1 record that anywhere other than that paragraph
2 that you referred me to?

3 A. No. The gist of my observations is
4 contained in that particular paragraph.

5 Q. Do you have any other opinions as to
6 Dr. Roberts that we have not yet reviewed?

7 A. I believe that you have the gist of my
8 opinions regarding Dr. Roberts as well, I hope
9 you do, and I hope I've communicated them in a
10 manner which is not confusing.

11 Q. I noted in some of the materials that
12 we were provided that you were given a copy of a
13 case out of Columbia, what we call the Salters
14 case, are you familiar with is that?

15 A. I remember looking at it, but it
16 wasn't the foundation of my opinion.

17 Q. That's all I was going to ask you.
18 Does it have any bearing on your opinions in this
19 case?

20 A. No.

21 Q. Are there any textbooks that you are
22 partial to that you think are good go-to
23 textbooks that might be considered authoritative
24 in the field of psychiatry particularly relative

1 to ECT or bipolar disorder?

2 A. No. As I teach my students unlike
3 religion we don't have any authoritative texts.

4 Every book we have has some
5 information in it which is helpful, some that's
6 not helpful, some that is valid, some that's
7 mistaken and some that has simply outlived its
8 usefulness.

9 So you have to be a mindful reader.
10 You can't simply go ahead and scan the text and
11 have what you need to be able to treat patients
12 well.

13 Q. What text do you teach your students
14 out of?

15 A. I don't use any specific texts. My
16 students simply look at this text and that text
17 for various bits of information, but there is no
18 Bible of psychiatry contrary to the opinion of
19 some attorneys.

20 Q. All right. You agree that physicians
21 being sued for medical malpractice should not be
22 judged with hindsight, they should be judged by
23 the experts as if they were sitting in their
24 shoes at the time?

1 A. Yes, and that means two directions.
2 On the one hand, one doesn't want to go ahead and
3 assume that a clinician could have prevented a
4 harm when they couldn't have.

5 On the other hand, one doesn't want to
6 buy into denial which is that que sera sera that
7 whatever happened happened was inevitable.

8 Both types of policies can be a
9 result of hindsight. A clinician who is overly
10 critical of himself can assume they could have
11 prevented something when they couldn't have.

12 A clinical who is into denial and who
13 thinks that that they cannot have possibly
14 practiced below the standard of care will simply
15 say that what happened was inevitable and it had
16 to happen, and it was just the natural course of
17 illness and there was nothing they could have
18 done. Both types of error need to be avoided
19 from hindsight.

20 Q. Do you agree that standard of care
21 does not require perfection?

22 A. The standard of care does not require
23 perfection, but it does requires reasonable
24 prudence.

1 Q. Have you ever treated bipolar patients
2 who suffered with depression as a part of their
3 disease with antidepressant medication as a part
4 of your medication regime?

5 A. Under carefully controlled conditions,
6 yes, especially if there is no indication that
7 those antidepressants were, in fact,
8 precipitating hypermanic or manic episodes, and
9 if there was additional appropriate psychotherapy
10 and medication as part of a comprehensive
11 treatment plan.

12 Q. Well, that's something that you as a
13 clinician when you decide that the benefits
14 outweigh the risks and you go forward with that
15 regimen you simply are left to watch the
16 medication to see if it drives the cycle, right,
17 and then if it does you have to work to get the
18 patient off of the medication until the cycle
19 subsides, isn't's that how that work?

20 A. That's a great question, Jim, because
21 it's partially true, but there is on addition I
22 would make to it that it's absolutely crucial to
23 inform the patient of the possibility that the
24 antidepressant medication that you're giving them

1 may, in fact, precipitate mania or may
2 precipitate more rapid cycling, so that when it
3 happens the patient knows what to expect and the
4 patient can work with you as part of a
5 therapeutic alliance to catch it early enough
6 before it gets out of hand and the patient
7 requires hospitalization.

8 So educating patients and families
9 about the fact that this carries some foreseeable
10 risk and how to monitor that risk is absolutely
11 helpful.

12 In some instances I've asked family --
13 I've said to patients we're going to be using
14 antidepressants here. You may become hypomanic.
15 I need to see you more frequently. I need to be
16 able to talk to your family about how you're
17 doing and I get permission to do that.

18 Q. Do you disagree that the recent
19 hospitalizations Clair Johnson has undergone in
20 the recent years obviously since the ECT was
21 stopped is most probably related to her
22 underlying severe bipolar disorder?

23 A. I think it's an over simplification to
24 reduce it to that. Of course her underlying

1 bipolar disorder contributes to her
2 vulnerability, but so does the stress that, the
3 trauma that she suffered from due to her loss of
4 memory and the involuntary ECT due to the brain
5 injury that she suffered as well as the loss of
6 autonomy that she experienced while the ECT was
7 being administered on an involuntary basis and
8 then the fact that her mother became ill and she
9 lost her mother and the grief that she would have
10 experienced around her mother becoming more
11 fragile and losing her mother. That's huge.

12 It would be difficult enough for
13 anyone, more difficult for a patient with bipolar
14 disorder, you're absolutely right about that,
15 much more difficult for a patient who suffers
16 from major impairments in autobiographical memory
17 and has to grieve the loss of her memory and her
18 autonomy due to the involuntary massive doses of
19 involuntary ECT that she was subject to.

20 Q. And the loss of that autobiographical
21 memory is, you're basing that opinion on that
22 checklist that you went through with Mr. Early
23 earlier where she checked a few boxes saying she
24 didn't have that good autobiographical memory

1 anymore?

2 A. Not just based on her checking, but
3 when we tried to explore various dimensions, it's
4 clear that she had to think very long and very
5 hard to be able to retrieve pieces of her own
6 biography and in some instances she simply wasn't
7 able to do so. It's tragic.

8 Q. Did her deposition shed any light on
9 that as far as what she was able to tell us about
10 her history and her going to college and her high
11 school friends and things like that?

12 A. No, the deposition itself was
13 relatively superficial. It was not an
14 exploration of those areas of her life which
15 would be conflictual or involve deep -- in a
16 deposition what you -- the answer is no.

17 A deposition is not a psychiatric
18 examination of someone's autobiographical memory,
19 no.

20 Q. Well, is there any in depth
21 psychiatric evaluation of her autobiographical
22 memory performed by you other than that checklist
23 we went over earlier?

24 A. We talked and I observed what she was

1 able to remember and what she wasn't able to
2 remember and there were gaps in her memory about
3 her life.

4 Q. Have you offered any opinions in any
5 print anywhere, on any paper anywhere as far as
6 recommendations for dealing with the
7 post-traumatic stress disorder? I didn't see it
8 anywhere in your report.

9 A. I have not put in it writing, but she
10 certainly needs to do a great deal of grief work
11 around the loss of memory that she has
12 experienced.

13 She needs to, once again, feel a sense
14 of justice. It's going to be -- and she needs to
15 learn to adapt to the fact that she doesn't have
16 the easy access or any access in some instances
17 to meaningful relationships in her memory when
18 she needs to access her memory.

19 She needs to grieve. If I were to
20 reduce it in a simple, she needs to grieve the
21 loss of access to meaningful memories.

22 Q. I need to be clear if I am
23 understanding you, are you attributing the PTSD
24 to the loss of memory or the trauma of the

1 involuntary commitment because it sounds like the
2 therapy you'r recommending is more so for the
3 loss of her memory than it is for dealing with
4 this, what she alleges to be this traumatic
5 experience?

6 A. It's not the involuntary commitment
7 per se, that's something that she can metabolize,
8 but the involuntary administration of ECT which
9 led to the loss of her autobiographical memory.

10 That's the trauma that she lives with
11 and has not been able to go ahead and grieve
12 yet.

13 Q. Have you attempted to put any monetary
14 figure on the value of the necessary' therapy to
15 appropriately deal with those issues?

16 A. No.

17 Q. Well, has anybody asked you to that
18 thus far?

19 A. No.

20 Q. If at any time you're asked to do
21 something along those lines or asked to bolster
22 your opinions in anyway or argument your opinions
23 in that regard, please somebody let us know so we
24 can do this again and find out what you're going

1 to say.

2 MR. RAVENEL: You'll be the first to
3 know.

4 A. You have what I understand at this
5 point.

6 Q. Thank you for your time.

7 REDIRECT EXAMINATION BY MR. EARLY:

8 Q. Doctor, I really just have one
9 question maybe. Are you familiar with the terms
10 state of the art?

11 A. Yes, more or less state of the art is
12 a terms which is used in many different ways.

13 Q. Well, I'll tell you the context. In
14 the context that something may be considered
15 malpractice by the standards of 2010, but might
16 not be by the malpractice standards of 1998, in
17 other words, medicine evolves and what doctors
18 understand and the risks and foreseeability of
19 certain things and certain procedures change over
20 time, you agree with that concept?

21 A. I do. What stays constant is being
22 reasonable prudent and primum non nocere.

23 Q. But the knowledge, if you will, that
24 goes into that prudence certainly changes over

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1 time in medicine as it does in law as in many
2 other fields; do you agree with that?

3 A. Yes.

4 Q. Thank you, Doctor.

5 RE-CROSS-EXAMINATION BY MR. SCOTT:

6 Q. I do actually have a couple more
7 questions, if you don't mind. You signed an
8 affidavit early on in this case; do you remember
9 that?

10 A. Yes.

11 Q. And you were of the opinion that, as I
12 understand, it's your opinion that Clair Johnson
13 did not regain the mental capacity to understand
14 and appreciate the harm she suffered as a
15 consequence of the negligent acts or omissions
16 specified above particularly regarding the
17 involuntary ECT until she began reviewing the
18 records in January of 2010, correct?

19 A. Yes.

20 Q. I just wanted to confirm that that was
21 your opinion. Can you explain the basis for that
22 opinion?

23 A. Well, if you have major gaps in your
24 autobiographical memory because of massive doses

1 of involuntary ECT, you won't recognize what harm
2 it caused you and put two and two together until
3 such time you have something riding in front of
4 you which can go ahead and help you understand or
5 remind you of how you felt about it and what
6 happened.

7 Q. But what are you relying on is what I
8 am getting at? What are you relying for the
9 expert opinion that it wasn't until June 2010
10 until she appreciated this?

11 A. Because of the loss of
12 autobiographical memory. That was evident in my
13 examination, that was evident in her self-reports
14 and at the same time it's consistent with the
15 totality of the data which I reviewed and
16 analyzed.

17 Q. So you believe she regained her mental
18 capacity in June of 2010 basically at which time
19 she had regained her mental capacity and when she
20 reviewed those medical records that's when she
21 appreciated the harm; is that what you're saying
22 in essence.

23 A. No. What I am saying is that by
24 review those medical records she was able to have

1 the information she needed to go ahead and
2 appreciate the harm that had occurred to her.

3 Without reviewing those she could not
4 rely on her own memory to exercise her judgment.

5 It's the deficits of her
6 autobiographical memory and her executive
7 function that I was describing previously.

8 Q. Okay. And as far as the information
9 as far as when she reviewed those records to
10 appreciate this information, your basing that on
11 what she reported to you?

12 A. I am basing that on what she reported
13 to me, my observations of her during the
14 examination itself.

15 Q. Dr. B, where does the date of June
16 2010 come from, is that the date itself? I know
17 she didn't meet you until after that, but where
18 are you getting the date of June 2010 from?

19 A. That when she reported that she began
20 to read the medical records that she had, that
21 she was able to go ahead and get over given the
22 loss of her autobiographical memory, the trauma
23 that she suffered and the foreseeable avoidance
24 that she would have of that information because

1 she didn't want to be upset, she couldn't stand
2 being upset, that's when she said she began to
3 read those medical records in detail.

4 Q. Do you know when she ordered those
5 records?

6 A. I don't, but I wouldn't be surprised
7 it was years earlier even, but that's when she
8 actually began to study them.

9 Q. Okay. Thank you for your time.

10 A. Thank you, Will, and thank you, Jim,
11 appreciate it.

12 (Whereupon, the deposition was
13 concluded at 4:00 p.m.)

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MAGNA

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1 COMMONWEALTH OF MASSACHUSETTS

2 Middlesex, ss

3

4 I, Victoria S. Reade, Professional Court
5 Reporter and Notary Public in and for the
6 Commonwealth of Massachusetts, do hereby certify
7 that the witness whose deposition is hereinbefore
8 set forth, was duly sworn by me and that such
9 deposition is a true record of the testimony
10 given by the witness.

11 I further certify that I am neither related
12 to nor employed by any of the parties in or
13 counsel to this action, nor am I financially
14 interested in this action.

15 In witness whereof, I have hereunto set my
16 hand and affixed my seal on this 11th day of
17 November 2013.

18

19

20 Victoria S. Reade

21 NOTARY PUBLIC

22 My Commission Expires:

23 August 8, 2014

24

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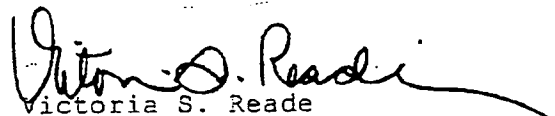
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THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

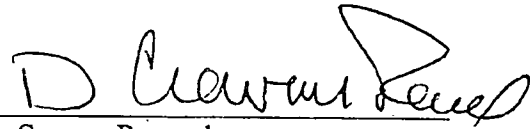
Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR the undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and does not contain any other material.



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Attorneys for Plaintiff

March 1, 2016

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.

Trial Court Case No.: 2011-CP-10-8318
2012-CP-10-02867

Appellate Case No. 2015-001463

Clair Craver Johnson.....Appellant

v.

John Roberts, M.D., Respondent Respondent

AND

Clair Craver Johnson..... Appellant

v.

Medical University of South Carolina.....Respondent

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STATE OF SOUTH CAROLINA) COURT OF COMMON PLEAS
COUNTY OF CHARLESTON) C/A #: 12-CP-10-2867

Clair Craver Johnson,
Plaintiff,
v.
John Roberts, M.D.,
Defendant.

(C) RECEIVED
MAR 31 2016
SC Court of Appeals

STATE OF SOUTH CAROLINA) COURT OF COMMON PLEAS
COUNTY OF CHARLESTON) C/A #: 11-CP-10-8318

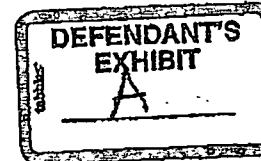
Clair Craver Johnson,
Plaintiff,
v.
Medical University of
South Carolina,
Defendant.

VIDEO DEPOSITION OF
CLAIR CRAVER JOHNSON

Friday, March 22, 2013
10:12 a.m. - 1:25 p.m.



CREEL COURT REPORTING, INC.
1230 Richland Street / Columbia, SC 29201
(803) 252-3445 / (800) 822-0896



1 Foust, other than that, what memory or memories
2 do you have regarding any of your ECT
3 treatments at MUSC, whether they're inpatient
4 or outpatient?

5 A: The only memories I have is when it was
6 outpatient and I have one other memory, like
7 when you go, I can't remember if you have to
8 change or not.

9 Q: Well, before, can you tell me what date that
10 was or what time?

11 A: No.

12 Q: '06 to '08?

13 A: '06 to '08.

14 Q: And is it just one time you remember or more
15 than one time?

16 A: Well, I remember these, the one instance that
17 I refused to sign and then I remember another
18 instance, well, I guess I have three memories.

19 Q: Well, we've already talked about the one you
20 refused to sign.

21 A: Right. One time the anaesthesiologist had to
22 stick me like ten times. And Dr. Foust had to
23 let me go. I remember that. And then one time
24 I remember, prior to going in, he had two
25 nurses and I was upset, in tears, crying that,

1 that I -- something I just remember telling
2 them that I had no way to support myself and
3 that it was since the ECT had started, I was,
4 you know, I was aware that, what was happening
5 and described it to them and I just remember
6 one of the nurses saying yes you can or
7 something like that.

8 Q: What do you mean by that? You were aware of
9 what was happening. Are you talking about
10 memory loss?

11 A: I guess so. I mean, I just remember being
12 upset and talking about the fact that I was no
13 longer capable of supporting myself in any way.

14 Q: Well, did you attribute that to the ECT or to
15 other things?

16 A: To the ECT..

17 Q: So, just so I understand, you told a nurse
18 during one of your ECT treatments that you were
19 upset with the ECT because it was causing you
20 to not be able to support yourself, is that
21 right?

22 A: Well, I don't remember verbatim exactly. I
23 just, you know, remember that I was crying.

24 Q: And you were upset because of the ECT?

25 A: Correct.

1 stuff like that.

2 Q: Did you ever tell any of your physicians
3 whether it be Dr. Roberts, private physician,
4 somebody at MUSC, that you had forgotten how to
5 take care of your activities of daily living?
6 Did you ever tell anybody that?

7 A: Well, I don't recall. I didn't see anyone for
8 quite a while after I stopped talking to Dr.
9 Roberts and even then, see I don't, we just
10 talked on the phone. I never even saw him. So,

11 Q: Let me ask it this way. It's my understanding
12 from reading your records and I can show you
13 the log book again that your last ECT treatment
14 at MUSC would have been in June of 2008.

15 A: Okay.

16 Q: Do you agree with that? Want me to show you?

17 A: I know it was '08.

18 Q: Okay.

19 A: But I didn't realize it was June.

20 Q: At what point did you lose the ability to stop
21 taking care of the activities of daily living
22 on your own and have to seek other people to
23 help you do that? When was it after June of
24 2008?

25 A: It was probably that ---

- 1 Q: So it was during your ECT?
- 2 A: I mean the divorce went on for three and a half
- 3 years.
- 4 Q: I understand. But just so the record's clear,
- 5 you lost your ability to take care of your
- 6 activities of daily living prior to, before
- 7 your last treatment of ECT?
- 8 A: (Nods head affirmatively.)
- 9 Q: Is that a yes?
- 10 A: Right.
- 11 Q: And you attributed that to the ECT?
- 12 A: Oh, absolutely. I mean ---
- 13 Q: You did then and you do now?
- 14 A: (Nods head affirmatively.)
- 15 Q: Is that a yes?
- 16 A: Yes.
- 17 Q: And that was because of memory? You had
- 18 forgotten how to do those things?
- 19 A: It was not only memory, it was a much more of
- 20 a physical deterrent that I was going through,
- 21 I mean physically, it effected everything.
- 22 Q: That's the first I've heard of anything
- 23 physical now. Tell me what affected you
- 24 physically.
- 25 A: Well, I mean, like I mentioned, well, I

1 any research, look into what happens, you know,
2 get two or three opinions from other doctors.
3 I mean, you know, with my dog, he wants to take
4 my dog to different vet and things of that
5 sort, but didn't care enough, you know, to do
6 that for me.

7 Q: Okay.

8 A: But I, particularly since my mother died, I
9 just keep my thoughts to myself. But I mean I
10 think that they -- well it just shouldn't have
11 happened. And it just is what it is.

12 Q: All right. A few questions about the lawsuit.
13 Let me ask you this. When do you, when did you
14 first start believing that ECT was causing you
15 some memory problems?

16 A: During the maintenance ECT.

17 Q: Okay. And did you express that to these folks
18 that we're talking about?

19 A: I did.

20 Q: Who all did you tell?

21 A: The two nurses, which I don't remember their
22 names, but they were always the same two
23 nurses.

24 Q: And just to be clear, I think we've already
25 talked, you're talking about the two nurses

1 you're upset that what you consider to be the
2 effect of the ECT, that it had on you and my
3 question is simply, is that, is this a
4 reiteration of what you're talking about from
5 that complaint you had with the nurses about
6 the ECT?

7 A: I guess.

8 Q: Ma'am?

9 A: I would -- yeah, I mean pretty much.

10 Q: All right. I, I saw a reference somewhere that
11 you were concerned, and this was around the
12 summer of 2010, I believe, that you were
13 concerned your husband, you ex-husband
14 threatened to reduce your alimony or something
15 like that?

16 A: Right.

17 Q: You remember that? What was that about?

18 A: Well, it was when I was diagnosed with my eye
19 disorder and I went to him to ask if he would,
20 if -- that would be the last time I've seen him
21 in person. So, if you have the date, that
22 would be when it was.

23 Q: I actually don't, but I apologize.

24 A: Oh.

25 Q: I think it was around the summer of 2010, but

- 1 that you described earlier from MUSC?
- 2 A: Right.
- 3 Q: Okay. Anybody else that you've told? Your
- 4 dad, your mom?
- 5 A: I have no idea. I would -- whoever, very few
- 6 people I may have talked to I'm sure I told.
- 7 Q: And that's -- well, strike that. Bear with me
- 8 for one second. I --there's a note from, if
- 9 y'all don't mind, I'm just going to stand
- 10 because I don't have any extra copies, but this
- 11 is Roberts 051 it's from Dr. John Roberts'
- 12 chart. Can I walk over?
- 13 A: Sure.
- 14 MR. SCOTT: And this is dated, Cravens, 1/6/09. Oh,
- 15 you've got it. 37. Okay.
- 16 MR. EARLY: Cravens, it's in your stack.
- 17 MR. RAVENEL: Is it?
- 18 MR. EARLY: Exhibit 37.
- 19 Q: I've highlighted, ma'am, I don't mind if you
- 20 just look at the highlighted portion. That's
- 21 what I'm interested in. And just let me know
- 22 when you're finished.
- 23 A: Yeah, that's pretty much still what's going on
- 24 now.
- 25 Q: My question to you is, Dr. Roberts notes that

CLAIRE
JANSSON

1-6-09

"Nothin... I cancelled out almost all my work outs last month... but I started up this month and I started back on my metabolic diet."

Upset & what she considers to be the effect ECT has had on her.

- feels she has no self-confidence
- feels she has no motivation

∴ processed her feelings and explored options

Mood stable & euthymic.

sleep, appetite & energy ok

starting diet again

working out 3/week

not ambivalent, hopeful & suicidal

Having trouble seeing a positive future tends to dwell on the negative & it inhibits her

∴ processed her feelings about the situation & explored options

Maintains mood

FLU of water



00253

LIFE CARE PLANNING ASSOCIATES, LLC

150 Oakland Avenue, Suite 215 ~ PO Box 2528, Rock Hill, South Carolina, 29732
(803) 829-4114 fax (803) 329-4771

Life Care Plan

Date: January 30, 2007

To: Shannon Jones
Attorney at Law

From: Wendy J. Garland, OTR/L, CLCP, MSCC
Certified Life Care Planner
Medicare Set Aside Consultant Certified

DOB: 08/25/1966

SS#: 247.33.0359

RE: Clair Johnson

LCPA File No: G1184

Reason for Referral

Ms. Clair Johnson is a 40 year old female referred to Life Care Planning Associates, LLC for development of a Life Care Plan. The purpose of this evaluation is to assess the degree to which Ms. Johnson's limitations impede activities of daily living (ADLs). The Life Care Plan will include recommendations for related goods and services required to life expectancy.

Demographic Data

Address: 1835 Omni Boulevard, Mount Pleasant, South Carolina 29466

County: Charleston

Phone: 803.781.8078 (parents)

Marital Status: Separated

Birthplace: Knox County, Tennessee

Citizen: United States

Glasses: No

Height: 5 feet 4 inches

Weight: 150 lbs.



Re: Clair Johnson G1184

Records Reviewed

In completing this Life Care Plan, my opinion is based on the listed records and is subject to modification if other evidence presents itself.

Defendant's Answers to
Plaintiff's First Interrogatories

07/06/2006

Medical University of South Carolina
Institute of Psychiatry
Letter

08/09/2006

Milton J. Foust, Jr., MD

Admission
Discharge Summary
Physician's Order Sheet
Admission Database
Nurses' Notes
Progress Notes
Electroconvulsive Therapy Notes
Anesthesia Records

11/26 - 12/23/2003

Stephen McLeod-Bryant, MD

Admission
Discharge Summary
Physician Orders
Medication Administration
Progress Notes

09/24 - 10/21/2003

Stephen McLeod-Bryant, MD

Piedmont Medical Center
Admission
Discharge Summary
Psychosocial Assessment
Physician Orders
Progress Notes
Nurses' Progress Notes
History & Physical

09/16 - 09/24/2003

Delfin F. Valita, MD

Palmetto Baptist Center
Admission
Discharge Summary
Progress Notes
Radiology Reports

12/09 - 12/23/2003

Timothy D. Malone, MD

Brooks Beekerd Pharmacy
Pharmacy Records

01/27/2003 - 04/17/2006

Medical Bills

Re: Clair Johnson G1184

Brief Chronology of Events

Ms. Clair Johnson is a 40 year old Caucasian woman with a history of Bipolar Affective Disorder. Per record review, she has been hospitalized numerous times for severe escalation of symptoms including paranoia, grandiose thoughts with flight of ideas, pressured speech, irritability, delusional ideas, manic behavior, and psychosis with threat of harm to self or others. As well, she has a long history of medication noncompliance.

Most recently, she has been receiving outpatient electroconvulsive therapy (ECT) on a routine basis for maintenance. Per Dr. Foust's assessment, among the greatest difficulties with Ms. Johnson's care has been the frequency and severity of her relapses, her noncompliance with medication, and her failure to maintain stability despite frequent ECT treatments. Because of the unstable nature of Ms. Johnson's illness with frequent relapses, the possibility of rehospitalization is present. He further described her prognosis for full recovery as poor.

Diagnoses

- Bipolar affective disorder, manic with episodes of psychosis
- Hypothyroidism

Present Treatment Program

TREATING PHYSICIANS/THERAPISTS

<u>Provider</u>	<u>Specialty</u>	<u>Frequency</u>
John M. Roberts, MD	Psychiatry	1-2 times a week
Milton J. Foust, MD	Psychiatry/ECT	Varies; 4-6 times per month

MEDICATION

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Purpose</u>	<u>Prescribing MD</u>
Synthroid	.1 mg	1 per day	Thyroid product	Roberts, MD
Geodon	40 mg	2 per day	Antipsychotic	Roberts, MD
Ambien	10 mg	1-2 per day	Sedative hypnotic	Roberts, MD

Medical History

- Vascular headaches/migraines
- Functional heart murmur
- Eczema
- Urinary tract infections
- Alcohol and marijuana abuse in remote past

Surgical History

Surgical history is unremarkable.

Re: Clair Johnson G1184

Assessment Summary

Wendy Jensen Garland OTR/L, CLCP, MSOC of Life Care Planning Associates, LLC interviewed Clair Johnson's parents, Hope and Sandra Craver, at their home in Irmo, South Carolina on September 7, 2006. Both Mr. and Mrs. Craver were open and cooperative recalling information concerning Ms. Johnson's history and resultant functional status. The Craver's are Ms. Johnson's Guardian Ad-Litem and provide financial management, as well as transportation, and periodic care for Ms. Johnson.

IDENTIFYING INFORMATION

Clair Johnson is a 40 year old Caucasian female. She is approximately five feet four inches tall and currently weighs 150 pounds. The Craver's adopted Clair when she was approximately six weeks old; she was born in Knox County, Tennessee. Her parents are Sandra and Hope Craver. She has one sister, Elizabeth Woodward, and one brother, Hope Craver, Jr., both of the Columbia, South Carolina area.

PRESENT COMPLAINTS

Clair Johnson lives alone in her home in Mt. Pleasant, South Carolina. Per her parents report, a typical day begins at 6:00 a.m., when she arises and lets her dogs out. She may drink one or two Coca Colas, unconcerned of the hour telephone someone, smoke, and go back to bed for three to four hours. She usually gets up at midday, may go to the grocery store, drinks more Coca Cola, smokes cigarettes, watches television, listens to music, and looks out the window. Generally, she will telephone someone in the afternoon and talk on the telephone for one to two hours.

Per Mrs. Craver's report, it is difficult to maintain a telephone conversation with Clair, because her thoughts are disorganized and she skips from topic to topic. If a subject comes up that Clair does not want to discuss, she can be discourteous on the phone.

Ms. Johnson usually stays up late watching television or a movie. At night, she takes her medication, has to give her dogs heart medication, and then goes to bed around midnight. She never sleeps more than three or four hours at a time, and is up again. Her sleep has become more erratic lately, per Mrs. Craver's observations.

Ms. Johnson has maid service twice a month; otherwise, does not attend to household cleaning or laundry. She has been having increasing problems with her memory; she does not maintain her medication regime, complaining of being unable to find her medication. She frequently calls her parents, unable to find her cell phone, certain clothes, jewelry, etc., believing that someone has stolen her things. Her parents will go to her house, look through her things, and find these items for her.

Her parents also transport her to her ECT treatments, as she is unable to drive following a treatment. Her parents oversee her finances and medical management. Clair will come to stay with them for one week to one month periods of time. When she is at the Craver's home, they take her to the recreational center to exercise, otherwise, she does not exercise independently.

The Craver's stated they were committed to taking care of Clair the rest of their lives, clearly acknowledging that caring for Clair did not mean that she would be able to live with them. Their primary concern is Clair's well being and safety, as she is unable to care for herself because of her mental illness.

FUNCTIONAL ACTIVITIES

The following assessment of functional activities is based on Mr. and Mrs. Craver's assessment of Ms. Johnson's functional abilities:

Feeling/Sensation	Denied difficulty

Re: Clair Johnson G1184

Reaching	Denied difficulty
Lifting	Denied difficulty
Grip	Denied difficulty
Sitting	Denied difficulty
Walking	Denied difficulty
Bending/Twisting	Denied difficulty
Kneeling	Denied difficulty
Stooping/Squatting	Denied difficulty
Push/Pull	Denied difficulty
Climbing	Denied difficulty
Balance	Denied difficulty
Endurance	Physically deconditioned; has gained 90 lbs. in the past few months

ACTIVITIES OF DAILY LIVING

Dressing	Denied difficulty
Feeding	Denied difficulty
Grooming	Neglects grooming
Bathing	Denied difficulty
Toileting	Denied difficulty
Transfers	Denied difficulty
Mobility	Denied difficulty
Driving	Afraid to drive due to increased problems with memory; afraid of getting lost around Charleston; does not drive at night because of this; does drive self to psychiatrist appointments and to grocery store; parents drive to and from ECT treatments
Housework	Neglects; has maid twice a month for house cleaning
Meal Preparation	Eats frozen dinners, orders out for home delivery
Laundry	Neglects; has maid service twice a month for laundry
Yard Work	Neglects; parents manage having yard work done

Re: Clair Johnson G1184

BODY SYSTEMS

Breathing	Denied difficulty
Headaches	History of migraine headaches since childhood; does not have headaches currently
Vision	Denied difficulty
Hearing	Denied difficulty
Speech	Denied difficulty
Bowel	Reported constipation related to diet; takes laxative several times a week
Bladder	Denied difficulty

PERSONAL HABITS

Smoking	Currently smokes one pack per day
Alcohol	Denied use
Drugs	Reportedly self medicates with Tylenol, Advil, and Relpax for migraines

ENVIRONMENTAL INFLUENCE

Air Conditioning	Denied difficulty
Heat	Denied difficulty
Cold	Denied difficulty
Wet/Humid	Denied difficulty
Noise	Denied difficulty
Stress	Multiple daily stressors related to mood instability and delusional thoughts

SOCIOECONOMIC STATUS

Ms. Johnson qualified for Social Security Disability Income (SSDI) in February 2005, with regular checks beginning in February 2006. She also receives money from her husband for living expenses. Her parents manage her finances and pay her bills from her monthly income.

BEHAVIORAL OBSERVATIONS

Ms. Johnson was not present for the interview; therefore, no behavioral observations were made by the interviewer.

SOCIAL ACTIVITIES

Per the Craver's observation, Ms. Johnson is presently depressed and has become a recluse. She does not leave her house unless she has to go to the doctor and rarely goes to the grocery store. She will not let

Re: Clair Johnson G1184

anyone see her, as she is ashamed of her weight. Historically, Clair's depression has lasted for six to eight month periods.

OTHER AGENCY INVOLVEMENT

There is no agency involvement in Ms. Johnson's medical management.

EDUCATION AND TRAINING

Ms. Johnson completed a Bachelor of Arts Degree in Public Affairs from Columbia College in 1993. She worked for approximately two years as a pharmaceutical representative. She last worked in 1997.

MILITARY EXPERIENCE

Ms. Johnson has no military experience.

Re: Clair Johnson G1184

LIFE CARE PLAN - GENERAL COMMENTS

A Life Care Plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized concise plan for current and future needs with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs.

According to the South Carolina 2004 Code of Laws 19-1-150 Life Expectancy Tables, Clair Johnson's life expectancy at age 40 years 1-month is 42.00 years. Because of other possible health related conditions that may reduce her life expectancy, an expert in this field should be consulted to determine her adjusted life expectancy.

LIFE CARE PLAN - NARRATIVE SUMMARY OF TABLES

This section is a narrative description of the recommended incident-related goods and services, as they appear in the Life Care Plan Tables.

LIFE CARE PLAN - TABLES

Following the Narrative Summary are the Life Care Plan Tables. Each table outlines all of the recommendations, along with the current cost associated with each item. The figures exhibited in the Life Care Plan Tables are presented as current day costs. They do not reflect inflation rates or future price increases. An economist should be consulted to compute the present day value of the future medical and care costs set forth in this assessment. Allowances have not been made for future technological advancements in equipment, supplies, medications, treatment etc.

POTENTIAL COMPLICATIONS (For informational purposes only)

The final section of the Life Care Plan is the list of potential complications associated with Clair Johnson's diagnoses. This section of the Life Care Plan is for educational purposes only; there is no projection of frequency of occurrence available. In developing this Life Care Plan, I have made every effort to include goods and services to reduce the likelihood of development of complications. However, there are no guarantees that Clair Johnson's life will remain free of difficulties even if all of the recommendations in the Life Care Plan are instituted. Treatment costs are not factored into the overall figures of the Life Care Plan but the potential complications indicated in this section should, at least, be a consideration when looking into the future.

CONCLUSION

Careful consideration has been given to all of the physical, medical, and psychosocial data contained within this report.

Ms. Johnson has many needs that require management and coordination of services. Her parents have been handling all of this, maintaining proactive involvement in her medical and psychological well-being. Undenably, Ms. Johnson's instability requires inclusive comprehensive care as well as supervision for safety, organization and executive functions. Her quality of life is dependent upon the scope and quality of services she receives.

It should be noted that at no time in this Life Care Plan do we rely solely upon family members to provide supportive intervention. Should the family chose to provide services, these services have a value, and the best way to determine this value is to indicate what those services would cost on the open labor market. These are identified in the Life Care Plan.¹

This Life Care Plan is a dynamic document representing Clair Johnson's current and future needs and associated costs specific to her defined disabilities. It is my opinion to within a reasonable degree of professional certainty that the attached Life Care Plan Charts outline appropriate service needs and

Re: Clair Johnson G71184

current costs. The costs and reduction to present day value are not calculated and would require analysis by a qualified economist.

Respectfully submitted,

Wendy Jensen Garland, OTR/L, CLCP, MSCC
Certified Life Care Planner
Medicare Set-Aside Consultant Certified

¹ Winkler, TM. Spinal cord injury and life care planning. In: Deutsch, FM, Sawyer, HW, eds, *A Guide to Rehabilitation*. White Plains, NY: AHAB Press, Inc., 2004: §16.01 - §16A200.

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

COURT OF COMMON PLEAS
C/A #: 2012-CP-10-2867

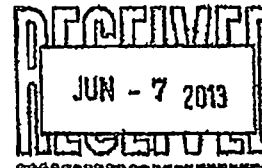
Clair Craver Johnson,

Plaintiff,

v.

John Roberts, M.D.,

Defendant.



STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

COURT OF COMMON PLEAS
C/A #: 11-CP-10-8318

Clair Craver Johnson,

Plaintiff,

v.

Medical University of
South Carolina,

Defendant.

This is the Examination Before Trial of

PETER R. BREGGIN, M.D.

held on the 21st day of May, 2013,

held at Cornell University, 140 Garden

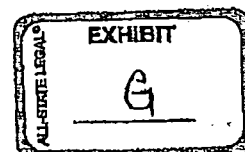
Avenue, Kingshaw Hall, Ithaca, New York.

REPORTED BY: CHRISTINE FERGUSON

Shorthand Reporter

Notary Public

MAGNA
LEGAL SERVICES



Page 210 1 took her off stimulants and antidepressants which 2 was a good practice, correct? 3 A Yes. 4 Q And going back to the exhibit the last 5 two pages, you called it a negligence list, I 6 think there are 17; would you look at that for 7 me? 8 A Yep. 9 Q And I have actually, the list I have 10 doesn't include a number 14. Does yours have a 11 14? 12 A No, it doesn't have a 14. 13 Q So there are actually 16? 14 A Yeah. 15 Q And are there any opinions that you have 16 as we sit here today, and I just explored what I 17 think you might have. Are there any opinions 18 about MUSC, as we sit here today, against MUSC in 19 the Clark Johnson case? 20 A I would like to say, first I'm going to 21 read the list over, but I'm including in my 22 negligence everything we have said today and the 23 chronology. So, not just this list, we have done 24 a lot more since this list.	Page 212 1 what we talked about today and this list, is that 2 inclusive of all of your opinions as we sit here 3 today against MUSC in this case? 4 A If we include my testimony today, 5 generally. 6 Q The chronology itself, do you have 7 anything in your chronology that is an indictment 8 towards anybody at MUSC that is not included 9 what's on your negligence list that has those 16 10 or 17 bullet points? 11 A I can't be certain about that. I can 12 take a look at it and think about it. But I'm 13 not certain. 14 Q Let's venture through your list the first 15 point on your list is "using ECT to treat or 16 cover up flawed psychiatric treatment including 17 medical malpractice by Dr. Roberts." Did I read 18 that right? 19 A Yes. 20 Q We talked extensively what you believed 21 to be that medical malpractice, and I believe 22 you're talking about here the prescription of 23 Wellbutrin to a patient who had mania in the 24 past?
Page 211 1 Q I understand. 2 A I wanted to correct that. Let me read it 3 over, okay? 4 Q Sure. I know we have talked about some 5 things already on the list. 6 A Uh-huh. I'd like to refine number two 7 where I talked about -- 8 Q I'm going to through them all. 9 A Oh, God, all right. I would add not 10 informing the husband, who shouldn't have been 11 involved, and the parents about the true 12 risk/benefit issues with ECT. 13 Q What number are you looking at when you 14 talk about that? 15 A Right, I say not adequately informing the 16 patient. She was involuntary, so it's really 17 about not adequately warning the father who 18 shouldn't haven't been involved -- I mean the 19 husband that shouldn't have been involved. And 20 in my opinion, the parents shouldn't have been 21 involved. But they didn't give them informed 22 consent. Okay. 23 Q Do you have any further, other than you 24 said some might be in your chronology, other than	Page 213 1 A And mania at the time. 2 Q And if, in your opinion, if Wellbutrin 3 had not been prescribed to Ms. Johnson, do you 4 believe that she would have had a need for 5 hospitalization at MUSC in 2003 and 2005? 6 A You know, it's very hard to approach it 7 in that direction, but I would say more probably 8 not, that she would not, but she certainly would 9 not have ended up losing her life to ECT. 10 Q Just so I understand that, if the 11 prescription of the Wellbutrin had not been made, 12 in your opinion, she would not have had the need 13 for or the perceived need for ECT treatment; is 14 that right? 15 A Yes. 16 Q Is a hospital under some type of duty to 17 assume or speculate that a treating physician 18 outside its walls is committing medical 19 malpractice as you say Dr. Roberts was? 20 A Not to determine if he was giving 21 malpractice but whether his medical treatment was 22 causing the problem and that that should be 23 addressed rather than giving shock treatment. 24 Q In that first hospitalization, you agree

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.

Trial Court Case No.: 2011-CP-10-8318
2012-CP-10-2867

Appellate Case No.: 2015-001463

Clair Craver Johnson.....Appellant,

v.

John Roberts, M.D.....Respondent.

AND

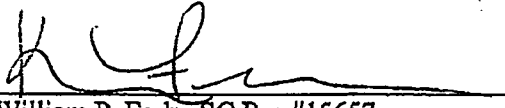
Clair Craver Johnson.....Appellant,

v.

The Medical University of South Carolina.....Respondent.

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR the undersigned hereby certifies that the Supplemental Record on Appeal contains all material proposed to be included by any of the parties and does not contain any other material.


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4/19, 2016
Charleston, South Carolina

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

FINAL BRIEF OF APPELLANT

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<u>Langley v. Pierce</u> , 313 S.C. 401, 438 S.E.2d 242 (1993)	8
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STATEMENT OF ISSUES ON APPEAL

- I. THE LOWER COURT ERRED BY CONCLUDING THAT THE TRIGGER DATE FOR COMPUTING THE RUNNING OF THE SIX YEAR STATUTE OF REPOSE AND THREE YEAR STATUTE OF LIMITATIONS WAS DECEMBER 10, 2003, THE DATE OF THE FIRST OF EIGHTY-SIX ELECTROCONVULSIVE THERAPY TREATMENTS ENDING ON JUNE 26, 2008, THE DATE OF THE EIGHTY-SIXTH SUCH TREATMENT, THE ERROR BEING THAT ELECTROCONVULSIVE THERAPY TREATMENT DID NOT CAUSE IDENTIFIABLE INJURY TO APPELLANT UNTIL NO EARLIER THAN 2009-2010 THEREBY TRIGGERING A THREE YEAR PERIOD IN WHICH TO INITIATE A CLAIM PURSUANT TO S.C. CODE ANN. § 15-545(A).

STATEMENT OF THE CASE

These two (2) medical malpractice actions, consolidated by consent for discovery and trial, arise from medical treatment and advice provided to Appellant, Clair Craver Johnson, by staff of the Respondent Medical University of South Carolina (MUSC) and by the Appellant's personal psychiatrist, Respondent John Roberts, M.D. (Roberts), who participated in Appellant's care, including approval of the use of electroconvulsive therapy applied by Respondent MUSC to the brain of Appellant.

MUSC, with the knowledge and consent of Roberts, initiated a series of what became eighty-six (86) separate applications of electrical current into the brain of Appellant beginning on December 3, 2003 and ending on June 26, 2008 and at some point in that period permanent damage resulted. See Depositions and Affidavit of Harold B. Bursztjan, M.D. (R. p. 322-325; p. 332)

Appellant contends that she did not discover nor was it reasonable to expect discovery of her claims against Respondents until she recovered some control of her mental faculties in 2010, giving her until 2013 (three years after connection of her loss

with Electroconvulsive therapy and within six years of the date of the cumulative impact of Respondents' acts constituting medical malpractice) to initiate an action or actions against Respondents. (R. p. 29-30; p. 33-44)

Appellant contends the filing and service of the Summons and Complaints in these actions in 2011/2012 were therefore timely.

Respondents contend and the Court held that service by Appellant of Summons and Complaints in 2011 and 2012 were untimely since the initiation of electroconvulsive therapy in 2003 constituted the act of malpractice triggering the six (6) year statute of repose for Appellant to initiate actions against Respondents. Appellant contends that the evidence of the date triggering the statute of repose is not a question of law for the Court but is one of fact.

STATEMENT OF FACTS

Respondent Medical University of South Carolina (MUSC) holds itself out to the public as a hospital capable of safely administering electroconvulsive therapy to patients like Appellant.

Respondent John Roberts, M.D. (Roberts) holds himself out to the public as a medical doctor with a specialty in psychiatry.

Respondents MUSC and Roberts treated Appellant for mental disorders. Roberts prescribed a drug known as Wellbutrin for Appellant and jointly with MUSC agreed upon an undetermined series of electroconvulsive treatments for Appellant in addition to Wellbutrin. (R. p. 111-112)

Wellbutrin dosage continued and simultaneously Respondents subjected Appellant to electroconvulsive therapy (electrical current introduced into Appellant's

brain) beginning on December 3, 2003 with five (5) separate treatments, seven (7) separate treatments in April 2005, four (4) treatments in December of 2005, four (4) treatments in January of 2006, four (4) treatments in February of 2006, six (6) treatments in March of 2006, four (4) treatments in April of 2006, four (4) treatments in May of 2006, two (2) treatments in June of 2006, one (1) occasion in July 2006, two (2) occasions in September 2006, three (3) occasions in October 2006, five (5) occasions in November 2006, four (4) occasions in December 2006, three (3) occasions in January 2007, two (2) occasions in February 2007, three (3) occasions in March 2007, one (1) occasion in April 2007, one (1) occasion in May 2007, one (1) occasion in June 2007, one (1) occasion in July 2007, one (1) occasion in August 2007, one (1) occasion in October 2007, one (1) occasion in January 2008, one (1) occasion in March 2008, one (1) occasion in June 2008, totaling eighty-six (86) electroconvulsive therapy treatments. See Depositions and Affidavit of Harold B. Bursztajn, M.D. (R. p. 278-285)

Appellant was examined by Harold B. Bursztajn, M.D. following these eighty-six (86) treatments of electrical current into her brain and was found to be so mentally impaired as a result of the cumulative effect of the referenced use of electrical current between December of 2003 and June of 2008, that she was unable to understand her loss and its relationship to the eighty-six (86) applications of electroconvulsive therapy. (R. p. 27-30)

Appellant's position is that S.C. Code Ann. § 15-3-545(A) gave Appellant a cause of action arising from the application of electroconvulsive therapy that resulted in brain damage to Appellant not for electroconvulsive therapy treatment that did not result in symptoms. Appellant had three years from her final treatment of electroconvulsive

therapy, June 26, 2008, in which to initiate a timely action since the symptoms complained of did not arise until 2009 following the final electroconvulsive therapy treatment in June of 2008. (R. p. 209)

Appellant filed a timely motion for reconsideration of the joint order granting summary judgment filed in these consolidated cases on February 25, 2014. (R. p. 221) Separate orders denying Appellant's motion for reconsideration were signed in each of these consolidated actions on May 26, 2015 and filed on May 29, 2015. (R. p. 319-321)

ARGUMENT

This medical malpractice action arises from medical care for "bipolar disorder with psychosis" provided to Appellant, Clair Craver Johnson, by employees of the Respondent, Medical University of South Carolina (MUSC) and by Respondent, John Roberts, M.D. (Roberts). (R. p. 14-17)

Appellant was being treated by Respondent Roberts, a psychiatrist who referred Appellant to MUSC for the electroconvulsive therapy (ECT) that was administered by MUSC beginning December 10, 2003 and continuing until June 26, 2008. See Affidavit of Harold J. Burstzajn, M.D., attached to the Summons and Complaints in both referenced actions and the two Depositions of Harold J. Burstzajn, M.D. (R. p. 14-17)

Respondent, MUSC with Respondent Roberts concurrence, subjected Appellant to eighty-six (86) courses of ECT treatment between December 3, 2002 and June 26, 2008. ECT was applied to Appellant on five (5) occasions in December of 2003; on seven (7) occasions in April of 2005; on six (6) occasions in October of 2005; on four occasions in December of 2005; on four (4) occasions in January of 2006; on four (4) occasions in February of 2006; on six (6) occasions in March of 2006; on four (4) occasions in April

of 2006; on four (4) occasions in May of 2006; on two (2) occasions in June of 2006; on one (1) occasion in July 2006; on two (2) occasions in September of 2006; on three (3) occasions in October of 2006; on five (5) occasions in November of 2006; on four (4) occasions in December of 2006; on three (3) occasions in January 2007; on two (2) occasions in February of 2007; on three (3) occasions in March of 2007; on one (1) occasions in April of 2007; On one (1) occasion in May of 2007; on one (1) occasion in June of 2007; on one (1) occasion in July of 2007; on one (1) occasion in August of 2007; on one occasion in October of 2007; on one occasion in November of 2007; on one occasion in January of 2008; on one occasion in March of 2008; and on one occasion in June of 2008 for a total of eighty-six (86) electroconvulsive treatments. (R. p. 37-43)

As a direct result of the cumulative effect of this treatment Appellant suffered from mental confusion and memory repression. Appellant's mental confusion and the repression of Appellant's memory became symptomatic as early as 2009. See Bursztajn's Deposition July 26, 2013 at p. 1-10. Appellant "... relayed to physicians and others that she believed she was having problems with ECT as early as 2009. . . ." Deposition of Harold B. Bursztajn, M.D., July 26, 2013, p. 72, L. 1-10. (R. p. 33-43; p. 237-286)

Given testimony that Appellant first experienced problems with electroconvulsive therapy in 2009 a jury issue is present over the timeliness of these actions. The issue is not whether use of electroconvulsive therapy is negligent from the first treatment but at what point (number and timing and type of electroconvulsive therapy) does use of electroconvulsive therapy constitute negligence.

See also p. 54, L. 1-24, p. 55, L. 1. Deposition of Harold B. Bursztajn, M.D., October 29, 2013 over the danger of using bilateral electroconvulsive therapy. (R. p. 251) Following termination of electroconvulsive therapy until June 25, 2010, Appellant's mental condition improved to the point that she could appreciate the claims she had against MUSC and John Roberts, M.D. at which point she filed a Notice of Intent to File Suit naming Respondent MUSC as a defendant. (R. p. 111-114; p. 221-225)

Appellant subsequently filed a Notice of Intent to File Suit against Respondent John Roberts, M.D. on November 4, 2011, followed by filing and serving a complaint against John Roberts, M.D. on or about April 27, 2012. Appellant also filed suit against MUSC on November 8, 2011 and effected service on November 23, 2011. (R. p. 22-30; p. 76-78; p. 222-224)

Appellant contends that the cumulative effect of these electroconvulsive therapy treatments constituted an independent tort damaging Appellant's brain and ultimately resulting in loss of her ability to reason and recall past events which she began to recognize in 2009-2010 following the termination of the electroconvulsive therapy in June of 2008.

Appellant further contends that applying the Six Year Statute of Repose found in S.C. Code Ann. § 15-3-545(A) to the cumulative electroconvulsive therapy treatment creates, at a minimum, a fact issue over the timeliness of the medical malpractice claims for injury related to electroconvulsive therapy taking place within six years of the symptom producing electroconvulsive therapy and within three years of the discovery of these claims. These actions were commenced within three years of the date

electroconvulsive therapy produced symptoms that reasonably ought to have been discovered, i.e., 2009.

The complaint in Clair Craver Johnson vs. Medical University of South Carolina was served on MUSC on November 23, 2011. Appellant contends that applying the Six Year Statute of Repose to the date of service of Appellant's action makes these actions timely.

S.C. Code Ann. § 15-545(A) contains a three year limitation of action provision for medical malpractice requiring any such action to be "commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action from date of discovery or when it reasonably ought to have been discovered; not to exceed six years from date of occurrence" The occurrence is the question. Is the first electroconvulsive therapy treatment on December 3, 2003 "the occurrence" or is the occurrence the date the electroconvulsive therapy treatment resulted in recognizable symptoms? Appellant contends that even protection of the medical community cannot justify defining date of occurrence as the date of the initial electroconvulsive treatment. The "delects" central to this action are the large number of electroconvulsive therapy treatments not the mere use of electroconvulsive therapy. A fact issue over when electroconvulsive therapy could have been found to have caused permanent brain damage is present and requires action by a jury. Appellant is entitled to a reasonable time from the date the loss was discoverable to initiate suit. Initial discovery apparently took place in 2009. Less than three years later suit was commenced.

While it is a simple matter to determine the running of the six (6) year statute of repose when there is a single act of negligence involved, the presence of eighty-six (86)

acts over a period beginning on December 2, 2002 and running to and including June 26, 2008, each of which may not be characterized an act of negligence but collectively at some point can be so characterized is more difficult task and cannot be determined by the Court as a matter of law.

A fact issue as to when Clair Johnson allegedly sustained injuries are present in this action making O'Tuel as guardian v. Villani, 318 S.C. 24, 455 S.E.2d 698 (1995) inapposite to Clair Johnson's claim. There is evidence from which one could conclude that her damages occurred less than six (6) years from the date of the alleged negligence and within three (3) years of the malpractice alleged to have caused the injury.

Langley v. Pierce, 313 S.C. 401, 438 S.E.2d 242 (1993) involved claim of failure to diagnose cancer from lesions removed in 1979 and 1980. Langley filed suit in 1991 more than six years following the negligent act and was barred.

Ms. Johnson was treated for her condition by electroconvulsive therapy from 2003 to 2008 and the question is unresolved as to when and whether the use of electroconvulsive therapy caused her permanent mental issues.

Harrison v. Bevilacqua, 354 S.C. 129, 580 S.E.2d 109 (2008) involved application of the continuous treatment rule to toll the statute of limitations and whether South Carolina would adopt that rule. It refused to do so and Ms. Johnson has not sought the application of such a rule to her facts. Ms. Johnson contends that her claim arose less than three years after it became available to her and certainly fewer than the six year statute of repose. Again, this case is not factually similar to the case at bar.

Clair Johnson was treated with electroconvulsive therapy involving the application of electrical current to her brain to treat bi-polar disorders and no evidence

exists to demonstrate at what point the use of electroconvulsive therapy caused the permanent loss of memory about which Ms. Johnson complains.

The earliest that memory impairment and confusion were the subject of complaints by Ms. Johnson was in 2009. Suit was initiated in 2011, two years after the first indication of brain damage.

These reported cases are not supportive of Respondents contention that Ms. Johnson is barred by the six year statute of repose. There is no evidence in this action that memory loss and mental confusion are the anticipated side effect of electroconvulsive therapy or when it would be expected to appear.

Did Ms. Johnson's mental issues arise in 2009 or 2010 as the result of electroconvulsive therapy delivered in 2008? If so, Ms. Johnson had until 2014 to initiate her action and remain within the statute of repose.

CONCLUSION

In summary, fact issues abound in this action that must be presented to a jury and which cannot be decided by the Court as a matter of law in a summary judgment motion.



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March 28, 2016

**THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS**

Appeal from Charleston County
Court of Common Pleas

R. Markley Dennis, Jr., Circuit Court Judge

Appellate Case No. 2015-001463
Circuit Court Case Nos. 2012-CP-10-2867 and 2011-CP-10-8313

Clair Craver Johnson,

Appellant,

v.

John Roberts, M.D.,

Respondent.

And

Clair Craver Johnson,

Appellant,

v.

Medical University of South Carolina,

Respondent.

**FINAL BRIEF OF RESPONDENT
JOHN ROBERTS, M.D.**

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INTRODUCTION

In this appeal Ms. Johnson¹ challenges the circuit court's twin summary judgments in favor of Dr. Roberts and MUSC,² i.e., Ms. Johnson challenges the circuit court's grant of summary judgment to the respective defendant in both of her consolidated actions for medical malpractice.

Ms. Johnson's challenge should fail, not only because the circuit court correctly concluded that her claims are barred by the six-year statute of repose for medical malpractice actions in S.C. Code Ann. § 15-3-545(A), but also, as threshold matter, because it is clear that Ms. Johnson cannot carry the burden that she, as the appellant, must shoulder to upset the presumptive validity of the judgments she appeals; indeed, it is neither appropriate nor necessary for this Court to even reach the merits of Ms. Johnson's appeal, because her only appellate argument is not preserved for review, and, in any event, it is rendered moot by the two-issue rule.

¹ Plaintiff/Appellant Clair Craver Johnson is referred to as "Ms. Johnson."

² Defendants/Respondents John Roberts, M.D., and the Medical University of South Carolina are referred to as "Dr. Roberts" and "MUSC," respectively; collectively, they are referred to as the "Respondents."

COUNTER-STATEMENT OF ISSUES ON APPEAL

- I. As a threshold matter, is it appropriate or necessary for the Court to reach the merits of Ms. Johnson's appeal?
 - A. Is Ms. Johnson's appellate argument preserved for review?
 - B. Is Ms. Johnson's appellate argument rendered moot by the two-issue rule?
- II. Assuming, *arguendo*, the merits are properly considered, did the circuit court correctly conclude that Ms. Johnson's claims are time-barred under § 15-3-545(A)?

COUNTER-STATEMENT OF THE CASE

Both of the medical malpractice lawsuits involved in this appeal were commenced by Ms. Johnson in Charleston County, in the Court of Common Pleas, one on November 8, 2011, against MUSC, the other on May 1, 2012,³ ⁴ against Dr. Roberts, a psychiatrist in private practice. With the consent of all parties the cases were consolidated in the circuit court.

In both cases Ms. Johnson has alleged professional negligence relating to electroconvulsive therapy ("ECT") she received at MUSC on a number of occasions while under Dr. Roberts's care for certain mental disorders. The

³ Previously, on November 8, 2011, Ms. Johnson had filed notice of her intent to sue Dr. Roberts. The matter was not resolved through pre-suit mediation.

⁴ Ms. Johnson's operative complaint against Dr. Roberts is her amended complaint filed May 16, 2012.

alleged negligence dates back to at least 2003,⁵ when the course of treatment via ECT was commenced—after this course began in 2003, Ms. Johnson continued with ECT periodically until 2008. According to Ms. Johnson, the ECT was involuntary and improper and caused her damages, including loss of memory and exacerbated mental impairment. (R. pp. 10-17 [Dr. Roberts]; R. pp. 22-44 [MUSC].)

The Respondents moved for summary judgment, contending that Ms. Johnson's claims were time-barred under § 15-3-545(A), and their motions were heard in the circuit court on January 9, 2014, the Honorable R. Markley Dennis, Jr., presiding. (R. pp. 52-53; R. pp. 54-72; R. pp. 73-74; R. pp. 75-110; R. pp. 111-190; R. pp. 191-208.) The circuit court granted the Respondents' motions and thereafter denied Ms. Johnson's motion for reconsideration. (R. pp. 209-220; R. p. 310 [Dr. Roberts]; R. p. 311 [MUSC].)

This appeal follows.

⁵ Although not expressly pleaded, Dr. Roberts has been accused, via expert testimony on behalf of Ms. Johnson, of negligence dating back to February of 2002 relating to his prescription of certain medication to Ms. Johnson. (R. pp. 63-64.)

ARGUMENT

- I. As a threshold matter, it is neither appropriate nor necessary for the Court to reach the merits of Ms. Johnson's appeal to affirm the summary judgments in favor of the Respondents.

To prevail on appeal Ms. Johnson has the affirmative obligation to present argument/analysis that is both preserved for review and sufficient to show reversible error as to every independent ground supporting the circuit court's summary judgments.⁶ It is clear that Ms. Johnson has not met this

⁶ See Jones v. Lott, 387 S.C. 339, 346, 692 S.E.2d 900, 903 (2010) ("Under the two issue rule, where a decision is based on more than one ground, the appellate court will affirm unless the appellant appeals all grounds because the unappealed ground will become the law of the case."); Elam v. S.C. Dep't of Transp., 361 S.C. 9, 25, 602 S.E.2d 772, 780 (2004) (explaining that South Carolina's preservation requirements are "mandatory"); Jinks v. Richland County, 355 S.C. 341, 344, 585 S.E.2d 281, 283, n. 3 (2003) (an issue which is not argued in the brief is deemed abandoned and precludes consideration on appeal); I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 420-22, 526 S.E.2d 716, 723-24 (2000) (explaining, "as expressed in Rule 220(c), SCACR, . . . an appellate court may affirm the lower court's judgment for any reason appearing in the record on appeal[,] . . . [but] [a]n appellate court may not, of course, reverse for any reason appearing in the record.") (emphasis in original); Anderson v. S.C. Dep't of Highways & Pub. Transp., 322 S.C. 417, 420, 472 S.E.2d 253, 255 n. 1 (1996) (noting that the two-issue rule is applicable to circuit court orders); Watson v. Underwood, 407 S.C. 443, 452, 756 S.E.2d 155, 160, n. 9 (Ct. App. 2014) ("'[A]ppellants have the responsibility to identify errors on appeal, not the [c]ourt.' '[A]ppellate courts in this state, like well-behaved children, do not speak unless spoken to and do not answer questions they are not asked.'") (citations omitted); McCall v. IKON, 380 S.C. 649, 659-60, 670 S.E.2d 695, 701 (Ct. App. 2008) (noting an appealed order comes to the appellate court with a presumption of correctness, with the burden on the appellant to demonstrate reversible error); First Union Nat'l Bank of S.C. v. Soden, 333 S.C. 554, 566, 511 S.E.2d 372, 378 (Ct. App. 1998) (holding an

obligation; therefore, it is neither appropriate nor necessary for the Court to reach the merits of Ms. Johnson's appeal to affirm the summary judgments in favor of the Respondents.

A. Ms. Johnson's appellate argument is not preserved for review.

"Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court." Elam, 361 S.C. at 23, 602 S.E.2d at 779-80. Also, to be preserved, an argument must be "sufficiently specific to inform the trial court of the point being urged" Wilder Corp. v. Wilke, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998).

In her issue statement Ms. Johnson frames the circuit court's alleged error as one of invasion of the province of the jury as to a question of fact and expressly identifies the error as "being that [ECT] treatment did not cause identifiable injury to appellant until no earlier than 2009-2010 thereby triggering a three[-]year period in which to initiate a claim pursuant to . . . § 15-[3]-545(A)." (App's Br. at p. 1 (capitalization and emphasis omitted).) In the body of her brief Ms. Johnson goes on to say, "the evidence of the date triggering the statute of repose is not a question of law for the Court but

"unchallenged ruling, right or wrong, is the law of the case and requires affirmance"); Cont'l Ins. Co. v. Shives, 328 S.C. 470, 474, 492 S.E.2d 808, 811, n. 2 (Ct. App. 1997) (an issue not raised in the appellant's principal brief may not be raised via a reply brief).

is one of fact”⁷ and that “[her] position is that . . . § 15-3-545(A) gave [her] a cause of action arising from the application of [ECT] that resulted in brain damage to [her] not for [ECT] treatment that did not result in symptoms”⁸ and that, with respect to the timeliness of her suits, “[t]he issue [for a jury] is not whether use of [ECT] therapy is negligent from the first treatment but at what point (number and timing and type of [ECT]) does use of [ECT] constitute negligence.” (App’s Br. at p. 5.)

Ms. Johnson simply did not make this argument to the circuit court in opposition to the Respondents’ motions for summary judgment—and, of course, it was not ruled on by the circuit court. Indeed, this argument is contradictory to the argument she did make to the circuit court in opposition to the motions.⁹ Ms. Johnson’s appellate argument—her only appellate argument—is not preserved for review, and her appeal necessarily fails. Elam, 361 S.C. at 23, 602 S.E.2d at 779-80; I’On, L.L.C., 338 S.C. at 420-

⁷ (App’s Br. at p. 2.)

⁸ (App’s Br. at p. 3.)

⁹ At the summary-judgment hearing Ms. Johnson’s counsel argued as follows:

[T]his lady received electro-convulsive shock therapy eighty-six times over a several years period of time -- 2003 to 2008. Each time she received that, it was a blow to her head, a tort. Each one . . . standing alone.

(R. p. 196, lines 11-17.)

22, 526 S.E.2d at 723-24; Wilder Corp., 330 S.C. at 76, 497 S.E.2d at 733; *see also* Taylor v. Medenica, 324 S.C. 200, 479 S.E.2d 35 (1996) (party may not argue one ground for objection at trial and another ground on appeal); *cf.* I'On, L.L.C., 338 S.C. at 420-22, 526 S.E.2d at 723-24; Watson, 407 S.C. at 452, 756 S.E.2d at 160, n. 9; McCall, 380 S.C. at 659-60, 670 S.E.2d at 701.

B. Ms. Johnson's appellate argument is rendered moot by the two-issue rule.

As a matter of law the circuit court ruled that “the six-year statute of repose [under § 15-3-545(A)] begins to run upon an ‘occurrence’ of medical negligence[.]”¹⁰ that “the initiation of ECT in 2003 is the occurrence from which the statute of repose is set to run[.]”¹¹ and that there was no tolling mechanism available to Ms. Johnson. (R. pp. 215-217.) Aside from the fact that Ms. Johnson's appellate argument is unpreserved, because it is exclusively focused on the supposed existence of a question of fact for a jury, it does not sufficiently challenge the circuit court's legal analysis, which is, thus, the law of the case and requires affirmance under the two-issue rule. Jones, 387 S.C. at 346, 692 S.E.2d at 903; Jinks, 355 S.C. at 344, 585 S.E.2d at 283, n. 3; Anderson, 322 S.C. at 420, 472 S.E.2d at 255 n. 1; Soden, 333 S.C. at 566, 511 S.E.2d at 378; Shives, 328 S.C. at 474, 492

¹⁰ (R. p. 213.)

¹¹ (R. p. 215.)

S.E.2d at 811, n. 2; *cf. I'On, L.L.C.*, 338 S.C. at 420-22, 526 S.E.2d at 723-24; *Watson*, 407 S.C. at 452, 756 S.E.2d at 160, n. 9; *McCall*, 380 S.C. at 659-60, 670 S.E.2d at 701.

II. Assuming, *arguendo*, the merits are properly considered, the circuit court correctly concluded that Ms. Johnson's claims are time-barred under § 15-3-545(A).

While Ms. Johnson may *now*¹² argue, “[t]he issue is not whether use of [ECT] is negligent from the first treatment but at what point . . . does use of [ECT] constitute negligence[,]”¹³ nonetheless, “[she] contends that the *cumulative effect* of these [ECT] treatments constituted an independent tort” (App’s Br. at p. 6 (emphasis added).) This idea of divorcing cumulative effect from causative origin is not only illogical but also contrary to § 15-3-545(A).¹⁴

¹² To be clear, as noted above, this is contrary—and improperly so, *see Taylor*, 324 S.C. 200, 479 S.E.2d 35—to the position Ms. Johnson has previously taken in this case. (See R. pp. 196, lines 11-17 (wherein Ms. Johnson’s counsel argued that each instance of ECT administered to her was “a tort . . . standing alone”); R. p. 113 (wherein Ms. Johnson describes the Respondents as “continuing to treat [her] in a negligent manner”); R. p. 11 (wherein Ms. Johnson alleges that Dr. Roberts breached duties of care owed to her “in connection with her 2003 to 2008 course of treatment”).)

¹³ (App’s Br. at p. 6.)

¹⁴ In pertinent part, § 15-3-545(A) provides as follows:

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

To begin, it seems that Ms. Johnson has conflated the date of accrual of a cause of action¹⁵ with the date of occurrence under § 15-3-545(A). As observed in Langley v. Pierce, however, in effecting the economic balance struck by the legislative body, “[s]tatutes of repose by their nature impose on some plaintiffs the hardship of having a claim extinguished before it is discovered, *or perhaps before it even exists.*”) 313 S.C. 401, 404, 438 S.E.2d 243, 244 (1993) (emphasis added) (citation omitted).

Moreover, in Harrison v. Bevilacqua, our Supreme Court “declin[ed] to adopt the continuous treatment rule or the doctrine of continuing tort.” 354 S.C. 129, 141, 580 S.E.2d 109, 115 (2003). Quoting its prior decision in Preer v. Mims, the Harrison Court first summarized the “continuous treatment rule” as follows:

“The so-called ‘continuous treatment’ rule as generally formulated is that if the treatment by the

licensed health care provider as defined in Article 5, Chapter 79, Title 38 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.

¹⁵ See Bergstrom v. Palmetto Health Alliance, 358 S.C. 388, 397, 596 S.E.2d 42, 46 (2004) (“A cause of action accrues at the moment when the plaintiff has a legal right to sue on it.”) (citation omitted).

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."

Id. at 135, 580 S.E.2d at 112 (quoting Preer, 323 S.C. 516, 519, 476 S.E.2d 472, 473 (1996)).

The Harrison Court went on to explain that—notwithstanding numerous policy considerations supporting adoption of the rule—"the continuous treatment rule should not be judicially adopted," because, "[p]ut simply, . . . judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set via the statutes discussed above¹⁶." Id. at 136-38, 580 S.E.2d at 112-13; *see also* Epstein v. Brown, 363 S.C. 372, 378, 610 S.E.2d 816, 819 (2005) ("Notwithstanding the very legitimate policy rationales in favor of adoption

¹⁶ Among "the statutes discussed above" was, of course, the medical malpractice statute of repose in § 15-3-545(A). Id. at 137-38, 580 S.E.2d at 113 (explaining, "The primary argument against adoption of the continuous treatment rule is that it offends the clear policy set by the Legislature in its adoption of statutes of limitations and statutes of repose[,]," then expressly citing the repose provision in § 15-3-545(A) and noting the "economic balance struck by the legislative body" in enacting such a statute of repose) (citations omitted).

of a continuous treatment rule, we declined to adopt it, finding the Legislature has set absolute time restrictions for the bringing of medical malpractice actions in the statutes of repose both for medical malpractice and for persons operating under disability”) (citing Harrison, 354 S.C. at 136-37, 580 S.E.2d at 113).

The Harrison Court then addressed—and rejected—Harrison’s additional argument that it should adopt the “continuing tort doctrine.” Id. at 139, 580 S.E.2d at 114 (“Citing Georgia law, petitioner also argues the Court should adopt the continuing tort doctrine. We disagree.”). It explained,

Under Georgia law, the doctrine of continuing tort:

applies “where any negligent or tortious act is of a continuing nature and produces injury in varying degrees over a period of time.” . . . Under this theory, the statute of limitation does not begin to run “until such time as the continued tortious act producing injury is eliminated.”

Id. (quoting Mears v. Gulfstream Aerospace Corp., 225 Ga. App. 636, 484 S.E.2d 659, 664 (Ct. App. 1997) (citations omitted)).

Having explained the continuing tort theory, the Harrison Court explained that in Georgia, “the ‘continuing tort’ theory is inapplicable to actions for medical malpractice ‘since it would nullify the intent of the

[Georgia] General Assembly that, after five years, no medical malpractice action could be brought . . . because the statute of repose abolishes any action five years after the negligent or wrongful act or omission.” Id. (quoting Charter Peachford Behavioral Health Sys. v. Kohout, 233 Ga. App. 452, 504 S.E.2d 514, 521 (Ct. App. 1998)). “Thus,” the Harrison Court concluded, “*for the same reason* we reject adoption of the *continuous treatment rule*, Georgia has rejected application of its own *continuous tort theory* to medical malpractice claims. Accordingly, we find [Harrison’s] argument on the *continuing tort doctrine* unavailing.” Id. (emphasis added).

Ms. Johnson’s claims, which arise out of a course of treatment initiated by 2003, but were not pursued via legal action until more than six years thereafter, are barred by the medical malpractice statute of repose in §15-3-545(A). Her argument to the contrary is incompatible with that statute (more specifically—and most importantly—the legislative intent reflected thereby¹⁷), while the circuit court’s analysis faithfully adheres to

¹⁷ Of course, “[i]t is well-established that ‘[t]he cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature.’” Grier v. AMISUB of S.C., Inc., 397 S.C. 532, 535, 725 S.E.2d 693, 696 (2012) (quoting Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)). And, with respect to statutes of repose, our Supreme Court has recognized that they are “typically an *absolute time limit* beyond which liability no longer exists and 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 244 (emphasis in original).

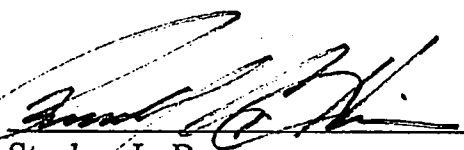
the overriding responsibility of ascertaining and effectuating the legislature's intent.

CONCLUSION

For the reasons set forth herein, as well as those set forth in MUSC's brief, which, except insofar as they may be inconsistent herewith, Dr. Roberts adopts by reference pursuant to Rule 208(b)(6), SCACR, Dr. Roberts asks the Court to affirm summary judgment in his favor.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.

Trial Court Case No. 2011-CP-10-8318
2012-CP-10-02867

Appellate Case No. 2015-001463

Clair Craver Johnson, Appellant,

John Roberts, M.D., Respondent, Respondent

AND

Clair Craver Johnson, Appellants,

Medical University of South Carolina, Respondent.

BRIEF OF RESPONDENT
THE MEDICAL UNIVERSITY OF SOUTH CAROLINA

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STATEMENT OF ISSUES ON APPEAL

- I. THE SOLE ARGUMENT BRIEFED BY APPELLANT WAS NOT RAISED TO AND RULED UPON BY THE LOWER COURT AND IS THEREFORE NOT PRESERVED FOR REVIEW.
- II. THE LOWER COURT CORRECTLY CONCLUDED APPELLANT'S MEDICAL MALPRACTICE CLAIMS AGAINST MUSC ARE TIME-BARRED BY THE ABSOLUTE SIX-YEAR STATUTE OF REPOSE ESTABLISHED BY THE GENERAL ASSEMBLY.

INTRODUCTION

This appeal involves issues of statutory construction concerning the application of the medical malpractice statute of repose and relevant tolling provisions. In South Carolina, the absolute six-year repose period for claims arising out of medical malpractice is deemed to run from the date of the treatment giving rise to the injury. S.C. Code § 15-3-545. The date of treatment in this case, i.e. the occurrence from which the statute of repose is set to run, is not disputed. In fact, this date of treatment controls regardless of whether Appellant has or should have discovered her injury. For this reason, South Carolina has consistently refused to adopt tolling mechanisms such as the continuous treatment rule, which would otherwise permit Appellant's claims under the rationale asserted in her brief and rejected by the circuit court below.

Notwithstanding, Appellant has overlooked this guiding legal framework in an attempt to circumvent the six-year statute of repose bar by arguing an issue of fact exists as to the date of the occurrence, i.e. initiation of treatment. Not only does this argument fail for lack of preservation, it ignores prevailing jurisprudence and asks this Court to apply the continuous treatment rule, a doctrine which has never been adopted in South Carolina. Regardless whether Appellant discovered or should have discovered her injury, Appellant's failure to file suit until nearly eight years after the treatment alleged to have given rise to Appellant's claim, and two years after the expiration of the statute of repose, constitutes an unequivocal bar to Appellant's claims. As a strict

outside limitation period enacted by the General Assembly, the medical malpractice statute of repose represents “an absolute time limit beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body.” Capco of Summerville, Inc. v. J.H. Gayle Constr. Co., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006).

Simply put, under these circumstances, the legislature intended § 15-3-545(A) to bar Appellant’s action. Permitting Appellant’s malpractice claims to proceed under the rationale argued by Appellant would violate the legislatively proscribed six-year repose provision. For these reasons, as detailed herein, this Court should affirm the February 4, 2014 Order of the circuit court finding Appellant’s claims barred for failure to file suit within the requisite repose period.

STATEMENT OF THE CASE

Appellant 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”) treatment administered sporadically from 2003 until 2008 for the treatment of severe depression and mania. (R. pp. 10-11). Appellant filed a separate action against her private psychiatrist, Dr. John Roberts, associated with his prescription of certain medication which caused Appellant’s need for ECT treatment, as well as the ECT treatment itself. Both cases have been consolidated. The events giving rise to this action are as follows.

Since the mid-1980s Appellant has been suffering from bi-polar disorder and depression. She was formally diagnosed with borderline bipolar disorder while attending Winthrop in the mid-1980s. Appellant’s 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, Appellant was relatively stable and led a normal life. In 1997, her mania spiked once again, requiring hospitalization. Dr. John Roberts began treating Appellant at this time. Over the next few years, Appellant required several

hospitalizations in Rock Hill, Columbia and Charleston, during which she was treated with several different psychiatric medications.

During one of these numerous hospitalizations, she 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 3, 2003, Appellant began ECT treatments. Appellant 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. Appellant's last ECT treatment was on June 26, 2008.

Notwithstanding evidence to the contrary, Appellant's expert claims that the Appellant did not "regain the mental capacity to understand and appreciate the harm she suffered as a consequence" of ECT until June of 2010. (R. p. 324). On June 25, 2010, prior to filing the Summons and Complaint in the instant action, Appellant filed a Notice of Intent to File Suit, wherein she sought an extension of time to file an expert affidavit as provided by S.C. Code Ann. §§ 15-79-125 and 15-36-100. The notice stated "time constraints" prevented Appellant from filing an affidavit of a medical expert. While § 15-36-100 provides a period of forty-five days within which to file the expert witness affidavit, no extension was provided by the Court. By Appellant's own admission, as stated in the Notice of Intent to File Suit, the limitations period was believed to expire within ten days from the date of the Notice of Intent to File Suit, dated June 25, 2010. Thus, according to Appellant, her claims would expire on July 5, 2010.

On August 25, 2010, Appellant dismissed the matter without prejudice. Appellant eventually obtained an expert witness affidavit on August 10, 2011, and the instant Complaint was

subsequently filed on November 16, 2011, nearly eight years after Appellant began receiving ECT treatments, and almost two years after the expiration of the six-year statute of repose.

By order dated February 4, 2014, the circuit court granted summary judgment in favor of Respondents MUSC and John Roberts M.D., finding Appellant's claims barred by the statute of repose. Appellant thereafter filed a Motion to Alter or Amend and for Reconsideration under Rule 59(e), SCRCP, which was denied on May 29, 2015. This appeal follows.

STANDARD OF REVIEW

On appeal from an order granting summary judgment, the appellate court applies the same standard that governs the trial court. David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 626 S.E.2d 1 (2006). A trial court may properly grant a motion for summary judgment when "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 judgment as a matter of law." Rule 56(c), SCRCP; Pittman v. Grand Strand Entm't, Inc., 363 S.C. 531, 611 S.E.2d 922 (2005). "Questions of statutory interpretation are questions of law, which we are free to decide without any deference to the court below." Columbia/CSA-HS Greater Columbia Healthcare Sys., LP v. S. Carolina Med. Malpractice Liab. Joint Underwriting Ass'n, 411 S.C. 557, 560, 769 S.E.2d 847, 848 (2015), reh'g denied (Apr. 9, 2015) (citing Grier v. AMISUB of S.C., Inc., 397 S.C. 532, 535, 725 S.E.2d 693, 695 (2012) (quoting CFRE, LLC v. Greenville Cnty. Assessor, 395 S.C. 67, 74, 716 S.E.2d 877, 881 (2011))).

ARGUMENT

- I. **THE SOLE ARGUMENT BRIEFED BY APPELLANT WAS NOT RAISED TO AND RULED UPON BY THE LOWER COURT AND IS THEREFORE NOT PRESERVED FOR REVIEW.**

To defeat the statute of repose bar, Appellant asserts for the first time on appeal that an issue of fact exists as to when and whether the use of ECT caused her permanent mental injuries. (Appellant's Brief at p. 8). This argument being raised now for the first time on appeal is not preserved for appellate review.

It is well-settled that an issue not raised and ruled upon cannot be raised for the first time on appeal. Elam v. S. Carolina Dep't of Transp., 361 S.C. 9, 23, 602 S.E.2d 772, 779-80 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."). Appellant's argument before the lower court centered solely on the tolling provisions of the disability statute. Specifically, relying on S.C. Code § 15-3-40, Appellant maintained the time period within which to file suit was tolled from 2003 until 2010 during which "her capacity to comprehend what was going on in her life" was diminished by her ECT and underlying mental illness. (R. pp. 112-113). Appellant further relied exclusively on this argument in her Reply to Defendant's Opposition to Plaintiff's Motion for Reconsideration.

Accordingly, because Appellant failed to raise the issue as to when and whether ECT caused Appellant's injuries, the argument is barred from this Court's consideration for lack of preservation. See Wilder Corp. v. Wilke, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998) ("It is axiomatic that an issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review.").

II. THE LOWER COURT CORRECTLY CONCLUDED APPELLANT'S MEDICAL MALPRACTICE CLAIMS AGAINST MUSC ARE TIME-BARRED BY THE ABSOLUTE SIX-YEAR STATUTE OF REPOSE ESTABLISHED BY THE GENERAL ASSEMBLY.

Even if preserved, Appellant's misguided assertion that an issue of fact exists as to when and whether the use of ECT caused her permanent mental injuries overlooks and misinterprets the prevailing jurisprudence and legislative intent underlying the enactment of the six-year repose

provision barring this matter. For the reasons that follow, this Court should affirm the Order of the lower court dismissing Appellant's claims as time-barred.

A. Appellant's claims are barred by the absolute six-year statute of repose for medical malpractice actions.

The General Assembly has enacted a six-year statute of repose for medical malpractice actions, which provides in relevant part:

[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 repose creates a substantive right in those protected to be free from liability after a legislatively determined period of time." Capco of Summerville, Inc., 368 S.C. at 142, 628 S.E.2d at 41 (citing Langley v. Pierce, 313 S.C. 401, 403-04, 438 S.E.2d 242, 243 (1993)). "A statute of repose is typically an *absolute time limit* beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body." Id. (emphasis added) (citing Langley, 313 S.C. at 404, 438 S.E.2d at 243). Thus, "[s]tatutes of repose by their nature impose on some plaintiffs the hardship of having a claim extinguished before it is discovered, or perhaps before it even exists." Columbia/CSA-HS Greater Columbia Healthcare Sys., LP, 411 S.C. at 560-61, 769 S.E.2d at 848-49 (quoting Capco of Summerville, Inc., 368 S.C. at 142, 628 S.E.2d at 41 (quotation omitted)).

The question posed by Appellant is whether the statute of repose applicable to Appellant's action was triggered at the date of first treatment so as to bar Appellant's claims against Respondent MUSC. "The cardinal rule of statutory construction is to ascertain and effectuate the

intent of the legislature.” Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) (quoting Charleston Cnty. Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 5, 437 S.E.2d 6, 8 (1993)).

Section 15-3-545(A) provides in relevant part:

[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 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, 340, 380 S.E.2d 821, 822 (1989).¹

Interpreting the plain and unambiguous language of 15-3-545(A), the legislature clearly intended the repose provision to set the time limit for filing a claim based upon the act or omission of the defendant, in this case MUSC. Because Appellant’s claims arise out of her ECT treatment, the trigger date/occurrence for the statute of repose is the date of her first treatment on December 3, 2003. See Harrison v. Bevilacqua, 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003) (rejecting the continuous treatment rule, finding claims not brought within six years of onset of treatment are barred pursuant to the medical malpractice statute of repose). It is from this date that the absolute outer limit of the six year repose provision established by the legislature was set to run. Thus, Appellant was required to bring the instant action no later December 3, 2009, six years from the date of the onset of treatment.

¹ The six-year repose provision of § 15-3-545 applies to both government and private hospitals. 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).

The expiration of the statute of repose on December 3, 2009 therefore extinguished all Appellant's causes of action, including those that may later accrue and those that have already accrued. See Capco of Summerville, Inc., 368 S.C. at 142, 628 S.E.2d at 41; see e.g. Columbia/CSA-HS Greater Columbia Healthcare Sys., 411 S.C. at 560, 769 S.E.2d at 848 (finding equitable indemnification claim brought ten years after event giving rise to medical malpractice action barred by six-year statute of repose).

Such a strict construction of the statute of repose under the circumstances of this case is further supported by the legislature's expressed intent to limit exceptions to the statute to only three scenarios: (1) Section 15-3-545(B) excludes from the operation of the statute of repose actions where a foreign object, such as a surgical instrument, is left in the "body or person of any one" and permits these actions to "be commenced within two years from date of discovery or when it reasonably ought to have been discovered;" (2) Section 15-3-545(C) excludes actions that arose "prior to June 10, 1977;" and (3) Section 15-3-545(D) provides tolling for claims of minors. S.C. Code Ann. § 15-3-545. If the General Assembly desired to expand the reach of these exceptions to incorporate the situation at issue here, it certainly could have done so. See Columbia/CSA-HS, 411 S.C. at 562, 769 S.E.2d at 849 (noting the General Assembly limited the reach of the exceptions to the statute of repose to only those exceptions cited above, and stating, "[i]f the General Assembly desires to expand those exceptions to include the situation presented here, that decision lies exclusively in the Legislative Branch.").

Consistent with this legislative intent to limit exposure and foster quality health care services, 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. As explained in Harrison v. Bevilacqua, 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. at 138, 580 S.E.2d at 114.

Furthermore, because the only tolling provided by § 15-3-545 is contained in Subsection (D) and applicable only to minors, the insanity or incompetency tolling provisions of the disability statute, S.C. Code Ann. § 15-3-40, do not apply. See Langley, 313 S.C. at 403, 438 S.E.2d at 243. Consistent with this rationale, the disability statute’s inapplicability to medical malpractice actions was recently reaffirmed in Sims v. Amisub of S. Carolina, Inc., 408 S.C. 202, 216, 758 S.E.2d 187, 195 (Ct. App. 2014), reh’g denied (May 19, 2014), cert. granted (Nov. 19, 2014), aff’d, No. 2014-001179, 2015 WL 4751030 (S.C. Aug. 12, 2015). There, the South Carolina Court of Appeals reinforced the controlling precedent established in Langley, observing that if the disability statute were to apply to medical malpractice actions, it would be in conflict with the six year statute of repose set forth in § 15-3-545(A). Id.

Here, as in Harrison, Sims and Langley, application of the discovery rule or tolling provided by § 15-3-40 will not revive a claim that is filed outside the absolute limitations period established by the statute of repose.² Consequently, as the lower court properly determined, Appellant’s claims, having been brought nearly eight years from the onset of treatment, are barred by the absolute six-year statute of repose imposed by § 15-3-545(A).

² Courts in other jurisdictions have similarly declined to apply statutes such as South Carolina’s disability statute § 15-3-40 to medical malpractice statutes of repose. In Calaway ex rel. Calaway v. Schucker, 193 S.W.3d 509 (Tenn. 2005), the Supreme Court of Tennessee found no tolling exception for minority with regard to its three-year medical malpractice statute of repose, premising its holding on the clear language of the statute and its consistent characterizations of the medical malpractice statute of repose as an absolute three-year bar to such claims. In so finding, the Calaway court emphasized that the Tennessee disability statute “serves to toll only statutes of limitations and not statutes of repose.”

B. Even assuming Appellant lacked the mental capacity to comprehend her injuries, Appellant's claims are barred by the expiration of the limitations period set by the disability statute.

As an alternative ground for granting summary judgment, the circuit court correctly ruled that even assuming the disability statute applied, Plaintiff's action was still 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 Appellant 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. § 15-3-40.³ 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.**

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

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)).

³ The repose provision of § 15-3-545 limits the time during which the insanity provisions of § 15-3-40 would permit an action to be brought.

Here, Appellant and her expert assert she "...did not regain the mental capacity to understand and appreciate the harm..." allegedly caused by ECT until June 2010. (R. pp. 3-4, 16-17). Therefore, the disability statute required Appellant to file the instant action by June 25, 2011. Although Appellant filed a Notice of Intent on June 25, 2010, the dismissal of the action without prejudice on August 25, 2010, precluded Appellant from tolling the action so as to render Appellant's November 16, 2011 Complaint time-barred. (R. p. 9); see Davis v. Lunceford, 287 S.C. 242, 243, 335 S.E.2d 798, 799 (1985) ("When an action is dismissed without prejudice, the statute of limitations will bar another suit if the statute has run in the interim.").

Furthermore, substantial evidence in the record, including Appellant's sworn deposition testimony, statements to her treating physicians, and materials from her divorce 2007 proceedings indicate she acknowledged her alleged problems associated with ECT much earlier than June of 2010. Specifically, Appellant testified 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. (R. pp. 69-70, Deposition of Appellant, p. 68, line 9 – p. 69, line 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 loss *at the time* to ECT. (R. p. 71, Deposition of Appellant, p. 81, line 20 – p. 82, line 21). Appellant's prior knowledge was again reiterated in her deposition wherein she testified 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. (Suppl. R. p. 7, lines 12-19). Similarly, there are references to Appellant's memory loss from ECT date back to Appellant's divorce proceedings in 2007. (Suppl. R. pp. 14-15, Life Care Plan for Clair Johnson, dated January 30, 2007, noting "[Appellant] has been having increasing problems with her memory, . . . has reportedly developed

increasing problems with directionality and memory” and that Appellant admitted being “afraid to drive due to increased problems with memory. . .”).

Based on this evidence, Appellant comprehended her injuries as early as 2006, affording her only one year within which to bring a claim under the disability statute. Consequently, even if applicable, neither the disability statute nor the discovery rule could revive the instant action.

C. Appellant’s claims are not subject to the tolling provision of 15-79-125 where the Notice of Intent was defective.

Section 15-79-125(A) of the South Carolina Code imposes pre-litigation filing requirements upon individuals intending to file suit for medical malpractice, which provide, in pertinent part:

Prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness, subject to the affidavit requirements established in Section 15-36-100 . . .

The filing of the notice of intent will toll the limitations period. However, “[w]hen an action is dismissed without prejudice, the statute of limitations will bar another suit if the statute has run in the interim.” Davis, 287 S.C. at 243, 335 S.E.2d at 799; see cf. Mende v. Conway Hospital, Inc., 304 S.C. 313, 404 S.E.2d 33 (1991) (recognizing the ruling in Davis, but finding the statute of limitations defense had been waived).

Here, despite filing the Notice of Intent on June 25, 2010, Appellant dismissed the matter without prejudice on August 25, 2010. Adopting Appellant’s assertion that the limitations period accrued as late as July 5, 2010, the dismissal without prejudice filed on August 25, 2010 deprived Appellant from benefiting from the tolling provision of § 15-79-125, barring Appellant’s November 16, 2011 Complaint.

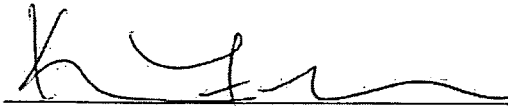
Moreover, a notice of intent will not toll the limitations period if the notice is defective. See Grier v. Amisub of South Carolina, 397 S.C. 532, 725 S.E.2d 693 (2012) (observing failure to conform pre-suit affidavit to requirements of § 15-79-125 would bar medical malpractice action). Pursuant to section 15-79-125(A), an affidavit of an expert witness must be filed contemporaneously with the notice of intent to file suit. S.C. Code Ann. § 15-79-125(A) (Supp. 2012). In contravention of the pre-suit requirements of § 15-79-125(A), Appellant failed to file an expert witness affidavit with the Notice. Rather, the Notice sought an extension of time to file the affidavit, citing "time constraints" as preventing Appellant from filing an affidavit of a medical expert. In certain circumstances and upon approval from the court, the rule provides a plaintiff an additional forty-five days to file an expert affidavit. However, Appellant failed to file an expert witness affidavit until August 10, 2011, over one year after the expiration of the forty-five day period provided by § 15-36-100(C)(1).

Thus, even assuming the action was tolled despite the subsequent dismissal without prejudice, the tolling provision of § 15-79-125 was never triggered because the Notice of Intent failed to comply with §§ 15-79-125 and 15-36-100. Accordingly, the statute of limitations having expired on July 5, 2011, bars Appellant's claims.

CONCLUSION

For the reasons addressed herein, Appellant's action against MUSC having been commenced neither within six years of the occurrence, nor within one year after the alleged disability of the Appellant was removed, is barred by the absolute limitations period established by the legislature, and Respondent respectfully requests that the Court affirm the Order of the Circuit Court granting summary judgment in favor of MUSC on these grounds. Respondent

further asks the Court to affirm the Order presently on appeal for any ground appearing on the record or previously argued to the lower court as provided by Rule-220(c), SCACR.



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4/21, 2016
Charleston, South Carolina

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

APPELLANT'S FINAL REPLY BRIEF

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STATEMENT IN REPLY TO DEFENDANTS' INITIAL BRIEFS

ARGUMENT

- I. THE LOWER COURT ERRED BY CONCLUDING THAT THE TRIGGER DATE FOR COMPUTING THE RUNNING OF THE SIX YEAR STATUTE OF REPOSE AND THREE YEAR STATUTE OF LIMITATIONS WAS DECEMBER 10, 2003, THE DATE OF THE FIRST OF EIGHTY-SIX ELECTROCONVULSIVE THERAPY TREATMENTS ENDING ON JUNE 26, 2008, THE DATE OF THE EIGHTY-SIXTH SUCH TREATMENT, THE ERROR BEING THAT ELECTROCONVULSIVE THERAPY TREATMENT DID NOT CAUSE IDENTIFIABLE INJURY TO APPELLANT UNTIL NO EARLIER THAN 2009-2010 THEREBY TRIGGERING A THREE YEAR PERIOD IN WHICH TO INITIATE A CLAIM PURSUANT TO S.C. CODE ANN. § 15-545(A).

Respondents, The Medical University of South Carolina and John Roberts, M.D. (Respondents), contention that Respondents' argument was not raised to and ruled upon by the Lower Court and is not preserved for review wrongly assumes that Appellant Clair Craver Johnson's (Appellant) argument is subject to a single conclusion, i.e., that the six year statute of repose was triggered by the initial electroconvulsive therapy (ECT) treatment in 2003 when a fact issue exists as to on what date Appellant sustained permanent injury.

Respondents began treating Appellant with bilateral ECT treatment in 2003 and continued that treatment until June 26, 2008. (R. p. 37-44)

A fact issue exists on Appellant's mental condition when the treatment was initiated in June of 2003 and when the treatment ended on June 26, 2010.

A fact issue is present as to at what point in her course of treatment did Appellant sustain the initial damage of which she complains.

Respondents contend that the initial bilateral ECT treatment started the clock running and that the six year statute of repose ran in 2009 thereby disregarding any need

to establish the point in time when the use of bilateral ECT treatment actually resulted in permanent brain damage.

Respondents' reliance on reported cases that hold that, for example, that South Carolina has rejected the "continuous treatment rule" is misplaced. Section 15-3-545(A) provides that:

In any action . . . to recover damages for injury to the person arising out of any medical, surgical or dental treatment, omission, or operation giving rise to the cause of actions 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.

In Harrison v. Bevilacqua, 354 S.C. 129, 136, 580 S.E.2d 109 (2008) that court citing Langley v. Pierce, 313 S.C. 410, 438 S.E.2d 242, 243 (1993) refused to adopt the continuous treatment rule while acknowledging that it had recognized that the six-year statute of repose provision in § 15-3-545 "constitutes an outer limit beyond which a medical malpractice claim is barred, regardless of whether it has or should have been discovered."

The Bevilacqua court went on to say that "a statute of repose is typically an absolute time limit beyond which liability no longer exists and is not tolled for any reasons because to do so would upset the economic balance struck by the legislative body." Langley v. Pierce, 313 S.C. 401, 438 S.E.2d 242 at 244.

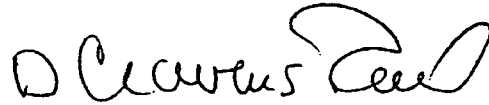
What Bevilacqua does not say is that if a physician, dentist or other medical practitioner has treated a patient for more than six years that patient is barred from initiating a claim for injury caused by a negligent act or omission occurring after six years of treatment but within three years of the date the injury takes place.

Respondents ask this Court to find the trigger of the limitation of action provision that is the six-year statute of repose by the initial date of treatment rather than the date of the initial injury when the condition for which Respondents received ECT made Appellant mentally confused and unable to understand and appreciate her condition. Only when the ECT treatment stopped was Appellant able to recognize her memory loss. When the loss became permanent is a question of fact. Respondents stopped ECT treatment when Appellant's condition became permanent, i.e., she was "cured" of the confusion for which she was receiving ECT treatment. The "trade off" for this cure was permanent brain damage.

Appellant contends that a fact issue exists as to when the permanent consequences of the Respondent's course of ECT treatment arose. Only when the fact finder is allowed to digest the information provided by the records and expert testimony will it be possible to determine the date on which the statute of repose began to run.

CONCLUSION

Electroconvulsive therapy treatment can be administered without permanent disability. Appellant should be permitted to make her case that Respondents took her ECT treatment to a point where permanent injury took place less than six years prior to the initiation of these actions.



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March 28, 2016

**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Clair Craver Johnson, Appellant,

v.

John Roberts, M.D., Respondent.

And

Clair Craver Johnson, Appellant,

v.

Medical University of South Carolina, Respondent.

Appellate Case No. 2015-001463

Appeal From Charleston County
R. Markley Dennis, Jr., Circuit Court Judge

Opinion No. 5535
Heard September 20, 2017 – Filed February 7, 2018

REVERSED

Jonathan Blake Asbill, of Baker Ravenel & Bender, LLP
and Bradley Lewis Lanford, of The Law Office of
Kenneth E. Berger, LLC, both of Columbia for
Appellant.

Donald Jay Davis, Jr., Stephen Lynwood Brown, James
Edward Scott, IV, and Russell Grainger Hines, all of

Young Clement Rivers of Charleston for Respondent
John Roberts, M.D.

William Peele Early, of Pierce, Hems, Sloan & Wilson,
LLC, of Charleston, for Respondent Medical University
of South Carolina.

LOCKEMY, C.J.: In this action Clair Craver Johnson appeals the circuit court's entry of summary judgment in favor of John Roberts, M.D. and the Medical University of South Carolina (MUSC) (collectively Respondents). Johnson asserts the circuit court erred in finding her claims were time-barred by the statute of repose applicable to medical malpractice claims. We reverse.

Johnson suffers from bi-polar disorder and depression. In 1997 she experienced severe mania, which required hospitalization. Dr. Roberts, a licensed psychiatrist, began treating Johnson at that time.

Johnson experienced several episodes of mania between 1997 until November 2003. On November 26, 2003, Johnson's doctors admitted her to MUSC, and on December 10, 2003, they began treating her with electroconvulsive therapy (ECT).¹ Between December 10, 2003 and June 26, 2008, Johnson's doctors treated her with ECT on eighty-six separate occasions. According to Johnson, she sustained serious permanent cognitive damage as a result of the ECT.

Johnson, proceeding pro se, filed a Notice of Intent to File Suit against MUSC on June 25, 2010. She alleged "due to having ECT . . . for an extended period of time between 2003 and 2008 [I] am now left with cognitive impairment and memory loss." Johnson also requested an extension to file an expert affidavit because "I am informed and have a good faith belief that the statute of limitation on my cause of action in this matter (absent a discovery exception) will expire within the next 10 days from the date my Notice of Intent to File Suit is filed." On August 20, 2010,

¹ "Electroconvulsive therapy is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses." Mayo Clinic Staff, Electroconvulsive Therapy (ECT), Mayo Clinic (May 9, 2017), <http://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/basics/definition/prc-20014161>.

Johnson filed a Stipulation of Dismissal without Prejudice of her Notice of Intent to Sue.

On November 16, 2011, Johnson filed a complaint against MUSC, asserting medical malpractice claims resulting from her ECT treatments. Johnson claimed, "[d]uring, after and a direct and proximate result of this extensive and involuntary ECT treatment, [she] lacked the mental capacity to understand and appreciate the detrimental effect the ECT had upon her until 2010" Johnson also filed an affidavit from Harold J. Burstztajn, M.D., corroborating her claims that she was incapacitated as a result of the ECT until 2010. On May 16, 2012, Johnson filed an Amended Complaint against Dr. Roberts for damages resulting from the ECT treatments.

Following discovery, Respondents filed motions for summary judgment alleging Johnson's claims were barred by the statute of limitations and the statute of repose. Dr. Roberts contended the first act of negligence would have occurred between 2002 and 2003, meaning the statute of repose would bar any claims filed after 2009. MUSC also asserted, "Plaintiff's complaint against MUSC having arisen out of ECT treatment initiated in 2003 is time barred."

The circuit court held a hearing on Respondents' motions and later issued its order granting Respondents' summary judgment, finding Johnson's claims were time-barred by the statute of repose. Johnson filed a motion for reconsideration pursuant to Rule 59(e). The circuit court denied the motion. This appeal followed.

LAW

"An appellate court reviews a grant of summary judgment under the same standard applied by the [circuit] court pursuant to Rule 56, SCRCF." *Lanham v. Blue Cross & Blue Shield of S.C., Inc.*, 349 S.C. 356, 361, 563 S.E.2d 331, 333 (2002). A circuit court should grant a motion for summary judgment when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law." Rule 56(c), SCRCF.

South Carolina law requires claims for medical malpractice be filed 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" S.C. Code Ann. § 15-3-545(A) (Supp. 2017). Section 15-3-545(A) creates a six-year statute of repose, beyond which a patient

cannot sue their medical provider for malpractice. *Id.*, see also *Kerr v. Richland Mem. Hosp.*, 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009) ("Accordingly, the statute of repose provision within section 15-35-545(A) applies as an absolute limit applicable in *any* medical malpractice action."). "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, 866 (4th Cir.1989)).

ANALYSIS

Initially, we note Respondents assert the arguments Appellant presents to this court are different from the arguments presented to the circuit court and Appellant has not appealed the circuit court's ruling on the previous argument. We disagree.

During the circuit court's hearing on Respondents' motions for summary judgment, Appellant asserted she "received [ECT] eighty-six times over a several years period of time – 2003 to 2008. Each time she received that, it was a blow to her head, a tort." Appellant conceded the "continuous treatment rule" was unavailable to her, but she argued "each of these is an individual to[rt]." The circuit court found

Plaintiff's medical records indicate ECT was commenced on December 20, 2003. For purposes of the statute of repose, such allegations constitute an occurrence beginning as early as the commencement of treatment in 2003. . . . 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 § 15-3-545.²

In her briefing to this court, Appellant's statement of issue on appeal was

The lower court erred by concluding that the trigger date for computing the running of the six[-]year statute of repose and the three[-]year statute of limitation as

² Judge Dennis made the same finding as to Dr. Roberts.

December 10, 2003, the date of the first of eighty-six [ECT] treatments ending on June 26, 2008, the date of the eighty-sixth such treatment, the error being that [ECT] did not cause identifiable injury to appellant until no earlier than 2009-2010 thereby triggering a three-year period in which to initiate a claim pursuant to S.C. Code Ann. § 15-545(A).

Our supreme court has cautioned that issue preservation "is not a 'gotcha' game aimed at embarrassing attorneys or harming litigants." *Atl. Coast Builders & Contractors, LLC v. Lewis*, 398 S.C. 323, 329, 730 S.E.2d 282, 285 (2012).

"While it may be good practice for us to reach the merits of an issue when error preservation is doubtful, we should follow our longstanding precedent and resolve the issue on preservation grounds when it *clearly* is unpreserved." *Id.* at 330, 730 S.E.2d at 285 (emphasis added). The factual theory Appellant presented to the circuit court is not identical to the factual theory she argues here. But Appellant's statement of issues on appeal is broad enough to encompass the argument she presents to this court, and the circuit court's ruling makes clear the judge's belief that the date of occurrence in this case was the first date of treatment. Appellant asserts in her brief she is "not [seeking] the application of [the continuous treatment] rule to her facts Johnson contends that *her claim arose . . . certainly [within] the six year statute of repose.*"

It cannot be said that Appellant's arguments are clearly preserved. But in light of the foregoing, it also cannot be said that Johnson's arguments are clearly unpreserved. In these situations, "where the question of issue preservation is subject to multiple interpretations, any doubt should be resolved in favor of preservation." *Id.* at 333, 730 S.E.2d at 287 (Toal, C.J., concurring in result in part and dissenting in part). Therefore, we find Appellant has preserved her arguments to this court, and has adequately appealed the circuit court's order.

In *Marshall v. Dodds*, this court confronted the issue of whether the medical malpractice statute of repose bars subsequent acts of negligence in the course of a prolonged medical treatment. 417 S.C. 196, 789 S.E.2d 88 (Ct. App. 2016), *cert. granted*, August 23, 2017. Virginia Marshall was diagnosed with a rare form of blood cancer while she was under the care of two physicians. *Id.* at 199, 789 S.E.2d at 89. She initially began seeing the two doctors in 2000 and 2004, but neither noticed signs in her blood and urine tests which indicated the presence of cancer. *Id.* In 2011, after her diagnosis, she sued her doctors, alleging they

committed malpractice by not discovering her cancer sooner. *Id.* at 200, 789 S.E.2d at 90. The circuit court found the claims were time barred "because the statute of repose began to run after the first alleged misdiagnoses" *Id.* at 202, 789 S.E.2d at 90. "[T]he court reasoned . . . [any] subsequent misdiagnoses were merely a continuation of the first misdiagnoses, not distinct acts of negligence that could serve as new trigger points for the statute of repose." *Id.*

This court reversed. The court found if a plaintiff alleges a "misdiagnosis or failure to diagnose a condition within the six-year period—which an expert witness opines to be a breach of the physician's duty of care—the statute of repose does not bar the cause of action merely because the physician previously misdiagnosed the condition outside the repose period." *Id.* at 205, 789 S.E.2d at 92. The court found the plaintiffs alleged specific dates and appointments within the statute of repose when Marshall's doctors failed to diagnose her with cancer. *Id.* at 205-06, 789 S.E.2d at 93-94. Accordingly, the court found Marshall's claims for medical malpractice for alleged negligent acts which occurred within the six-year statute of repose would not be time barred. *Id.* at 206, 789 S.E.2d at 93.

The *Marshall* court found this analysis to be consistent with our supreme court's decision in *Harrison v. Bevilacqua*, 354 S.C. 129, 580 S.E.2d 109 (2003). In *Harrison*, the court declined to adopt the continuous-treatment rule which would toll the statute of repose until the termination of a patient's treatment. *Id.* at 138, 580 S.E.2d at 114. The plaintiff in *Harrison* was a diagnosed schizophrenic that was involuntarily committed to the care and treatment of the Department of Mental Health (the Department) in 1982. *Id.* at 132, 580 S.E.2d at 111. He remained in the Department's care through 1995, when he was discharged. *Id.* He was appointed a guardian ad litem in 1994 that successfully petitioned for his release, and subsequently filed a complaint alleging the Department should have discharged him as early as 1983. *Id.* The circuit court determined Harrison would only be allowed to present evidence of acts of negligence that occurred within the five-year statute of repose contained within the Tort Claims Act. *Id.* at 134, 580 S.E.2d at 111-12. A jury returned a verdict in favor of Harrison, but for only \$1 in damages. *Id.* at 133, 580 S.E.2d at 111. Harrison then appealed the circuit court's decision, arguing the court should adopt the continuous treatment rule, meaning the statute of repose would have begun running after his discharge. *Id.* The *Harrison* court disagreed and found the continuous treatment rule would conflict with the General Assembly's objective to limit liability for medical malpractice cases. *Id.* at 138, 580 S.E.2d at 114.

Our court in *Marshall* noted, "[o]ur interpretation . . . is entirely consistent with *Harrison* because we are not suggesting the statute of repose is tolled until the termination of the physician's course of treatment." 417 S.C. at 208, 789 S.E.2d at 94. Rather, "we hold the statute begins to run at the time of a medical professional's alleged negligent act or omission for which the plaintiff seeks to impose liability without regard to when the course of treatment ended." *Id.*

The allegations in this case are indistinguishable from *Marshall*. Appellant asserts she has been harmed as a result of treatment she received within the six-year statute of repose. Because there is evidence that her injury occurred as a result of treatment within the six years prior to her lawsuit, the circuit court erred in finding as a matter of law her claim is barred by the statute of repose.

CONCLUSION

Accordingly, the circuit court's order is

REVERSED.

HUFF and HILL, JJ., concur.

**THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS**

Appeal from Charleston County
Court of Common Pleas

R. Markley Dennis, Jr., Circuit Court Judge

Circuit Court Cases No. 2012-CP-10-2867 and 2011-CP-10-8313

Appellate Case No. 2015-001463

Clair Craver Johnson,		Appellant,
	v.	
John Roberts, M.D.,		Respondent.
And		
Clair Craver Johnson,		Appellant,
	v.	
Medical University of South Carolina,		Respondent.

PETITION FOR REHEARING
*****WITH SUGGESTION FOR REHEARING EN BANC*****
BY RESPONDENT JOHN ROBERTS, M.D.

YOUNG CLEMENT RIVERS, LLP
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*Attorneys for Respondent
John Roberts, M.D.*

NOW COMES Respondent John Roberts, M.D. (“Dr. Roberts”), by and through his undersigned counsel, and hereby petitions this Honorable Court for rehearing of this matter, suggesting it be reheard en banc.

SUGGESTION FOR REHEARING EN BANC

The Court decided this consolidated appeal by published opinion filed February 7, 2018 (the “Subject Decision”),¹ reversing the circuit court’s summary judgments in favor of Dr. Roberts and Respondent Medical University of South Carolina (“MUSC”).²

As set forth below, Dr. Roberts contends, most respectfully, that the Subject Decision is not only erroneous but also, with particular regard to its ruling on the preservation questions in this appeal (the Court finding Appellant to have “preserved her [appellate] arguments . . . and . . . adequately appealed the circuit court’s order” even though “[t]he factual theory Appellant presented to the circuit court is not identical to the factual theory she argue[d] [on appeal]”³) the Subject Decision stands to be a problematic outlier, incongruous with our state’s jurisprudence in an area of law that “is a fundamental component of appellate

¹ By order filed February 22, 2018, the Court extended the time for serving and filing Respondents’ petitions for rehearing until March 9, 2018.

² For ease of reference, a copy of the Subject Decision (with page numbers added for citation purposes) is attached hereto as Exhibit A.

³ (Exhibit A p. 5.)

practice.” See, e.g., *Kennedy v. S.C. Retirement Sys.*, 349 S.C. 531, 532-33, 564 S.E.2d 322-23 (2001) (“We reiterate this Court’s longstanding principle of error preservation. Preserving issues for appellate review is a fundamental component of appellate practice. South Carolina appellate courts do not recognize the plain error rule. The appellants have the responsibility to identify errors on appeal, not the Court. South Carolina cases clearly hold that one cannot present and try a case on one theory and then attack the result below by presenting another theory on appeal.”) (internal citation and quotation marks omitted).

Accordingly, pursuant to Rule 219, SCACR, Dr. Roberts suggests this matter be reheard en banc because (1) consideration by the full Court is necessary to secure or maintain uniformity of its decisions, and (2) this proceeding involves a question of exceptional importance.

MATERIAL POINTS
OVERLOOKED OR MISAPPREHENDED

Again, most respectfully, the Subject Decision is erroneous. Dr. Roberts submits that the following material points were overlooked or misapprehended by the Court.

I. The Court's finding that "Appellant . . . preserved her [appellate] arguments . . . and . . . adequately appealed the circuit court's order"⁴ is erroneous; to the contrary, Appellant's argument clearly is unpreserved, and, as such, it is error to not decide this appeal (in favor of Respondents) on preservation grounds.

A. Appellant only made one argument on appeal.

As an initial matter, the Subject Decision is worded as if Appellant presented the Court with multiple appellate arguments. (*See generally Exhibit A* (making reference to Appellant's "arguments," plural.) As both Respondents pointed out in their briefs, however,⁵ Appellant only made one argument on appeal, and it is this: *that the circuit court erred in granting summary judgment in favor of Respondents on the basis of the repose provision in S.C. Code Ann. § 15-3-545(A) (i.e., the medical malpractice statute of repose) because there existed a material issue of fact as to when (i.e., at what point in time) Appellant's treatment with ECT constituted negligence.* (*See Appellant's Br. p. i [Table of Contents]* (stating one argument and identifying "the error" on the part of the circuit court as "being that

⁴ (*Exhibit A* p. 5.)

⁵ (*See generally* Dr. Roberts Br. pp. 4-8; MUSC Br. pp. 4-5.)

[ECT] did not cause identifiable injury to Appellant until no earlier than 2009-2010 thereby triggering a three year period in which to initiate a claim pursuant to S.C. Code Ann. § 15-[3-]545(A)”) (emphasis omitted); *id.* at p. 1 [Statement of “Issues” on Appeal] (stating one issue and identifying “the error” on the part of the circuit court the same as quoted above); *id.* at 2 (“Appellant contends that the evidence of the date triggering the statute of repose is *not a question of law* for the Court *but is one of fact.*”) (emphasis added); *id.* at p. 5 (“Given testimony that Appellant first experienced problems with [ECT] in 2009 *a jury issue is present* over the timeliness of these actions. The issue is not whether use of [ECT] is negligent from the first treatment but at what point (number and timing and type of [ECT]) does use of [ECT] constitute negligence.”) (emphasis added); *id.* at p. 7 (“*A fact issue* over when [ECT] could have been found to have caused permanent brain damage is present and requires action by a *jury.*”) (emphasis added); *id.* at pp. 7-8 (“[T]he presence of eighty-six (86) acts over a period beginning on December 2, 2009 and running to and including June 26, 2008, each of which may not be characterized an act of negligence but collectively at some point can be so characterized . . . cannot be determined by the Court as a matter of law.”); *id.* at p. 8 (“A fact issue as to when [Appellant] allegedly sustained injuries [is] present in this action Ms. Johnson was treated for her condition by [ECT] from 2003 to 2008 and the question is unresolved as to when and whether the use of [ECT]

caused her permanent mental issues.”) (emphasis in original).)

B. The Court overlooked established preservation rules—under which, Appellant’s argument clearly is unpreserved.

The Subject Decision does not actually address any of the established rules of preservation; rather, it sights but one authority, *Atlantic Coast Builders & Contractors, LLC v. Lewis*, 398 S.C. 323, 730 S.E.2d 282 (2012), essentially for the proposition that Appellant’s argument is preserved because it could not, in the Court’s view, be said to be clearly unpreserved. (See Exhibit A p. 5.) Dr. Roberts will address why he believes the Court misapprehended *Atlantic Coast Builders, infra*, but he would first draw attention to the established preservation rules that the Court overlooked—and under which it is clear that Appellant’s argument is unpreserved.

As the Court itself acknowledged in the Subject Opinion, Appellant’s appellate argument is different from the argument she presented to the circuit court. (See Exhibit A p. 5 (“The factual theory [Ms. Johnson] presented to the circuit court is not identical to the factual theory she argues here.”);⁶ see also *id.*

⁶ To be clear, in no way does the Court’s use of the language “not identical to the factual theory” diminish Appellant’s preservation problem. As a practical matter, the Court’s language is merely another way of saying her appellate argument is *different* from what she argued below, which, as further explained, *infra*, is plainly contrary to establish preservation rules. Moreover, in this particular case, as explained in I.A. above, the new “factual theory” on which Appellant’s argument is premised cannot possibly be deemed immaterial here,

(stating, “Appellant’s statement of issues on appeal is broad enough to encompass *the argument she presents to this court . . .*,” and, thus, necessarily implying that the argument Appellant presented below is not “the argument she presents to this [appellate] court”) (emphasis added). This alone renders Appellant’s argument clearly unpreserved and requires that her appeal be decided (against her) on preservation grounds because, under South Carolina law, where an issue or argument is not preserved, it is error for an appellate court to reach the merits—the court must decide it on preservation grounds. *See Elam v. S.C. Dep’t of Transp.*, 361 S.C. 9, 25, 602 S.E.2d 772, 780 (2004) (instructing that South Carolina’s preservation requirements are “mandatory”); *see also id.* at 23, 602 S.E.2d at 779 (“[A] great number of reported cases in South Carolina for at least four generations, and more recently the appellate court rules and rules of civil procedure, have emphasized the importance and absolute necessity of ensuring that all issues and arguments are presented to the lower court for its consideration.”); *State v. Langford*, 400 S.C. 421, 435, 735 S.E.2d 471, 479, n. 5 (2012) (“Preservation in South Carolina is a threshold issue and if an issue is unpreserved, it is not properly before the court and the merits should not be reached.”) (citing *State v. Roach*, 377 S.C. 2, 3, 659 S.E.2d 107, 107 (2008) (noting that issues not

where her Appellant’s sole argument on appeal is about the supposed existence of a *factual* question—her new “factual theory” is a new argument entirely.

preserved for review should not be addressed)); *see also Elam*, 361 S.C. at 24, 602 S.E.2d at 780 (“South Carolina appellate courts do not recognize the ‘plain error rule,’ under which a court in certain circumstances is allowed to consider and rectify an error not raised below by the party.”); *I’On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 420-22, 526 S.E.2d 716, 723-24 (2000) (explaining, “as expressed in Rule 220(c), SCACR, . . . an appellate court may affirm the lower court’s judgment for any reason appearing in the record on appeal[,] . . . [but] [a]n appellate court may not, of course, *reverse* for any reason appearing in the record.”) (emphasis in original).

Accordingly, because Appellant’s appellate argument is different from her argument to the circuit court, the circuit court, of course, did not rule on it; therefore, her appellate argument is unpreserved pursuant to the established requirement that, to be preserved, all issues and arguments must be raised to and ruled on below. *Elam v. S.C. Dep’t of Transp.*, 361 S.C. at 23, 602 S.E.2d at 779-80 (“Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court.”); *see also Kennedy*, 349 S.C. at 532-33, 564 S.E.2d 322-23 (“South Carolina cases clearly hold that one cannot present and try a case on one theory and then attack the result below by presenting another theory on appeal.”). Moreover, because this new argument was Appellant’s *only* appellate argument, Appellant never actually presented any challenge to what the

circuit court *did* rule on; therefore, the circuit court's ruling is the law of the case, any potential challenge thereto by Appellant having been abandoned, and affirmance of the circuit court's summary judgments is mandated under the two-issue rule. *See Jones v. Lott*, 387 S.C. 339, 346, 692 S.E.2d 900, 903 (2010) ("Under the two issue rule, where a decision is based on more than one ground, the appellate court will affirm unless the appellant appeals all grounds because the unappealed ground will become the law of the case."); *Jinks v. Richland County*, 355 S.C. 341, 344, 585 S.E.2d 281, 283, n. 3 (2003) (an issue which is not argued in the brief is deemed abandoned and precludes consideration on appeal); *Anderson v. S.C. Dep't of Highways & Pub. Transp.*, 322 S.C. 417, 420, 472 S.E.2d 253, 255 n. 1 (1996) (noting that the two-issue rule is applicable to circuit court orders); *First Union Nat'l Bank of S.C. v. Soden*, 333 S.C. 554, 566, 511 S.E.2d 372, 378 (Ct. App. 1998) (holding an "unchallenged ruling, right or wrong, is the law of the case and requires affirmance"); *Cont'l Ins. Co. v. Shives*, 328 S.C. 470, 474, 492 S.E.2d 808, 811, n. 2 (Ct. App. 1997) (an issue not raised in the appellant's principal brief may not be raised via a reply brief).

C. The Court misapprehended *Atlantic Coast Builders*: that case actually supports Dr. Roberts's contention that this appeal must be decided (in favor of Respondents) on preservation grounds.

As noted above, the Court's preservation analysis relies on a single legal authority: *Atlantic Coast Builders*. (See generally Exhibit A pp. 4-5). Citing

Atlantic Coast Builders, the Court states, “Our supreme court has *cautioned* that issue preservation ‘is not a ‘gotcha’ game aimed at embarrassing attorneys or harming litigants.’” (*Id.* at 5 (citing *Atlantic Coast Builders*, 398 S.C. at 329, 730 S.E.2d at 285) (emphasis added by *this* Court, i.e., this emphasis was not in the Supreme Court’s opinion).) Respectfully, the Court misapprehends *Atlantic Coast Builders*.

The Subject Decision isolates the “‘gotcha’ game” language and does not place it in proper context. In context, it is clear that the *Atlantic Coast Builders* majority was actually making a very different point (indeed, pretty much the opposite point) than that reflected in the Subject Decision.

Explaining its disagreement with Chief Justice Toal (who, as she stated in a separate opinion—to which, it should be noted, she was the lone subscriber—that she *would* reach the merits of the appellant’s arguments) and why it *could not* reach the appellant’s arguments because they were unpreserved, the *Atlantic Coast Builders* majority stated as follows:

The Chief Justice would not find that the two-issue rule applies in this case. The thrust of her argument is that the master’s order does not award damages for unjust enrichment, correctly noting that the actual expenditures made by Atlantic are not a proper measure for unjust enrichment. Thus, in her view, the master did not enter judgment in favor of Atlantic on its unjust enrichment claim and no unappealed theory of liability exists to trigger the two-issue rule.

However, our review of the record shows the master intended to award damages for all causes of action, including unjust enrichment. In fact, he went so far as to specifically state he was excluding certain expenditures from his award because they did not unjustly enrich Lewis. While his calculation of damages may have been incorrect, an unappealed ruling, right or wrong, is the law of the case. Therefore, the master awarded damages to Atlantic based on a theory of unjust enrichment, and because the master made this alternate finding of liability from which Lewis did not appeal, the two-issue rule bars us from considering Lewis's arguments regarding negligent misrepresentation and breach of contract.

In the Chief Justice's view, applying the two-issue rule to this case is an "over-zealous application" of our long-standing error preservation rules because she does not believe the rule's application is clear. We certainly share her concerns about a hypertechnical application of a procedural bar to appellate arguments, *but error preservation has been a critical part of appellate practice in this State for a long time, serving to ensure, as noted by the Chief Justice, that we do not reach issues which were not ruled upon by the trial court. We therefore agree that we are not precluded from finding an issue unpreserved even when the parties themselves do not argue error preservation to us.* In fact, a rule which would permit such an "appeal by consent" is contrary to the very core of our preservation requirement

....

Nevertheless, *these rules must also be applied consistently and not selectively. If our review of the record establishes that an issue is not preserved, then we should not reach it.* This is so regardless, to use the Chief Justice's terms, of the "life-blood litigant or criminal defendant" before us. However, *this is not a "gotcha" game aimed at embarrassing attorneys or harming litigants, but rather is an adherence to settled principles that serve an important function.* While it may

be good practice for us to reach the merits of an issue when error preservation is doubtful, *we should follow our longstanding precedent and resolve the issue on preservation grounds when it clearly is unpreserved.* Here, we do not believe the existence of this procedural bar is questionable and would place no weight on the fact that neither the parties nor the court of appeals raised it. Therefore, the two-issue rule precludes our consideration of Lewis's arguments.

398 S.C. at 329-30, 730 S.E.2d at 285 (emphasis added).

Contrary to the view endorsed by the Subject Decision, the majority in *Atlantic Coast Builders* did not at all “caution[]” that preservation rules are not a “gotcha game;” rather, it made clear that these rules are not trivial, that they should not be looked at as a mere “gotcha game,” “but rather . . . [as] settled principles that serve an important function” that should consistently be applied by the appellate court where they applicable—even in cases (unlike the instant case) where they were not raised by the parties themselves.

D. The Subject Decision is irreconcilable with South Carolina precedent placing the burden on the appellant to demonstrate reversible error.

Respectfully, reading *Atlantic Coast Builders* in the context provided above shows that the language cited by the Court in the Subject Decision about it perhaps being good practice to reach the merits of an issue/argument when preservation is “doubtful” is at best *dicta*. Even assuming, *arguendo*, the Subject Opinion is correct in finding that Appellant's argument was neither clearly preserved nor

clearly unpreserved, the Court's decision to reach the merits in such a situation is nonetheless irreconcilable with established precedent according presumptive validity to an appealed order and placing an affirmative burden on the appellant to preserve and present sufficient appellate argument to demonstrate reversible error. *See, e.g., Watson v. Underwood*, 407 S.C. 443, 452, 756 S.E.2d 155, 160, n. 9 (Ct. App. 2014) (“[A]ppellants have the responsibility to identify errors on appeal, not the [c]ourt.” “[A]ppellate courts in this state, like well-behaved children, do not speak unless spoken to and do not answer questions they are not asked.”) (citations omitted); *McCall v. IKON*, 380 S.C. 649, 659-60, 670 S.E.2d 695, 701 (Ct. App. 2008) (noting an appealed order comes to the appellate court with a presumption of correctness, with the burden on the appellant to demonstrate reversible error);

II. The Subject Decision is also erroneous on the merits.

A. The circuit court correctly concluded Appellant's claims are time-barred under § 15-3-545(A).

The Court overlooked/misapprehended the premise of Appellant's argument about the supposed “cumulative effect” of ECT treatments. (*See* Appellant's Br. p. 6 (“The issue is not whether use of [ECT] is negligent from the first treatment but at what point . . . does use of [ECT] constitute negligence[,]” nonetheless, “[she] contends that the *cumulative effect* of these [ECT] treatments constituted an independent tort”) (emphasis added).) This idea of divorcing cumulative

effect from causative origin is not only illogical but also contrary to § 15-3-545(A).⁷

The Court overlooked/misapprehended Appellant's conflation of the date of accrual of a cause of action⁸ with the date of occurrence under § 15-3-545(A). As observed in *Langley v. Pierce*, however, in effecting the economic balance struck by the legislative body, "[s]tatutes of repose by their nature impose on some plaintiffs the hardship of having a claim extinguished before it is discovered, or perhaps before it even exists.") 313 S.C. 401, 404, 438 S.E.2d 243, 244 (1993) (emphasis added) (citation omitted).

Moreover, in *Harrison v. Bevilacqua*, our Supreme Court "declin[ed] to adopt the continuous treatment rule or the doctrine of continuing tort." 354 S.C. 129, 141, 580 S.E.2d 109, 115 (2003). Quoting its prior decision in *Preer v. Mims*,

⁷ In pertinent part, § 15-3-545(A) provides as follows:

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 as defined in Article 5, Chapter 79, Title 38 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.

⁸ See *Bergstrom v. Palmetto Health Alliance*, 358 S.C. 388, 397, 596 S.E.2d 42, 46 (2004) ("A cause of action accrues at the moment when the plaintiff has a legal right to sue on it.") (citation omitted).

the *Harrison* Court first summarized the “continuous treatment rule” as follows:

“The so-called ‘continuous treatment’ rule as generally formulated is that if 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.”

Id. at 135, 580 S.E.2d at 112 (quoting *Preer*, 323 S.C. 516, 519, 476 S.E.2d 472, 473 (1996)).

The *Harrison* Court went on to explain that—withstanding numerous policy considerations supporting adoption of the rule—“the continuous treatment rule should not be judicially adopted,” because, “[p]ut simply, . . . judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set via the statutes discussed above⁹.” *Id.* at 136-38, 580 S.E.2d at 112-13; *see also Epstein v. Brown*, 363 S.C. 372, 378, 610 S.E.2d 816, 819 (2005) (“Notwithstanding the very legitimate policy rationales in favor of

⁹ Among “the statutes discussed above,” was, of course, the medical malpractice statute of repose in § 15-3-545(A). *Id.* at 137-38, 580 S.E.2d at 113 (explaining, “[t]he primary argument against adoption of the continuous treatment rule is that it offends the clear policy set by the Legislature in its adoption of statutes of limitations and statutes of repose,” then expressly citing the repose provision in § 15-3-545(A) and noting the “economic balance struck by the legislative body” in enacting such a statute of repose) (citations omitted).

adoption of a continuous treatment rule, we declined to adopt it, finding the Legislature has set absolute time restrictions for the bringing of medical malpractice actions in the statutes of repose both for medical malpractice and for persons operating under disability”) (citing *Harrison*, 354 S.C. at 136-37, 580 S.E.2d at 113).

The *Harrison* Court then addressed—and rejected—Harrison’s additional argument that it should adopt the “continuing tort doctrine.” *Id.* at 139, 580 S.E.2d at 114 (“Citing Georgia law, petitioner also argues the Court should adopt the continuing tort doctrine. We disagree.”). It explained,

Under Georgia law, the doctrine of continuing tort:

applies “where any negligent or tortious act is of a continuing nature and produces injury in varying degrees over a period of time.” . . . Under this theory, the statute of limitation does not begin to run “until such time as the continued tortious act producing injury is eliminated.”

Id. (quoting *Mears v. Gulfstream Aerospace Corp.*, 225 Ga. App. 636, 484 S.E.2d 659, 664 (Ct. App. 1997) (citations omitted)).

Having explained the continuing tort theory, the *Harrison* Court explained that, in Georgia, “the ‘continuing tort’ theory is inapplicable to actions for medical malpractice ‘since it would nullify the intent of the [Georgia] General Assembly that, after five years, no medical malpractice action could be brought . . . because

the statute of repose abolishes any action five years after the negligent or wrongful act or omission.” *Id.* (quoting *Charter Peachford Behavioral Health Sys. v. Kohout*, 233 Ga. App. 452, 504 S.E.2d 514, 521 (Ct. App. 1998)). “Thus,” the *Harrison* Court concluded, “for the same reason we reject adoption of the *continuous treatment rule*, Georgia has rejected application of its own *continuous tort theory* to medical malpractice claims. Accordingly, we find [Harrison’s] argument on the *continuing tort doctrine* unavailing.” *Id.* (emphasis added).

Appellant’s claims, which arise out of a course of treatment initiated by 2003 but were not pursued via legal action until more than six years thereafter, are barred by the medical malpractice statute of repose in §15-3-545(A). Her argument to the contrary is incompatible with that statute (more specifically—and most importantly—the legislative intent reflected thereby¹⁰), while the circuit court’s analysis faithfully adheres to the overriding responsibility of ascertaining and effectuating the legislature’s intent.

¹⁰ Of course, “[i]t is well-established that ‘[t]he cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature.’” *Grier v. AMISUB of S.C., Inc.*, 397 S.C. 532, 535, 725 S.E.2d 693, 696 (2012) (quoting *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)). And, with respect to statutes of repose, our Supreme Court has recognized that they are “typically an *absolute time limit* beyond which liability no longer exists and 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 244 (emphasis in original).

B. Alternatively, the Court should hold this case in abeyance pending the Supreme Court's decision in *Marshall v. Dodds*.

Assuming, *arguendo*, it is proper for the Court to address the merits (i.e., assuming, *arguendo*, that this appeal should not be decided (in favor of Respondents) on preservation grounds), because the Subject Decision relied on *Marshall v. Dodds*, 417 S.C. 196, 789 S.E.2d 88 (Ct. App. 2016), and that case is, as the Court recognized in the Subject Decision, presently before the Supreme Court on writ of certiorari granted August 23, 2017, the Court should hold this appeal in abeyance pending the Supreme Court's forthcoming decision in *Marshall*.

**INCORPORATION AND REITERATION
OF ARGUMENT/ANALYSIS IN DR. ROBERTS'S BRIEF**

As a general matter, Dr. Roberts incorporates the argument/analysis presented in his previously submitted appellate brief by reference herein and, thereby, reiterates the same and asks that the Court consider it along with the particular points above stated in support of this petition for rehearing.

**ADOPTION OF ARGUMENT/ANALYSIS
IN MUSC'S PETITION FOR REHEARING**

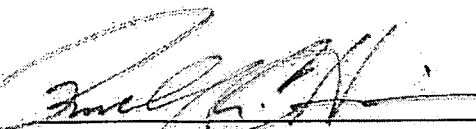
To the extent that it supports the grant of the relief sought in this petition, Dr. Roberts hereby joins in and adopts as his own the argument/analysis presented by MUSC in support of its separately filed petition for rehearing.

CONCLUSION

For the foregoing reasons, Dr. Roberts asks this Honorable Court to grant this petition; rehear this matter (again, en banc, it is suggested); withdraw the Subject Opinion; and decide this appeal anew, affirming the trial court's summary judgment in his favor.

Respectfully submitted,

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Dated: 3/8/18

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Clair Craver Johnson, Appellant,

v.

John Roberts, M.D., Respondent.

And

Clair Craver Johnson, Appellant,

v.

Medical University of South Carolina, Respondent.

Appellate Case No. 2015-001463

Appeal From Charleston County
R. Markley Dennis, Jr., Circuit Court Judge

Opinion No. 5535
Heard September 20, 2017 – Filed February 7, 2018

REVERSED

Jonathan Blake Asbill, of Baker Ravenel & Bender, LLP
and Bradley Lewis Lanford, of The Law Office of
Kenneth E. Berger, LLC, both of Columbia for
Appellant.

Donald Jay Davis, Jr., Stephen Lynwood Brown, James
Edward Scott, IV, and Russell Grainger Hines, all of

Exhibit A

Young Clement Rivers of Charleston for Respondent
John Roberts, M.D.

William Peele Early, of Pierce, Hems, Sloan & Wilson,
LLC, of Charleston, for Respondent Medical University
of South Carolina.

LOCKEMY, C.J.: In this action Clair Craver Johnson appeals the circuit court's entry of summary judgment in favor of John Roberts, M.D. and the Medical University of South Carolina (MUSC) (collectively Respondents). Johnson asserts the circuit court erred in finding her claims were time barred by the statute of repose applicable to medical malpractice claims. We reverse.

Johnson suffers from bi-polar disorder and depression. In 1997 she experienced severe mania, which required hospitalization. Dr. Roberts, a licensed psychiatrist, began treating Johnson at that time.

Johnson experienced several episodes of mania between 1997 until November 2003. On November 26, 2003, Johnson's doctors admitted her to MUSC, and on December 10, 2003, they began treating her with electroconvulsive therapy (ECT).¹ Between December 10, 2003 and June 26, 2008, Johnson's doctors treated her with ECT on eighty-six separate occasions. According to Johnson, she sustained serious permanent cognitive damage as a result of the ECT.

Johnson, proceeding pro se, filed a Notice of Intent to File Suit against MUSC on June 25, 2010. She alleged "due to having ECT . . . for an extended period of time between 2003 and 2008 [I] am now left with cognitive impairment and memory loss." Johnson also requested an extension to file an expert affidavit because "I am informed and have a good faith belief that the statute of limitation on my cause of action in this matter (absent a discovery exception) will expire within the next 10 days from the date my Notice of Intent to File Suit is filed." On August 20, 2010,

¹ "Electroconvulsive therapy is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses." Mayo Clinic Staff, Electroconvulsive Therapy (ECT), Mayo Clinic (May 9, 2017), <http://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/basics/definition/prc-20014161>.

Exhibit A

Johnson filed a Stipulation of Dismissal without Prejudice of her Notice of Intent to Sue.

On November 16, 2011, Johnson filed a complaint against MUSC, asserting medical malpractice claims resulting from her ECT treatments. Johnson claimed, "[d]uring, after and a direct and proximate result of this extensive and involuntary ECT treatment, [she] lacked the mental capacity to understand and appreciate the detrimental effect the ECT had upon her until 2010" Johnson also filed an affidavit from Harold J. Burstztajn, M.D., corroborating her claims that she was incapacitated as a result of the ECT until 2010. On May 16, 2012, Johnson filed an Amended Complaint against Dr. Roberts for damages resulting from the ECT treatments.

Following discovery, Respondents filed motions for summary judgment alleging Johnson's claims were barred by the statute of limitations and the statute of repose. Dr. Roberts contended the first act of negligence would have occurred between 2002 and 2003, meaning the statute of repose would bar any claims filed after 2009. MUSC also asserted, "Plaintiff's complaint against MUSC having arisen out of ECT treatment initiated in 2003 is time barred."

The circuit court held a hearing on Respondents' motions and later issued its order granting Respondents' summary judgment, finding Johnson's claims were time-barred by the statute of repose. Johnson filed a motion for reconsideration pursuant to Rule 59(e). The circuit court denied the motion. This appeal followed.

LAW

"An appellate court reviews a grant of summary judgment under the same standard applied by the [circuit] court pursuant to Rule 56, SCRPC." *Lanham v. Blue Cross & Blue Shield of S.C., Inc.*, 349 S.C. 356, 361, 563 S.E.2d 331, 333 (2002). A circuit court should grant a motion for summary judgment when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law." Rule 56(c), SCRPC.

South Carolina law requires claims for medical malpractice be filed 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" S.C. Code Ann. § 15-3-545(A) (Supp. 2017). Section 15-3-545(A) creates a six-year statute of repose, beyond which a patient

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cannot sue their medical provider for malpractice. *Id.*, see also *Kerr v. Richland Mem. Hosp.*, 383 S.C. 146, 148, 678 S.E.2d 809, 810 (2009) ("Accordingly, the statute of repose provision within section 15-35-545(A) applies as an absolute limit applicable in *any* medical malpractice action."). "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, 866 (4th Cir.1989)).

ANALYSIS

Initially, we note Respondents assert the arguments Appellant presents to this court are different from the arguments presented to the circuit court and Appellant has not appealed the circuit court's ruling on the previous argument. We disagree.

During the circuit court's hearing on Respondents' motions for summary judgment, Appellant asserted she "received [ECT] eighty-six times over a several years period of time – 2003 to 2008. Each time she received that, it was a blow to her head, a tort." Appellant conceded the "continuous treatment rule" was unavailable to her, but she argued "each of these is an individual to[rt]." The circuit court found

Plaintiff's medical records indicate ECT was commenced on December 20, 2003. For purposes of the statute of repose, such allegations constitute an occurrence beginning as early as the commencement of treatment in 2003. . . . 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 § 15-3-545.²

In her briefing to this court, Appellant's statement of issue on appeal was

The lower court erred by concluding that the trigger date for computing the running of the six[-]year statute of repose and the three[-]year statute of limitation as

² Judge Dennis made the same finding as to Dr. Roberts.

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December 10, 2003, the date of the first of eighty-six [ECT] treatments ending on June 26, 2008, the date of the eighty-sixth such treatment, the error being that [ECT] did not cause identifiable injury to appellant until no earlier than 2009-2010 thereby triggering a three-year period in which to initiate a claim pursuant to S.C. Code Ann. § 15-545(A).

Our supreme court has cautioned that issue preservation "is not a 'gotcha' game aimed at embarrassing attorneys or harming litigants." *Atl. Coast Builders & Contractors, LLC v. Lewis*, 398 S.C. 323, 329, 730 S.E.2d 282, 285 (2012). "While it may be good practice for us to reach the merits of an issue when error preservation is doubtful, we should follow our longstanding precedent and resolve the issue on preservation grounds when it *clearly* is unpreserved." *Id.* at 330, 730 S.E.2d at 285 (emphasis added). The factual theory Appellant presented to the circuit court is not identical to the factual theory she argues here. But Appellant's statement of issues on appeal is broad enough to encompass the argument she presents to this court, and the circuit court's ruling makes clear the judge's belief that the date of occurrence in this case was the first date of treatment. Appellant asserts in her brief she is "not [seeking] the application of [the continuous treatment] rule to her facts Johnson contends that *her claim arose . . . certainly [within] the six year statute of repose.*"

It cannot be said that Appellant's arguments are clearly preserved. But in light of the foregoing, it also cannot be said that Johnson's arguments are clearly unpreserved. In these situations, "where the question of issue preservation is subject to multiple interpretations, any doubt should be resolved in favor of preservation." *Id.* at 333, 730 S.E.2d at 287 (Toal, C.J., concurring in result in part and dissenting in part). Therefore, we find Appellant has preserved her arguments to this court, and has adequately appealed the circuit court's order.

In *Marshall v. Dodds*, this court confronted the issue of whether the medical malpractice statute of repose bars subsequent acts of negligence in the course of a prolonged medical treatment. 417 S.C. 196, 789 S.E.2d 88 (Ct. App. 2016), *cert. granted*, August 23, 2017. Virginia Marshall was diagnosed with a rare form of blood cancer while she was under the care of two physicians. *Id.* at 199, 789 S.E.2d at 89. She initially began seeing the two doctors in 2000 and 2004, but neither noticed signs in her blood and urine tests which indicated the presence of cancer. *Id.* In 2011, after her diagnosis, she sued her doctors, alleging they

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committed malpractice by not discovering her cancer sooner. *Id.* at 200, 789 S.E.2d at 90. The circuit court found the claims were time barred "because the statute of repose began to run after the first alleged misdiagnoses" *Id.* at 202, 789 S.E.2d at 90. "[T]he court reasoned . . . [any] subsequent misdiagnoses were merely a continuation of the first misdiagnoses, not distinct acts of negligence that could serve as new trigger points for the statute of repose." *Id.*

This court reversed. The court found if a plaintiff alleges a "misdiagnosis or failure to diagnose a condition within the six-year period—which an expert witness opines to be a breach of the physician's duty of care—the statute of repose does not bar the cause of action merely because the physician previously misdiagnosed the condition outside the repose period." *Id.* at 205, 789 S.E.2d at 92. The court found the plaintiffs alleged specific dates and appointments within the statute of repose when Marshall's doctors failed to diagnose her with cancer. *Id.* at 205-06, 789 S.E.2d at 93-94. Accordingly, the court found Marshall's claims for medical malpractice for alleged negligent acts which occurred within the six-year statute of repose would not be time barred. *Id.* at 206, 789 S.E.2d at 93.

The *Marshall* court found this analysis to be consistent with our supreme court's decision in *Harrison v. Bevilacqua*, 354 S.C. 129, 580 S.E.2d 109 (2003). In *Harrison*, the court declined to adopt the continuous-treatment rule which would toll the statute of repose until the termination of a patient's treatment. *Id.* at 138, 580 S.E.2d at 114. The plaintiff in *Harrison* was a diagnosed schizophrenic that was involuntarily committed to the care and treatment of the Department of Mental Health (the Department) in 1982. *Id.* at 132, 580 S.E.2d at 111. He remained in the Department's care through 1995, when he was discharged. *Id.* He was appointed a guardian ad litem in 1994 that successfully petitioned for his release, and subsequently filed a complaint alleging the Department should have discharged him as early as 1983. *Id.* The circuit court determined Harrison would only be allowed to present evidence of acts of negligence that occurred within the five-year statute of repose contained within the Tort Claims Act. *Id.* at 134, 580 S.E.2d at 111-12. A jury returned a verdict in favor of Harrison, but for only \$1 in damages. *Id.* at 133, 580 S.E.2d at 111. Harrison then appealed the circuit court's decision, arguing the court should adopt the continuous treatment rule, meaning the statute of repose would have begun running after his discharge. *Id.* The *Harrison* court disagreed and found the continuous treatment rule would conflict with the General Assembly's objective to limit liability for medical malpractice cases. *Id.* at 138, 580 S.E.2d at 114.

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Our court in *Marshall* noted, "[o]ur interpretation . . . is entirely consistent with *Harrison* because we are not suggesting the statute of repose is tolled until the termination of the physician's course of treatment." 417 S.C. at 208, 789 S.E.2d at 94. Rather, "we hold the statute begins to run at the time of a medical professional's alleged negligent act or omission for which the plaintiff seeks to impose liability without regard to when the course of treatment ended." *Id.*

The allegations in this case are indistinguishable from *Marshall*. Appellant asserts she has been harmed as a result of treatment she received within the six-year statute of repose. Because there is evidence that her injury occurred as a result of treatment within the six years prior to her lawsuit, the circuit court erred in finding as a matter of law her claim is barred by the statute of repose.

CONCLUSION

Accordingly, the circuit court's order is

REVERSED.

HUFF and HILL, JJ., concur.

Exhibit A

**THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS**

Appeal from Charleston County
Court of Common Pleas
R. Markley Dennis, Jr., Circuit Court Judge

Appellate Case No. 2015-001463
Circuit Court Case Nos. 2012-CP-10-2867 and 2011-CP-10-8313

Clair Craver Johnson,	v.	Appellant,
John Roberts, M.D.,		Respondent.
And		

Clair Craver Johnson,	v.	Appellant,
Medical University of South Carolina,		Respondent.

**MEDICAL UNIVERSITY OF SOUTH CAROLINA PETITION FOR REHEARING
WITH SUGGESTION FOR REHEARING *EN BANC***

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NOW COMES Respondent Medical University of South Carolina (“MUSC”), by and through the undersigned counsel, petitioning the Court of Appeals for a rehearing pursuant to Rule 221, SCACR, and a reconsideration of this matter, which the Court of Appeals decided via opinion filed on February 7, 2018 (the “Subject Opinion”), reversing the Circuit Court’s grant of summary judgment in favor of the Respondent MUSC, as well as the other Respondent John Roberts, M.D.

SUGGESTION FOR REHEARING *EN BANC*

Pursuant to Rule 219(b), SCACR, Respondent submits that the question addressed in the Subject Opinion—concerning the operation of the statute of repose for medical malpractice claims, S.C. Code Ann. § 15-3-545(A), specifically its operation with respect to the continuous treatment rule, is of exceptional importance to the bench and bar, and, in turn, the public, and therefore suggests a rehearing *en banc*. The full Court may also wish to address the error preservation questions presented by this appeal.

**MATERIAL POINTS
OVERLOOKED OR MISAPPREHENDED**

Most respectfully, the Subject Opinion reflects that the Court overlooked or misapprehended the following material points.

Plaintiff-Appellant Clair Craver Johnson’s Complaint alleges damages arising from her treatment at MUSC by way of electroconvulsive therapy (“ECT”). That treatment started at MUSC on December 10, 2003 and continued until June 26, 2008. Johnson did not bring an action against MUSC until November 16, 2011, nearly eight years after her allegedly negligent treatment at MUSC began.¹

¹ Johnson earlier filed a Notice of Intent to File Suit on June 25, 2010 without the requisite expert affidavit. S.C. Code Ann. §§ 15-79-125 and 15-36-100. When she could not obtain the requisite expert affidavit in a timely fashion, the Notice of Intent was dismissed.

I. APPELLANT JOHNSON'S ARGUMENT ON APPEAL WAS NOT PRESERVED AT THE TRIAL COURT LEVEL.

To defeat the statute of repose bar, Johnson asserts for the first time on appeal that an issue of fact exists as to when and whether the use of ECT caused her permanent mental injuries. Appellant Johnson's Brief at Page 8. This argument was not raised before the trial court, and cannot now be raised for the first time on appeal.

It is well-settled that an issue not raised and ruled upon cannot be raised for the first time on appeal. Elam v. S. Carolina Dep't of Transp., 361 S.C. 9, 23, 602 S.E.2d 772, 779-80 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."). Johnson's argument before the lower court centered solely on the tolling provisions of the disability statute. January 9, 2014 Hearing Transcript, R. pp. 197-205. Specifically, relying on S.C. Code § 15-3-40, Johnson maintained the time period within which to file suit was tolled from 2003 until 2010 during which "her capacity to comprehend what was going on in her life" was diminished by her ECT and underlying mental illness. Johnson's Memorandum in Opposition to Summary Judgment, R. pp. 112-113.

On appeal, Johnson pivoted to arguing that the "occurrence" that triggered the running of the statute of repose was some date other than her first ECT treatment in December of 2003. Appellant Johnson's Brief, Page 7.

Respectfully, the Court in the Subject Opinion chose to reverse the trial court on an issue that Johnson never raised or argued before the trial court, namely that the occurrence that triggered the statute of repose was not the initial ECT treatment in 2003, but rather could be continued to a later date. This was not an argument made by Johnson before the trial court. Rather, Johnson repeatedly argued that the disability statute somehow tolled the statute of repose, an argument directly refuted by the language of S.C. Code Ann. § 15-3-545 and Harrison v. Bevilacqua, 354

S.C. 129, 138, 580 S.E.2d 109, 114 (2003) (quoting Langley v. Pierce, 313 S.C. 401, 403, 438 S.E.2d 242, 243 (1993)).

It is not the Court of Appeals' role to identify issues on the record that were never raised by an appellant. See Jinks v. Richland County, 355 S.C. 341, 344, 585 S.E.2d 281, 283, n. 3 (2003) (an issue which is not argued in the brief is deemed abandoned and precludes consideration on appeal); Watson v. Underwood, 407 S.C. 443, 452, 756 S.E.2d 155, 160, n. 9 (Ct.App. 2014) (“‘[A]ppellants have the responsibility to identify errors on appeal, not the [c]ourt.’ ‘[A]ppellate courts in this state, like well-behaved children, do not speak unless spoken to and do not answer questions they are not asked.’”) (citations omitted); McCall v. IKON, 380 S.C. 649, 659-60, 670 S.E.2d 695, 701 (Ct.App. 2008) (noting an appealed order comes to the appellate court with a presumption of correctness, with the burden on the appellant to demonstrate reversible error); (First Union Nat'l Bank of S.C. v. Soden, 333 S.C. 554, 566, 511 S.E.2d 372, 378 (Ct.App. 1998) (holding an “unchallenged ruling, right or wrong, is the law of the case and requires affirmance”); Cont'l Ins. Co. v. Shives, 328 S.C. 470, 474, 492 S.E.2d 808, 811, n. 2 (Ct. App. 1997) (an issue not raised in the appellant's principal brief may not be raised via a reply brief); Rule 208(b)(1)(B), SCACR (“Ordinarily, no point will be considered which is not set forth in the statement of the issues on appeal.”).

Because Johnson failed to argue before the trial court that the “occurrence” that triggered the statute of repose was something other than the initial ECT treatment in 2003, the argument is barred from this Court's consideration for lack of preservation. See Wilder Corp. v. Wilke, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998) (“It is axiomatic that an issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review.”).

II. **THE MEDICAL MALPRACTICE STATUTE OF REPOSE, S.C. CODE ANN. § 15-3-545, CANNOT BE EXTENDED BY THE CONTINUOUS TREATMENT RULE OR THE CONTINUING TORT DOCTRINE AND BARS PLAINTIFF'S CLAIMS.**

A. **AS A MATTER OF LAW, THE STATUTE OF REPOSE CANNOT BE TOLLED BY A CONTINUOUS TORT.**

The General Assembly has enacted a three-year statute of limitations and a six-year statute of repose for medical malpractice actions:

[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(A) (emphasis added).

Subsection (D) of 15-3-545 provides a limited tolling provision, applicable only to minors. Inclusion 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 is inapplicable to the current matter. Harrison, 580 S.E.2d at 114 (quoting Langley, 438 S.E.2d at 243). As stated by the Supreme Court in Johnson “a statute of repose is typically an **absolute time limit beyond which liability no longer exists and is not tolled for any reason** because to do so would upset the economic balance struck by the legislative body.” Id. at 113-14 (quoting Langley, 438 S.E.2d at 243) (emphasis added in Harrison).

Thus, any disabilities other than minority, which is explicitly added by Section 15-3-545(D), including “insanity” as argued by Johnson, cannot toll the statute of repose as a matter of law. Johnson’s sole argument before the trial court and on appeal was that the statute of repose was tolled by Johnson’s insanity. Since this is wrong as a matter of law, the trial court should be affirmed solely on this grounds.

“A statute of repose creates a substantive right in those protected to be free from liability after a legislatively determined period of time.” Capco of Summerville, Inc., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006) (citing Langley, 438 S.E.2d at 243). “A statute of repose is typically an absolute time limit beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body.” Id. (citing Langley, 438 S.E.2d at 243). Thus, “[s]tatutes of repose by their nature impose on some plaintiffs the hardship of having a claim extinguished before it is discovered, or perhaps before it even exists.” Columbia/CSA-HS Greater Columbia Healthcare Sys., LP, 411 S.C. 557, 560-61, 769 S.E.2d 847, 848-49 (2015) (quoting Camacho v. Todd & Leiser Homes, 706 N.W.2d 49, 54 n. 6 (Minn. 2005)).

Interpreting the plain and unambiguous language of 15-3-545(A), the legislature clearly intended the repose provision to set a hard time limit for filing a claim based upon the act or omission of the defendant, in this case MUSC. That time limit may only be tolled by a person’s minority. It cannot be tolled by any court constructed rules, including the discovery rule, or other disabilities, including “insanity” as set forth in S.C. Code Ann. § 15-3-40(2).

In her Appellate Brief, Johnson attempts to incorporate the discovery rule into the statute of repose by claiming, without any evidentiary support, that Johnson’s injuries were not discovered until later. Appellant Johnson’s Brief, Page 7 (“A fact issue over when electroconvulsive therapy could have been found to have caused permanent brain damage is present and requires action by a jury. Appellant is entitled to a reasonable time from the date the loss was discoverable to initiate suit.”). This argument is contradicted by the plain language of Section 15-3-545(A), which allows for no tolling of the statute of repose by discovery or anything else, other than minority.

Similarly, the trigger date for the statute of repose is an “occurrence,” not when a full-blown claim with damages arose. Thus, in O’Tuel v. Villani, 318 S.C. 24, 27, 455 S.E.2d 698,

700 (Ct.App. 1995), overruled on other grounds by I'On, LLC v. Town of Mt. Pleasant, 338 S.C. 406, 423 & n. 12, 526 S.E.2d 716, 725 & n. 12 (2000), the Court of Appeals held that the "occurrence" that triggered the statute of repose was the date of a child's birth, when a physician allegedly failed to perform a cesarean delivery, not seven years later when the parents discovered the child had learning disabilities. 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).

Because Johnson's claims arise out of her ECT treatment, the trigger date or "occurrence" for the statute of repose is the date of her ECT treatment. The trigger date is not when a claim accrues, as Johnson argues, but when there is an "occurrence," that is an action or delict by the defendant that possibly leads to a claim.

Moreover, pursuant to Harrison, 580 S.E.2d at 114, the medical malpractice statute of repose cannot be extended by either the continuous treatment rule or the continuing tort rule. Thus, the trigger date for Johnson was the date of her first treatment on December 3, 2003. It is from this date that the absolute outer limit of the six year repose provision established by the legislature was set to run. Thus, Johnson was required to bring the instant action no later December 3, 2009, six years from the date of the onset of treatment.

The Subject Opinion distinguishes the Supreme Court's holding in Harrison based on the reasoning in Marshall v. Dodds, 417 S.C. 196, 209, 789 S.E.2d 88, 94 (Ct.App. 2016), cert. granted, wherein the Court reversed the trial court, holding the trial court had "erred in finding the statute of repose for medical malpractice actions begins to run after a medical professional's first alleged misdiagnosis."

Respectfully, Marshall was incorrectly decided and does not support affirmance here. This conclusion is, in part, supported by the fact that the Supreme Court has granted certiorari to review the Marshall opinion, although it has not reached a ruling as of this filing. If the Marshall opinion is overturned by the Supreme Court, then the reasoning for the Court's ruling in this matter would be completely undermined and would clearly justify affirmance of the trial court's ruling. This basis alone justifies a reconsideration of the Subject Opinion.²

The Marshall opinion and the Subject Opinion overlook and misapprehend the import of the Supreme Court's rejection of the continuing tort rule in Harrison. In Harrison, the Supreme Court rejected not only the continuous treatment rule but also the continuing tort rule. Both the Marshall opinion and the Subject Opinion ignored this holding. The continuing tort rule is not merely another name for the continuous treatment rule. Rather, the continuing tort rule is a separate concept, which the Harrison Court separately addressed and separately rejected. Harrison, 580 S.E.2d at 114 ("Citing Georgia law, petitioner also argues the Court should adopt the continuing tort doctrine. We disagree.").

The Harrison opinion began its discussion of the continuing tort rule explaining:

Under Georgia law, the doctrine of continuing tort:

applies "where any negligent or tortious act is of a continuing nature and produces injury in varying degrees over a period of time."... Under this theory, the statute of limitation does not begin to run "until such time as the continued tortious act producing injury is eliminated."

Id. (quoting Mears v. Gulfstream Aerospace Corp., 225 Ga. App. 636, 484 S.E.2d 659, 664 (Ct.App. 1997)) (citations omitted).

² MUSC would join in Respondent Roberts' suggestion that, if the Court is not inclined to reconsider this matter, it should at least hold it in abeyance pending the Supreme Court's decision in Marshall v. Dodds.

The Harrison Court then observed that under Georgia law “the ‘continuing tort’ theory is inapplicable to actions for medical malpractice ‘since it would nullify the intent of the [Georgia] General Assembly that, after five years, no medical malpractice action could be brought, even when a disability attaches to toll the running of the statute because the statute of repose abolishes any action five years after the negligent or wrongful act or omission.’” Id. (quoting Charter Peachford Behavioral Health Sys. v. Kohout, 233 Ga. App. 452, 504 S.E.2d 514, 521 (Ct.App. 1998)). The Harrison Court concluded:

for the same reason we reject adoption of the continuous treatment rule,³ Georgia has rejected application of its own continuous tort theory to medical malpractice claims. Accordingly, we find [the petitioner’s] argument on the continuing tort doctrine unavailing.

Id.

In declining to adopt the continuing tort rule, our Supreme Court expressly endorsed and, indeed, employed the very “same reason[ing]” as that underlying Georgia’s rejection of the continuing tort rule in the particular context of medical malpractice actions - again, the reason being that applying the rule in this context would nullify the legislative intent that the statute of repose abolishes any action with the passage of the prescribed number of years after the negligent or wrongful act or omission. Id. at 114. As stated by the Georgia Court of Appeals, “although the focus of a statute of repose is generally the date of the alleged negligent act, a later negligence 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, 302 Ga.App. 477, 479, 691 S.E.2d 564, 566 (2010).

³ The Harrison Court had already rejected adoption of the continuous treatment rule on the grounds it conflicted with legislative intent: “Put simply . . . judicial adoption of the continuous treatment rule would run afoul of the absolute limitations policy the Legislature has clearly set via the statutes discussed above.” Harrison, 580 S.E.2d at 114; see also id. at 113 (including the medical malpractice statute of repose in § 15-3-545(A) among “the statutes discussed above”).

With its rejection of the continuing tort rule, Harrison therefore stands for the following proposition, unaccounted for in Marshall and the Subject Opinion: When any negligent act is of a continuing nature - that is to say, when, under appropriate circumstances, the law regards certain negligent conduct, even though continuing, as legally indistinct and indivisible, which may be the case even if injury is produced in varying degrees over a period of time - the statute of repose for all claims arising out of such an act begins to run right away, i.e., when it first occurs. To hold otherwise would frustrate the legislative intent behind the statute of repose.

By the same token, MUSC's allegedly negligent treatment of Johnson occurred on a continuous basis from 2003 to 2008. Under the ruling in Harrison, it cannot and should not be viewed as a separate and distinct chain of torts, but rather as a single continuous tort. Moreover, since that single continuous tort allegedly started in 2003, the statute of repose deadline for Johnson passed in 2009, utterly extinguishing any claim she might have against MUSC at that time.

B. ACCORDING TO HER OWN EXPERT, JOHNSON'S CLAIMS ARISE OUT OF HER INITIAL TREATMENT IN 2003 AND THE INDIVISIBLE CONTINUATION OF THAT TREATMENT, WHICH CANNOT TOLL THE STATUTE OF REPOSE.

Johnson's expert, Harold J. Burstztajn, M.D., has testified that the Defendants' alleged deviation from the standard of care arose primarily from an alleged failure to obtain informed consent and an initial failure to consider alternatives. Although Dr. Burstztajn also references certain purported failures during the course of Johnson's treatment, these are all inextricably intertwined with the failures occurring at the start of her treatment and are a continuation of same:

Q. All right. Are you going to render an opinion in this case that the involuntary or the decision by the decision makers to use involuntary Electroconvulsive Therapy beginning in December of 2003 in and of itself was a deviation from the standard of care?

A. Relative to the lack of informed consent and the failure to explore alternatives prior to instituting such a process, yes.

Q. All right. Is it in and of itself a deviation from the standard of care to

involuntarily give someone Electroconvulsive Therapy?

A. Not by itself.

Q. Okay. And in this case, what makes that a deviation from the standard of care, that decision -- let me preface my question -- that decision to give the plaintiff in this case involuntary Electroconvulsive Therapy?

A. The failure to do an adequate evaluation or alternatives, the failure to institute treatments to restore the patient to competency, continuing to proceed with Electroconvulsive Therapy without adequate, an adequate informed consent process, an adequate process of monitoring and re-evaluation.

Q. Anything else?

A. That is some of what -- let me just take a quick look at my original, my original notes here. Yes. Instituting Electroconvulsive Therapy in a patient who would be foreseeably vulnerable to some of the known and recognized side effects of ECT without considering alternative treatment methods and instituting alternative treatment methods which would not have had these risks; the presentation of Electroconvulsive Therapy as an inevitable choice of treatment when it wasn't; and then continuing it well beyond the generally accepted number of treatments including the use of ECT on an ongoing maintenance basis without exploring alternatives; a failure to perform an adequate assessment of decision making competence while instituting involuntary ECT; proceeding with involuntary ECT which by itself is a foreseeably traumatic process to a patient who is already feeling helpless, hopeless and worthless by reason of having a mood disorder with depressive and manic components to it; without adequately providing the patient with ongoing psychotherapy which could explore with the patient, support the patient and minimize the potentially traumatic effects of involuntary ECT; proceeding with ECT in a context of an extended ECT, in the context where there was a potential conflict of interest among the people who gave so-called substituted judgment; not exhausting reasonable medical choices prior to instituting a course of 80 plus ECT treatments from 2003 to 2008; proceeding with such a course of ECT without giving Ms. Johnson the opportunity to benefit from a comprehensive program of psychotherapy; proceeding with ECT, including long-term bilateral ECT, without sufficient monitoring of the foreseeable risk of cognitive impairment, even when Ms. Johnson was complaining about it; and then insufficient response to such impairment when it obviously was occurring. And finally, there seems to be no consideration given to the foreseeably traumatic experience of forced ECT or the terror Ms. Johnson was likely to experience under these circumstances.

Q. All right. Those are the, your opinions in this case?

A. Yes, they are.

Q. Okay. All right. Do you have a --

A. I should also add that in exploring the informed consent forms which have been signed in this case, they are absolutely inadequate relative to the kind of informed consent process for ECT, which both the hospital guidelines indicate as well as the generally accepted guidelines for ECT such as the NICE, N-I-C-E, Guidelines which are the British National Health Service Guidelines for ECT, especially given the fact that what we have here is 80 plus ECT's over a course of

almost five years.

Deposition of Burstztajn, Pages 21:18 to 25:18, R. pp. 242-43.

Dr. Burstztajn's testimony makes clear that his primary complaint with the actions of the Defendants arose from the initiation of the ECT treatment in 2003. In particular, Dr. Burstztajn's primary concern is an alleged lack of informed consent and an alleged failure to explore other options prior to initiation of the ECT treatment in 2003, well outside the statute of repose window. Dr. Burstztajn also opines that this failure to obtain informed consent and explore other options continued throughout the treatment, and that the continuation of the treatment and the cumulative effect of the treatment are also failures on the part of the Defendants. But these allegations are simply a continuation of the initial alleged failure. They are not subsequent acts of purported negligence, but rather the continuation of the initial occurrence in 2003.

In short, Dr. Burstztajn has alleged a continuing tort. As stated by Harrison, Dr. Burstztajn has alleged "negligent or tortious act is of a continuing nature and produces injury in varying degrees over a period of time." Harrison, 580 S.E.2d at 114. Because these alleged omissions are part of a continuing tort, they cannot toll the medical malpractice statute of limitations, which can only be tolled by minority. Id.

In light of the above, the Subject Opinion sets up an impossible task for the parties and any trial court or jury that might hear this case. The Court's holding, if it stands, will allow Johnson to seek compensation for her treatment in the six years leading up to the filing of the complaint but not for the injuries she suffered from actions taken more than six years before the Complaint. In other words, the Subject Opinion invites the parties to undertake the impossible task of determining what injuries Johnson suffered from "occurrences" during the six year statute of repose window, while excluding any injuries arising outside of that window. This would of course

exclude injuries arising from the alleged initial failure to provide informed consent and Defendants' alleged initial failure to explore alternative treatments in 2003. These are the very delicts that form the basis for most of Dr. Burstztajn's allegations, and they are indisputably outside of the statute of repose window.

Certainly, Dr. Burstztajn has offered no opinion whether such a division of damages would even be possible. The subsequent acts and omissions are inextricably intertwined and indivisible from the initial treatment decision. With regards to Johnson's injuries, Dr. Burstztajn's affidavit speaks exclusively in terms of an alleged on-going and indivisible injury suffered over her entire treatment period and largely arising out of her initial hospitalization in 2003, purportedly without sufficient informed consent:

[Johnson sustained] prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental-health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process.

Burstztajn Affidavit, R. p. 16.

In other words, Dr. Burstztajn has drawn no distinction between the alleged failures and damages suffered prior to November of 2005, which would be barred by the statute of repose based on the Subject Opinion, and those failures and damages suffered after November of 2005, which would not be barred by the statute of repose according to the Subject Opinion.

Put simply, there is no evidence that Johnson's claims can be divided in this matter. Johnson's alleged damages do not arise from separate, distinct events, but rather from a

continuation of the same course of treatment over a five year period. Any effort to tease apart those damages ignores the clear legislative intent behind S.C. Code Ann. § 15-3-545(A), that all medical malpractice claims must be brought within six years of the date of occurrence, and that this time limit may only be tolled by minority. S.C. Code Ann. § 15-3-545(D).

III. JOHNSON'S CLAIMS ARE ALSO BARRED BY THE STATUTE OF LIMITATIONS.

In addition to failing to address the rejection of the continuing tort rule, the Subject Opinion also does not address the trial court's ruling that Johnson is also barred by the medical malpractice statute of limitations. The circuit court correctly ruled that, even assuming the disability statute applied, Johnson's action was still barred by the limitations period established under S.C. Code Ann. § 15-3-40, which establishes tolling guidelines for disabilities.

The statute of limitations for medical malpractice actions is "three years from date of discovery or when it reasonably ought to have been discovered." S.C. Code Ann. § 15-3-545(A). Johnson testified 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. R. pp. 69-70, Deposition of Johnson, p. 68, line 9 – p. 69, line 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 loss *at the time* to ECT. R. p. 71, Deposition of Johnson, p. 81, line 20 – p. 82, line 21. Johnson's prior knowledge was again reiterated in her deposition wherein she testified 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. Suppl. R. p. 7, Deposition of Johnson, p. 124, lines 12-19.

Similarly, there are references to Appellant's memory loss from ECT date back to Appellant's divorce proceedings in 2007. Suppl. R. pp. 14-15, Life Care Plan for Clair Johnson, dated January 30, 2007 ("[Johnson] has been having increasing problems with her memory, . . .

has reportedly developed increasing problems with directionality and memory” and Johnson admitted being “afraid to drive due to increased problems with memory”). Johnson’s last ECT treatment was on June 6, 2008.

Based on this evidence, Johnson comprehended her injuries as early as 2006, and certainly no later than June of 2008. If there is no tolling, her Complaint, filed on November 16, 2011 was past the statute of limitations deadline. S.C. Code Ann. § 15-3-545(A).

Johnson relies on the disability statute, which tolls the statute of limitations for a number of reasons, including insanity. Johnson and Dr. Burstztajn assert that Johnson “did not regain the mental capacity to understand and appreciate the harm” allegedly caused by ECT until June 2010, when Johnson filed her initial Notice of Intent to File Suit. R. pp. 3-4, 16-17. Although this Notice of Intent was dismissed on August 20, 2010, R. p. 9, it establishes the outer limits of Johnson’s effort to toll the statute of limitations.

Pursuant to the disability statute, Johnson’s action may be tolled due to “insanity,” but such tolling may not extend the statute of limitations “longer than one year after the disability ceases.”

S.C. Code Ann. § 15-3-40 states:

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.**

S.C. Code Ann. § 15-3-40 (emphasis added).

It should be beyond dispute that Johnson’s insanity tolling period ended at the latest in June of 2010, when the first Notice of Intent was filed. Johnson admits this in her brief. Appellant’s

Brief, Pages 1-2. Johnson, however, ignores the one year limit created by the tolling statute. Once Johnson emerged with her sanity in June of 2010, her disability ceased, and she had one year to file her claim within the statute of limitations. Since she did not file until November of 2011, her claim is not timely under the statute of limitations, even if she can rely upon the disability statute.

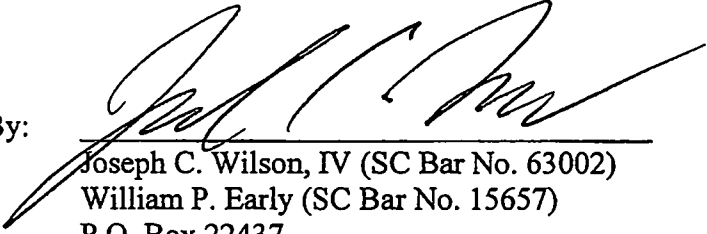
CONCLUSION

For the reasons set forth herein, as well as those set forth in the previously submitted appellate briefs of Respondents MUSC and Roberts's, as well as Respondent Roberts' Petition for Rehearing, which, except insofar as they may be inconsistent herewith, MUSC adopts by reference, MUSC asks the Court to affirm summary judgment in its favor.

Respectfully submitted,

PIERCE, HERNS, SLOAN & WILSON,
LLC

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March 8, 2018



The South Carolina Court of Appeals

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Re: Clair Johnson v. MUSC (John Roberts)
Appellate Case No. 2015-001463

Dear Counsel:

Enclosed is a copy of an order of the panel denying your petition for rehearing. Your petition for rehearing en banc was distributed to the judges, but it has been rejected. *See* Rule 219, SCACR.

Very truly yours,

V. Claims Allen, Deputy

CLERK

cc: Bradley Lewis Lanford, Esquire
Jonathan Blake Asbill, Esquire
The Honorable R. Markley Dennis, Jr.

The South Carolina Court of Appeals

Clair Craver Johnson, Appellant,

v.

John Roberts, M.D., Respondent.

And

Clair Craver Johnson, Appellant,

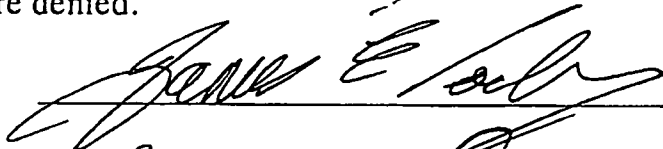
v.

Medical University of South Carolina, Respondent.

Appellate Case No. 2015-001463

ORDER

After careful consideration of the petitions for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petitions for rehearing filed by Respondents John Roberts, M.D. and Medical University of South Carolina are denied.

 C.J.

 J.

 J.

FILED

April 18, 2018 S.S.

Columbia, South Carolina

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The Honorable R. Markley Dennis, Jr.