

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

John C. Hayes, III, Circuit Court Judge

Case No. 2009-CP-46-03827

John R. Sexton and
Patricia Sexton Appellants

v.

Alex R. Espinal, M.D.
and Palmetto Surgery,
LLC Respondents.

RECORD ON APPEAL

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Attorneys for Appellants

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SC COURT OF APPEALS

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

FILED-RECEIVED
2011 AUG -4 AM 9:01
DAVID HAMILTON
C.C.C.P. & GS
YORK COUNTY, SC

JUDGMENT IN A CIVIL CASE
CASE NO: 2009CP4603827

John R Sexton vs. Alex R Espinal

CHECK ONE:

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

IT IS ORDERED AND ADJUDGED:

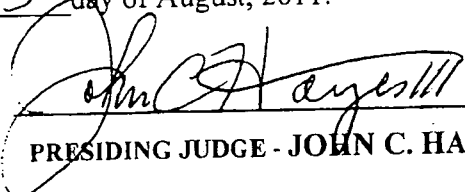
☐ See attached order;

☐ Statement of Judgment by the Court:

SEE ATTACHED VERDICT FORM

Dated at York, South Carolina, this 3 day of August, 2011.

Court Reporter: **WANDA NELSON**


PRESIDING JUDGE - JOHN C. HAYES, III.

This judgment was entered on the 4th day of August, 2011, and a copy mailed first class this 4th day of August, 2011, to attorneys of record or to parties (when appearing pro se) as follows:

Chad McGowan McGowan Hood & Felder L L C
1539 Health Care Dr. Rock Hill, SC 29732
William Jones Andrews Jr McGowan Hood & Felder LLC
1517 Hampton Street Columbia, SC 29201

H Spencer King & John E. Rogers II Attn:
Donna Hill/ The Ward Law Firm, Pa P.O. Box
3188 Spartanburg, SC 29304

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

DAVID HAMILTON

David Hamilton - Clerk of Court

SCRPC APP-24/FORM 4

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)
)
JOHN R. SEXTON AND)
PATRICIA SEXTON)
)
Plaintiffs,)
)
vs.)
)
ALEX R. ESPINAL, MD AND)
PALMETTO SURGERY, LLC)
)
Defendants,)
)
_____)

IN THE COURT COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

Case No.: 2009-CP-46-3827

VERDICT FORM

DAVID HAMILTON
C.C.P. & CS
YORK COUNTY, SC

FILED-RECEIVED
2011 AUG -4 AM 9:01

AS TO PLAINTIFF JOHN RICHARD SEXTON'S MALPRACTICE CLAIM

1. A. We find for the Plaintiff.
 X B. We find for the Defendants.

2. If you have checked 1 B, stop.

If you have checked 1 A, proceed to number 3 and answer the questions set forth at number 4.

3. If you have found for Plaintiff, set forth the amount of damages awarded Plaintiff.

\$ _____ Economic damages.

\$ _____ Non-Economic damages.

4. A. Was the Defendant Alex R. Espinal grossly negligent in his performance of the surgery on Plaintiff?

Yes _____
No _____

B. Was the Defendant Alex R. Espinal reckless in his performance of the surgery on Plaintiff?

Yes _____

No _____

AS TO PLAINTIFF PATRICIA SEXTON

_____ 1. We find for the Plaintiff Patricia Sexton for Loss of Consortium in the amount of \$ _____ Actual damages.

☒ 2. We find for the Defendants.

Foreperson

August 3, 2011

STATE OF SOUTH CAROLINA

COUNTY OF YORK

John R. Sexton and Patricia Sexton

Plaintiff(s)

vs.

Alex R. Espinal, M.D. and Palmetto Surgery, LLC

Defendant(s)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

09-CP - 46- 03827

(Please Print)

Submitted By: Chad A. McGowan, Esquire

Address: 1539 Health Care Drive, Rock Hill, SC 29732

SC Bar #: 999943

Telephone #: 803-327-7800

Fax #: 803-328-5656

Other:

E-mail: rhood@mcgowanhood.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

**If Action is Judgment/Settlement do not complete*

- ☒ **JURY TRIAL** demanded in complaint. ☐ **NON-JURY TRIAL** demanded in complaint.
- ☐ This case is subject to **ARBITRATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☐ This case is subject to **MEDIATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

- Contracts**
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

- Torts - Professional Malpractice**
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☒ Medical Malpractice (220)
- Previous Notice of Intent Case #
- 20 -CP- -
- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

- Torts - Personal Injury**
- ☐ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☐ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☐ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

- Real Property**
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

- Inmate Petitions**
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

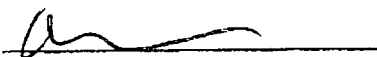
- Judgments/Settlements**
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Transfer of Structured Settlement Payment Rights Application (760)
- ☐ Other (799)

- Administrative Law/Relief**
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture-Consent Order (850)
- ☐ Other (899)

- Appeals**
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☐ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Administrative Law Judge (980)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

- Special/Complex /Other**
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Sexual Predator (510)

Submitting Party Signature:



Date:

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRPC, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF YORK)

John R. Sexton and Patricia Sexton,)

Case No.: 09-CP-46- 03827

Plaintiffs,)

vs.)

SUMMONS
(Jury Trial Demanded)

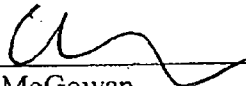
Alex R. Espinal, M.D. and Palmetto
Surgery, LLC,)

Defendants.)

FILED-RECEIVED
2009 SEP -4 PM 2:05
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

TO: THE DEFENDANTS ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to Answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said Complaint on the subscriber at his Office at 1539 Health Care Drive, Rock Hill, South Carolina, 29732, within thirty (30) days from the service hereof, exclusive of the date of such service; and if you fail to Answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.


Chad A. McGowan
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1539 Health Care Drive
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Rock Hill, South Carolina

August 31, 2009

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

File # 2009CP4603827

John R. Sexton,)
And Patricia Sexton,)
Plaintiffs,)

Vs.)

Alex R. Espinal, MD)
Palmetto Surgery, LLC)
Defendants.)

COMPLAINT FOR DAMAGES
(Jury Trial Demanded)

FILED-RECEIVED
2009 SEP -4 PM 2:05
DAVID HAMILTON
C.C.P. & GS
YORK COUNTY, SC

The Plaintiff, by and through her undersigned counsel, for a Complaint against the Defendants, does hereby allege as follows:

PARTIES

Plaintiff

1. The Plaintiffs, John and Patricia Sexton are citizens and residents of York County, SC and at all times relevant hereto were married to one another.

Defendants

2. Defendant Alex Espinal, MD is a physician licensed by the state of South Carolina with his principal place of business in York County, SC. Dr. Espinal holds himself out to the public as a specialist in the field of surgery. At all times relevant hereto, Defendant Espinal was an officer, employee, or agent of Defendant Palmetto Surgery, LLC and was always acting within the scope of his employment.

FACTUAL ALLEGATIONS

3. In March, 2007, Mr. Sexton was set to have an elective, non-emergency surgery to remove a benign colon polyp.

4. Prior to the procedure, Mr. Sexton had clear indications of inadequate lung function, including low oxygen saturations. Low levels of oxygen impair healing and are generally a contraindication to elective surgeries.

5. Despite the lung issues, Dr. Espinal decided to proceed without prior referral to a lung specialist for work-up and improvement of Mr. Sexton's lung function.

6. A physician is never allowed to unnecessarily endanger a patient.

7. A physician who exposes his patient to unnecessary danger deviates from the standard of care.

8. If a physician exposes his patient to unnecessary danger, and injury results, the physician is responsible for all injuries, damages, and losses that proximately flow therefrom.

9. Mr. Sexton's procedure did not go well as he developed a leak in his gut from the surgery that should have gone forward. As a result of this leak and the procedure itself, Mr. Sexton underwent numerous other procedures, and frankly almost died.

10. Dr. Espinal deviated from the applicable standard of care in various ways as outlined in the affidavit accompanying the Notice of Intent, which is incorporated herein.

11. The injuries of Mr. Sexton were the direct and proximate result of and was caused and occasioned by the negligence, carelessness, recklessness, willfulness, and wantonness on the part of Defendants, in failing to possess and exercise that degree of medical training, competency, and skill ordinarily and customarily possessed and exercised by nurses and other medical providers under similar circumstances and thereby rendered inappropriate medical care to Mr. Sexton by deviating from and falling below

the prevailing and acceptable standards of care. Plaintiff incorporates herein the affidavits of experts herein for a further description of the negligent acts identified to date.

FOR A FIRST CAUSE OF ACTION

(PERSONAL INJURY ACTION)

11. Plaintiff reiterates paragraphs 1-10 above as if set forth verbatim herein.

12. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the professional standards of care by Defendants, Mr. Sexton suffered from severe debilitating injuries which resulted in his conscious pain and suffering, medical expenses, lost earnings and earnings capacity, and other damages as a result of which Mr. Sexton is entitled to recover a sum to compensate him for his conscious pain and suffering, medical expenses, mental anguish, loss of earnings capacity, loss of enjoyment of life, loss of earnings and other damages. Plaintiff is also entitled to recover a sum of punitive damages to punish and deter these defendants and others like them from similar conduct in the future. All damages should be in an amount determined by a jury in this action.

FOR A SECOND CAUSE OF ACTION

(Loss of Consortium)

13. Plaintiff reiterates paragraphs 1-12 as though set forth verbatim herein.

14. Due to the conduct of the Defendants, Mrs. Sexton is entitled to an award of damages as determined by a jury for her loss of consortium from her husband.

WHEREFORE, Plaintiffs, respectfully pray for judgment against the Defendants for actual damages, special damages, consequential damages, and punitive damages in an amount to be determined by the jury at the trial of this action, for the costs and disbursements of this action and for such other and further relief as this court deems just and proper. Plaintiffs specifically aver that the damages at issue in this case are more than \$100,000, such averment made to allow all manner of discovery under South Carolina Law.


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Rock Hill, South Carolina

August 31, 2009

PLAINTIFFS DEMAND A JURY TRIAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	
John R. Sexton and Patricia Sexton,	)	
	)	
Plaintiffs,	)	C.A. No.: 2009-CP-46-03827
	)	
v.	)	
	)	ANSWER TO COMPLAINT ON BEHALF OF
Alex R. Espinal, M.D.	)	DEFENDANTS ALEX R. ESPINAL, M.D. AND
Palmetto Surgery, LLC,	)	PALMETTO SURGERY, LLC
	)	
Defendants.	)	
	)	

Defendants would should the Court:

FOR A FIRST DEFENSE
Rule 12(b)(6)

1. The Plaintiff's complaint fails to state facts sufficient to constitute a cause of action for which relief can be granted, and therefore, the Defendants move for dismissal pursuant to Rule 12(b)(6), South Carolina Rules of Civil Procedure.

FOR A SECOND DEFENSE
(General Denial)

2. The allegations of the First Defense are incorporated herein by reference.
3. Admits the allegations of Paragraphs 1 and 2 of the Complaint.
4. With respect to the allegations of Paragraph 3 admits that the procedure to remove the polyp was not emergent, but urgent, and it was not known as whether or not the polyp was a malignancy.
5. With respect to the allegations of Paragraphs 4, 5, 6, 7, 8, 9, 10 and 11, Defendants pray reference to the medical records and deny allegations of said paragraphs inconsistent therewith.

6. Denies the allegations of First Cause of Action Paragraphs 11 and 12.
7. Denies the allegations of the Second Cause of Action Paragraphs 13 and 14.
8. All prayers for relief are denied. Each and every allegations not herein above admitted are denied and strict proof thereof demanded.

FOR A THIRD DEFENSE
(Standard of Care)

9. The allegations of the First and Second Defenses are incorporated herein by reference.
10. At all times relevant to the matter set forth in the Complaint herein, this Defendant complied with generally accepted standards of medical care applicable to physicians rendering care to patients of the same or similar circumstances, and as a result thereof, these Defendants are in no way liable to the Plaintiff for the matter set forth in the Complaint.

FOR A FOURTH DEFENSE
(Estoppel)

11. The allegations of the First, Second and Third Defenses are incorporated herein by reference.
12. The allegations of the Complaint are barred by the doctrine of estoppel.

FOR A FIFTH DEFENSE
(Release)

13. The allegations of the First, Second, Third and Fourth Defenses are incorporated herein by reference.
14. The allegations of the Complaint are barred by the doctrine of release.

FOR A SIXTH DEFENSE

(Consent)

15. The allegations of the First, Second, Third, Fourth and Fifth Defenses are incorporated herein by reference.

16. The allegations of the Complaint are barred by the doctrine of consent.

FOR A SEVENTH DEFENSE

(Waiver)

17. The allegations of the First, Second, Third, Fourth, Fifth and Sixth Defenses are incorporated herein by reference.

18. The allegations of the Complaint are barred by the doctrine of waiver.

FOR AN EIGHTH DEFENSE

(Due Process)

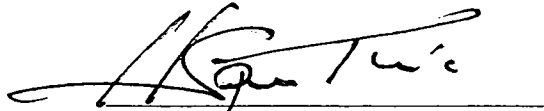
17. The allegations of the First, Second, Third, Fourth, Fifth, Sixth, and Seventh Defenses are incorporated herein by reference.

18. The Plaintiff is not entitled to an award for punitive damages as an award of punitive damages violates the Commerce Clause and Fifth and Fourteenth Amendments of the United States Constitution and Article I, Section 3, of the South Carolina constitution in that:

- (a) the judiciary's ability to correct a punitive damage award at the appellate level upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;
- (b) any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;
- (c) the jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards and is inconsistent with due process guarantees;

- (d) even if it could be argued that a standard governing imposition of punitive damage exists, the standard is void for vagueness; and
- (e) the Plaintiff's claim for punitive damages violates the Commerce Clause and Due Process of the Fourteenth Amendment of the United States Constitution and Article I, Section 3 of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth and status of the Defendant.

WHEREFORE, having fully answered, Defendants Alex R. Espinal, MD and Palmetto Surgery, LLC pray that the Complaint be dismissed, for the costs of this action and for such other and further relief as the Court deems just and proper.



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The Ward Law Firm, P.A.
Attorneys for Defendants
233 South Pine Street
Spartanburg, SC 29302
(864) 591-2364

September 25th, 2009

State of South Carolina.,)

)

)

)

)

County of York.,)

In The Common Pleas

Court of York

Case No.: 2009-CP-46-03827

John R. Sexton, et al.,)

)

Plaintiff,)

)

-vs.-)

)

Alex R. Espinal, et al.,)

)

Defendant.)

)

Transcript of Record

August 1-3, 2011

YORK, SOUTH CAROLINA

B E F O R E:

Honorable John C. Hayes, III, and a jury.

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

Mr. William J. Andrews

Attorney At Law

Sixteenth Judicial Circuit

York, South Carolina 29745

803-628-3020

Lcollins@yorkcountygov.net

For the Plaintiff

ORIGINAL

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Attorney at Law

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derekchiarenza@yahoo.com

For the Defendant

Wanda Nelson, CVR

Circuit Court Reporter

Sixteenth Circuit, At Large

Wnelson@sccourts.org

I-N-D-E-XWITNESS:PAGE NO.

Opening Statements

By: Mr. Andrews P.46-69

By: Mr. King. P.69-77

Doctor Robert Solymvari

By: Mr. McGowan P.82-135

. P.138-139

. P.160-164

By: Mr. King. P.140-159

. P.164-166

John R. Sexton

By: Mr. Andrews P.166-185

. P.208-209

By: Mr. Rogers. P.185-208

By: Mr. McGowan P.476 (In-Camera)

Patricia Sexton

By: Mr. Andrews P.216-228

By: Mr. Rogers. P.229-241

Charles A. Beard

By: Mr. Andrews P.241-245

. P.255

By: Mr. Rogers. P.245-248

E-X-H-I-B-I-T-S - CON'T

NO.	DESCRIPTION	ID.	EVD.
PL.24	HealthSouth Admitting	P.6	P.33
	H&P		
PL.25	HealthSouth	P.6	P.33
	Discharge Summary		
PL.26	Dr. Denenberg Consult	P.6	P.33
	Dated 3/8/07		
PL.27	Damages Summary	P.6	P.33
PL.28	Digestive Disease Assoc.	P.6	P.33
	(Entire Chart.)		
PL.29	Consents for both	P.6	P.33
	Procedures		
PL.30	PMC Anesthesia	P.6	P.33
	Records		
PL.31	Vitals	P.6	P.33
PL.32	Pathology Reports	P.6	P.33
	From 2nd procedure		
PL.33	Intake Sheets	P.6	P.33
	Palmetto Surgery		
PL.34	PMC -0027 H&P		P.160
DEF.1	PMC-0027 H&P.	P.159	
CT.1	Jury Note		P.559
REPORTER'S NOTE: All exhibits were filed with the York			
County Clerk of Court's Office.			

1 (ON THE RECORD MONDAY, AUGUST 1, 2011 AT 10:07 AM.)

2 (WHEREUPON: PLAINTIFF'S EXHIBIT NUMBERS ONE THROUGH
3 THIRTY-THREE PREMARKED FOR IDENTIFICATION - NOTEBOOK.)

4 THE COURT: Thank you. Take your seats.

5 Good morning. Members of the jury panel, I am John
6 Hayes from Rock Hill and along with Judge Alford we are
7 the two Circuit Court Judges who are assigned to York
8 County most of the time. We serve state wide so we have
9 other judges come in and we go to other places. But I'm
10 assigned this week to hold a term of what's called Common
11 Pleas Court; that is not Criminal Court, Civil Court cases
12 this week. I know the first we have is a medical case and
13 some other cases on the docket. I have a prior commitment
14 later this week. Of course our trial I won't be able to
15 tend to it but I do not plan unless I'm in a trial to hold
16 court Thursday and Friday, so you can take that into
17 consideration when you, if you're thinking about asking to
18 be changed to another time. I can tell you this looks
19 like it's going to be somewhat a fairly uncomplicated week
20 because of the obligation, it's not something crucial but
21 it's something I like doing and if I can I'm going to. So
22 Thursday and Friday it does not look like we'll be
23 working.

24 After the Clerk calls the roll I'll have some certain
25 things to go over with you involving your service. There

1 are certain qualifications when serving as a juror and
2 there are certain things that disqualify individuals from
3 serving as a juror, and there are certain exemptions, that
4 is some individuals -- One that comes to mind has to deal
5 with age, that allows people to serve or not serve if they
6 wish. So I'm going to ask you to listen very carefully to
7 the Clerk's instructions, answer with the information she
8 request. Now you don't need to shout but do use a good
9 strong voice. Myself and the attorneys who have cases
10 here would like to kind of meet you by seeing who you are
11 and hearing what you have to say. So try to project your
12 voice so that we can hear you. After we go through the
13 roll I will go over with you those exceptions,
14 qualifications and disqualifications.

15 Madame Clerk.

16 MADAME CLERK: Ladies and gentlemen, please stand and
17 raise your right hand for the jury oath.

18 (WHEREUPON: JURY SWORN AT 10:10 AM.)

19 (JURY ROLL CALL AT 10:10 AM.)

20 THE COURT: Anybody else?

21 (NO RESPONSE.)

22 THE COURT: All right, if you will give me your
23 attention for a few minutes, I'm now going to go over and
24 ask you these -- Well I'm not really asking. There are
25 certain qualifications and disqualifications and

1 exemptions from service as a juror in this particular type
2 of court. I'm going to go through this list and if any of
3 these apply to you to the extent that you need to discuss
4 them with me, I'm not going to ask you to stand up in
5 front of everyone like you've just done and tell me why
6 you feel like you need to talk with me. What I will do is
7 I will go through the entire list, when I get to the end
8 of the list I will step down by the Court Reporter; those
9 of you who need to discuss any of these matters with me to
10 come forward, the Clerk will stand there at the break in
11 the bar, you can come up one at a time. Now the attorneys
12 who have cases this week can gather around and hear what
13 we have to say but you won't have to stand up in front of
14 everyone.

15 First in order to serve as juror in this particular
16 type of court you must fall into one of the following
17 categories.

18 You must hold a valid driver's license. Or you must
19 hold a valid South Carolina Department of Public Safety
20 Identification Card, or you must be a registered voter, a
21 qualified elector. If you are not one of those, if you
22 don't fall into one of those categories, you don't have to
23 fall into all three but if you do not fall into at least
24 one of those categories please come forward in just a
25 moment.

1 If any of you are not a United States citizen or if
2 you reside in a county other than York County, South
3 Carolina, please come forward in just a moment.

4 If any of you work in one of our three court houses,
5 or if you hold any elected office in York County, please
6 come forward in just a moment.

7 If any of you hold a constable's license either with
8 or without pay, please come forward in just a moment.

9 If any of you have been convicted in a state or a
10 federal court for a crime to which you could have received
11 punishment with which you could have received punishment
12 which would have exceeded one year incarceration and if
13 your civil rights have not been restored by pardon or
14 amnesty, please come forward. This has to do with
15 offense which carry a penalty exceeding one year, it is
16 not tied to any sentence one may have received.

17 If any of you have less than a sixth grade education
18 or it's equivalent, or if you are unable to read, write,
19 speak or understand the English language, please come
20 forward in just a moment.

21 If any of you have any health impairments that
22 prevents you from serving with us as a juror this week,
23 please come forward in just a moment.

24 Any of you who are sixty-five or over have an
25 exemption. That means you have the right to serve and if

1 you are in that age bracket and wish to serve keep your
2 seat. If you're sixty-five and older and you wish to
3 exercise your exemption, please come forward in just a
4 moment.

5 If any of you have served on a jury such as this
6 within the last three calendar years, or if any of you
7 have served on a federal or state grand jury within the
8 last five -- Well let me go back. If any of you have
9 served on a county or state grand jury within the last
10 five calendar years, please come forward in just a moment.

11 For that statement or question the service as a juror
12 in a city court, municipal court, magistrate court or in
13 federal court, I misspoke a minute ago when I said federal
14 court, those do not apply. That is it would have had to
15 be a county grand jury, a statewide grand jury or a county
16 jury such as this, Common Pleas or General Sessions Court.

17 If any of you are the primary care giver for anyone
18 who is disabled and cannot take care of themselves, or if
19 you are the primary care giver for a child under the age
20 of seven, please come forward in just a moment.

21 When I say a disabled person I mean someone who
22 because of mental or physical infirmaries needs care
23 constantly and the person who provides that is you.

24 If any of you have any other reason why you could not
25 or should not serve as a fair and impartial juror, please

1 come forward at this time, and I will step down and we
2 will discuss those matters at this time.

3 Ms. Smarr, if you will stand there.

4 (COURT LEFT THE BENCH.)

5 MADAME CLERK: Number Ninety-eight, Thomas Nivens.

6 THE COURT: Good morning.

7 MR. NIVENS: Good morning, everybody. I'm on
8 disability and I have to take pain medication. I don't
9 think it would be fair for me to take any pain medication
10 and have to deal with it.

11 THE COURT: All right. I'll excuse you.

12 MR. NIVENS: Thank you, sir.

13 THE COURT: He will be excused.

14 MADAME CLERK: Number Seventy, Roy Jernigan.

15 THE COURT: Good morning.

16 MR. JERNIGAN: Good morning. I was recently injured
17 and I'm on pain medication and I don't think I can stay
18 awake.

19 THE COURT: Okay. Would you like to be transferred
20 to another time?

21 MR. JERNIGAN: Yes I would.

22 THE COURT: I'm sorry to hear that and sorry to see
23 that. We will transfer you to another time. If you will
24 just step right over here.

25 MADAME CLERK: Juror Number Seventy-three, James W.

1 Jones, III.

2 THE COURT: Good morning.

3 MR. JONES: Good morning, how are you. I been
4 residing in Sumter, South Carolina for employment. If I
5 leave here today I'll be going back to Sumter for work. I
6 think having to be here - -

7 THE COURT: Is your driver's license listed as York
8 County?

9 MR. JONES: Yes, sir. I been there since August of
10 last year at Shaw Air Force Base.

11 THE COURT: Well I'll have to let you stay. You will
12 have to serve somewhere and if your voter's registration
13 or your driver's license all that says York County I'll
14 have to let you serve here. I can transfer you to another
15 time but I've already said this is going to be a short
16 week.

17 MR. JONES: Okay. Could you transfer me?

18 THE COURT: All right. Just step on over there.

19 He'll be transferred. Yes, sir, be glad to.

20 MADAME CLERK: Juror Number One Twenty-three, David
21 L. Seward.

22 THE COURT: Good morning, how are you?

23 MR. SEWARD: I'm good. I stepped forward because I
24 would love to serve on a jury, I want to do my civic duty,
25 but I feel compelled to report that I work in the court

1 system as a counselor for the adult drug court in York
2 County.

3 THE COURT: All right. Well I'm very familiar with
4 that and of course I'm one of the judges that holds that,
5 but that would not -- We appreciate - Everybody
6 appreciates you being told that but you can stay with us.
7 Thank you.

8 MR. SEWARD: Great.

9 THE COURT: Thank you.

10 MADAME CLERK: Number Sixteen, Ashley Branham.

11 THE COURT: Good morning.

12 MS. BRANHAM: I think I do criminal court with you in
13 November.

14 THE COURT: Okay. Well just have a seat over here
15 and we'll double check.

16 MS. BRANHAM: Okay.

17 THE COURT: We gonna double check; she's indicated
18 she's served.

19 All right. Yes, sir.

20 MADAME CLERK: Number Fifty-six, Scott Finnigan.

21 THE COURT: Good morning.

22 MR. FINNIGAN: How are you?

23 THE COURT: Good.

24 MR. FINNIGAN: I just ask the bailiff, I wasn't too
25 sure about I got a baby due, that's August 31st and if it

1 comes early or what not so.

2 THE COURT: Well do you want to be transferred to
3 another time or?

4 MR. FINNIGAN: That's what I don't know. I mean
5 probably won't but you know.

6 THE COURT: I'll leave that up to you. We'll be glad
7 to transfer you but obviously if she goes into labor - -

8 MR. FINNIGAN: Can I just call an emergency number?
9 Can I do that?

10 THE COURT: Yeah.

11 MR. FINNIGAN: Unless it's a trial then - -

12 THE COURT: Well why don't we just -- rather than put
13 you in a situation of having and you've got enough going
14 on with a new baby coming and I understand that.

15 MR. FINNIGAN: Right.

16 THE COURT: Is this your first?

17 MR. FINNIGAN: Yeah.

18 THE COURT: Okay. Well I'm gonna transfer you to
19 another term.

20 We'll transfer him to a later time. I think that
21 will be best.

22 MR. FINNIGAN: All right. Thank you. Can I go now?

23 THE COURT: Yeah just step right over there.

24 Counsel, if you will sit down just a minute.

25 We're gonna take about a ten minute refresher break

1 and then we're gonna start into our first trial. I'll
2 tell you about that then and I'll have some more questions
3 to ask you. They will be case specific, they won't be
4 general questions like I've been asking. It takes a few
5 minutes to adjust after we figure out who all is here and
6 who is not here so we can get the computer fixed up so we
7 won't be drawing jurors who have been excused. So we'll
8 take about a ten minute refresher break, so be back at Ten
9 till according to that clock. Be back seated and ready to
10 go.

11 (COURT IN RECESS AT 10:40 AM.)

12 (COURT BACK IN SESSION AT 11:00 AM.)

13 THE COURT: Thank you, take your seats. We are going
14 to start our first trial for the week and it is the case
15 of John R. Sexton and Patricia Sexton. They are
16 represented by Mr. McGowan and I'm gonna let him introduce
17 co-counsel and the Sexton's.

18 MR. MCGOWAN: Thank you, Your Honor.

19 I am Chad McGowan and this is my law partner Jones
20 Andrews. Our clients,

21 If you will stand up.

22 (PLAINTIFF'S STOOD.)

23 MR. MCGOWAN: Ricky, John Ricky Sexton and his wife
24 Patricia Sexton.

25 THE COURT: Thank you.

1 MR. KING: And I'm Spencer King and this is my law
2 partner John Rodgers. And we represent Alex Espinal who
3 is a surgeon who practices in Rock Hill and his practice.

4 THE COURT: And this case is the Sexton's versus Alex
5 R. Espinal and Palmetto Surgery, LLC, and it's a medical
6 negligence allegations.

7 First, are any of you related by blood or marriage to
8 any of the individuals with whom you have just been
9 introduced, the lawyers or the litigants, if so, please
10 stand?

11 No one stands. Have any of you been represented by
12 either the law firm of McGowan as his firm under his name
13 I believe and others and Mr. King is with the Ward Law
14 Firm in Spartanburg.

15 No one stands. In addition to Doctor Espinal,
16 Palmetto Surgery is listed as a party. Do any of you have
17 any relationship with -- Well let me ask it like this.
18 Have any of you been treated by Doctor Espinal or Palmetto
19 Surgery or do you have any type of business relationship
20 with that entity? That is do you deliver coffee to them
21 or deliver medical supplies, so their phone service, or
22 anything like that, if so, please stand?

23 No one stands. Now this case alleges that in March
24 of 2007 a medical procedure was performed by Doctor
25 Espinal and the Sexton's claim that it did not go as it

1 should have; that it is -- They allege that they -- I
2 believe that it is Mr. Sexton was operated on and as a
3 result of that he has sued Doctor Espinal for medical
4 negligence. Does anybody know anything about this case;
5 have any of you heard about it from any source whatsoever,
6 have any of you formed or expressed any opinion about any
7 matter or issue which would be involved in this case; if
8 so, please stand?

9 No one stands. Have any of you or a member of your
10 family been involved in a situation -- it doesn't have to
11 be litigation but some sort of situation where you or a
12 family member believed they have -- they knew or they have
13 received care from a physician that amounted to negligent
14 care; if so, please stand?

15 All right. Now I'm not going to ask you to go into a
16 lot of particulars, I'm just going to have you give me
17 your name and number.

18 A. Jessica Smith, Number 128.

19 THE COURT: All right. Would the fact that you're
20 standing in response to that would that affect your
21 ability to be fair and impartial in this trial?

22 MS. SMITH: I truly believe so.

23 THE COURT: Okay. Well I'll excuse you. Don't leave
24 just have a seat. Thank you.

25 Yes, ma'am, your name and number?

1 A. Elaine Roberts, Number 118. My mother had surgery
2 and --

3 THE COURT: I'm not going to ask you to go into
4 particulars, I'm just going to ask, based on the fact that
5 you had stood indicating you had this in your life
6 experiences would that prevent you from being fair and
7 impartial in this trial?

8 MS. ROBERTS: No.

9 THE COURT: Okay. You will remain with us then.
10 Thank you. I appreciate both of you standing.

11 The following are possible witnesses in this case in
12 addition to the parties who may or may not testify, but
13 I've already talked to you about them, but the possible
14 witnesses according to the information I have in this
15 case, again they may not all testify, but if any of you
16 are related by blood or marriage or if you are a close
17 personal friend or acquaintance of any of these
18 individuals please stand. Chuck Beard, Glynnis Beard,
19 Doctor Robert Solymvari, and I don't think I'm pronouncing
20 that right, it's S-o-l-y-o-m-v-a-r-I, Doctor Eric S. Bour,
21 B-o-u-r; Doctor Susan Lupo, L-u-p-o; and perhaps
22 employees, this is a little vague but first I will ask you
23 those five witnesses, any of you know any of those five
24 witnesses, either the Beard's or the three doctors; if so,
25 please stand?

1 (NO ONE STANDS.)

2 THE COURT: All right the next statement I have as a
3 witness is or employees of Doctor Espinal or medical
4 surgery so I'm gonna ask it like this. Are any of you
5 related to or are you a friend of anybody who works for
6 Doctor Espinal or Palmetto Surgery, LLC; if so, please
7 stand?

8 No one stands. Do any of you have any moral,
9 religious, personal or political belief that prevents you
10 from being fair and impartial in a trial such as this, or
11 in this trial in particular, if so, please stand?

12 No one stands. Have any of you been a member -- been
13 a party to a law suit either a plaintiff or a defendant,
14 I'm not talking about Family Court, we already know some
15 of you been in Family Court, we're not talking about
16 Family Court, I'm not talking about Probate Court, that is
17 disputes about wills, but some type of -- I'm not talking
18 about criminal court either, but have any of you been a
19 party to a law suit involving some sort of tort claim,
20 some sort of negligence claim; if so, please stand?

21 (JUROR ONE TWENTY-EIGHT STOOD.)

22 Well you've already been excused. You don't have to
23 get up any more, but thank you. All right. And again I'm
24 not going to ask you to go into great detail, just tell me
25 your name and number and whether you were the plaintiff or

1 defendant in the law suit and then I'll ask you about the
2 fairness.

3 Yes, sir.

4 A. A defendant

5 MADAME COURT REPORTER: I'm sorry, Judge, I can't
6 hear him.

7 THE COURT: We can't hear you.

8 Can you get the microphone back there? Will one of
9 the bailiffs or one of the clerk's - -

10 A. General instruction law suit, I was the defendant and

11 THE COURT: All right. Would that affect your
12 ability to be fair and impartial in a trial of this case?

13 A. No.

14 THE COURT: All right. You can have a seat then.

15 MADAME COURT REPORTER: Judge, get his number.

16 THE COURT: Let's get, Sir, your name and number
17 again.

18 A. Dennis O'Connell, Number 100.

19 THE COURT: All right. Thank you. And I'm gonna ask
20 the clerk to walk back with the microphone.

21 A. Juror Number 84, Barron Mack, Junior, I was involved
22 in a legal malpractice as the defendant.

23 THE COURT: All right. Would that affect your
24 ability to be fair and impartial in the trial of this
25 case?

1 MR. MACK: No, sir.

2 THE COURT: All right.

3 A. Holly Starnes, Number 120. I was a plaintiff.

4 THE COURT: Would that affect your ability to be fair
5 and impartial in this trial?

6 MS. STARNES: No it won't.

7 THE COURT: Okay. You remain with us then. Thank
8 you.

9 THE COURT: Have any of you heard anything about law
10 suits involving medical negligence that prevents you from
11 being fair and impartial in a trial of a medical
12 negligence case; if so, please stand?

13 No one stands. Are you any of opposed to the
14 American Judicial System, that is trial by jury? Do any
15 of you have any oppositions to cases being resolved by
16 jury trial; if so, please stand?

17 No one stands. Would any of you be unable to follow
18 the law as I give it to you whether you agree with what I
19 charge you the law to be or not; if so, please stand?

20 No one stands.

21 Anything further from the plaintiffs?

22 MR. MCGOWAN: No, sir, Your Honor.

23 THE COURT: Defendant?

24 MR. KING: No, sir.

25 THE COURT: Do any of you know of any reason

1 whatsoever why you could not or should not serve as a fair
2 and impartial juror in the trial of this particular case;
3 if so, please stand?

4 No one stands. Now the way we draw jurors in this
5 court is as follows: A list will be presented or prepared
6 through the computer. The computer will give us twenty
7 names, out of that each side has the opportunity to strike
8 or excuse or remove four individuals leaving us twelve
9 jurors. We will on that list have additional three
10 individuals and from those three each has the opportunity
11 to excuse one leaving us one alternate, twelve jurors and
12 an alternate. Now we do not strike using your juror
13 number; we use preprinted numbers one through twenty. So
14 if you hear and you're Juror Number Seven and you hear
15 someone strike number Seven it could be you but it
16 probably isn't because we're not using your juror numbers.
17 Actually you will only know that you were on this list is
18 if you end up on it and seated as a juror. I'm going to
19 give the attorneys about ten or fifteen minutes after they
20 get the list to go over with their clients the list and
21 determine how they want to exercise their strikes. They
22 can utilize my office if they wish or they can utilize a
23 kind of lawyer's assembly room we call it back there. But
24 we're not going to take a break we'll just be at ease
25 while this process takes place.

1 Yes, sir.

2 MR. MCGOWAN: The computer doesn't challenge for
3 cause?

4 THE COURT: Okay. Well let's come over here.

5 (SIDE BAR CONFERENCE OFF THE RECORD AT 11:10 AM.)

6 THE COURT: All right. We'll be at ease for a few
7 minutes.

8 (COURT AT EASE AT 11:12 AM.)

9 (COURT BACK IN SESSION AT 11:30 AM.)

10 THE COURT: Plaintiff ready to strike? Plaintiff
11 ready?

12 MR. MCGOWAN: Yes, sir, Your Honor.

13 THE COURT: Defense ready?

14 MR. KING: Yes, sir.

15 THE COURT: Using the numbers on the far left
16 plaintiff strikes first.

17 MR. MCGOWAN: Plaintiff strikes Number 20.

18 MR. KING: Defendant strikes Number 5.

19 MR. MCGOWAN: Plaintiff strikes Number 16.

20 MR. KING: Defendant strikes Number 14.

21 MR. MCGOWAN: Plaintiff strikes Number 15.

22 MR. KING: Defendant strikes Number 17.

23 MR. MCGOWAN: Plaintiff strikes Number 8.

24 MADAME CLERK: What number was that?

25 MR. MCGOWAN: Eight.

1 MR. KING: Defendant strikes Number 7.

2 THE COURT: One each for the alternates.

3 MR. MCGOWAN: Plaintiff strikes Number 21.

4 MR. KING: Defendant strikes Number 23.

5 THE COURT: Anything from the Plaintiff involving the
6 strikes?

7 MR. MCGOWAN: No, sir, Your Honor.

8 THE COURT: Defense?

9 MR. KING: No, sir.

10 THE COURT: All right. If you hear your name called
11 please -- If you hear your name called please come forward
12 and bring with you any personal belonging that you may
13 have and the bailiff will tell you where to be seated in
14 the jury box. Oh, I'm sorry, let's verify strikes.

15 Thank you.

16 MADAME CLERK: I have the following strikes for the
17 Plaintiff. Number 20, 16, 15, 8 and as your alternate
18 Number 21. Is this correct?

19 MR. MCGOWAN: Yes, ma'am.

20 MADAME CLERK: For the Defendant I have the following
21 strikes. Number 5, 14, 17, 7 and as your alternate Number
22 23. Is that correct?

23 MR. KING: That is correct.

24 MADAME CLERK: Okay. And as the judge addressed,
25 when your name is called if you will come down and have a

1 seat to my left and you will be directed by the bailiff.

2 Juror Number 145, Tonya L. Williams.

3 (WHITE FEMALE COMING FORWARD.)

4 MADAME CLERK: Juror Number 61, Tonya F. Green.

5 (WHITE FEMALE COMING FORWARD.)

6 MADAME CLERK: Juror Number 83, Christopher T.

7 Luksch.

8 (WHITE MALE COMING FORWARD.)

9 MADAME CLERK: Juror Number 122, Jeanine M.

10 Schreiner.

11 (WHITE FEMALE COMING FORWARD.)

12 MADAME CLERK: Juror Number 38, Herbert C. Craft,

13 III.

14 (WHITE MALE COMING FORWARD.)

15 MADAME CLERK: Juror Number 69 - -

16 THE COURT: Ms. Schreiner, I'm going to ask you to be
17 the Foreperson. You will have this first seat up here.

18 MS. SCHREINER: Yes, sir.

19 MADAME CLERK: Juror Number 69, Joy M. Hyslop.

20 (WHITE FEMALE COMING FORWARD.)

21 MADAME CLERK: Juror Number 147, Dewayne A. Wilson.

22 (BLACK MALE COMING FORWARD.)

23 MADAME CLERK: Juror Number 136, Everett w. Tolbird.

24 (WHITE MALE COMING FORWARD.)

25 MADAME CLERK: Juror Number 1-0-6, Richard O. Poag.

1 (WHITE MALE COMING FORWARD.)

2 MADAME CLERK: Juror Number 35, Bonnie B. Connor.

3 (WHITE FEMALE COMING FORWARD.)

4 MADAME CLERK: Juror Number 48, Alexandria A. Defoe
5 White.

6 (WHITE FEMALE COMING FORWARD.)

7 MADAME CLERK: Juror Number 140, Shederian D. Walls.

8 (WHITE FEMALE COMING FORWARD.)

9 MADAME CLERK: And serving as the alternate is Juror
10 Number 149, Toni L. Wooldridge.

11 (WHITE FEMALE COMING FORWARD.)

12 THE COURT: Those of you who were not chosen I'm
13 going to allow you to leave. Please call back tonight
14 after Seven and you will receive some instructions. It
15 may be to come back in if we need you, it may be to call
16 back at a certain time, but make sure you call, make sure
17 you follow the instructions you receive. If you are
18 supposed to be here and you're not my job description
19 requires that I ask the sheriff to find out where you are.
20 I don't mean that as a threat that's just the way our
21 system works. But we're easy to work with. If you have
22 some event that prevents you from being here call the
23 clerk and let us know and we can deal with that. I'm
24 going to ask you to be quite as you leave or as quite as
25 possible so that I can start talking to this panel. Thank

1 you, and call back tonight.

2 (JURY POOL DISMISSED AT 11:35 AM.)

3 THE COURT: Those of you who were chosen, if you will
4 stand the Clerk will administer the oath.

5 MADAME CLERK: If you will please raise your right
6 hand.

7 (WHEREUPON: JURY PANEL SWORN AT
8 11:35 AM.)

9 MADAME CLERK: Thank you. You may be seated.

10 THE COURT: Somebody leave some sunglasses?

11 MADAME FOREPERSON: It's me. I left them in the
12 seat.

13 THE COURT: All right, members of the jury panel, I'm
14 going to chat with you just a moment and then turn the
15 case over to the attorneys. I just want to give you some
16 preliminary remarks.

17 The attorneys have the right but no obligation to
18 come before you in just a moment and tell you about their
19 case. Give you a blue print or an outline of the trial.
20 They're not arguing their case but at a later point in the
21 trial they will have the right to do that, an opportunity
22 to do that. Now they are not trying to convince you of
23 anything and they are not witnesses so they are not giving
24 testimony. But they are not witnesses so they are not
25 giving testimony. Now I have three primary jobs in this

1 trial. One, is I am the logistics person, I sometimes
2 call it the wagon master. That is I make sure we take
3 breaks and make sure we're sworn in, make sure one person
4 is speaking at a time, making sure you can hear and see
5 and take breaks, the mechanical part of the trial. I also
6 have the job of ruling on questions of evidentiary
7 matters, that is, if one side believes certain evidence
8 should be admitted into the record for your consideration
9 and the other based on some evidentiary principle or legal
10 principle believes the evidence is not appropriate it's up
11 to me to make that determination, and once I have ruled on
12 an evidentiary question that ruling is binding on the
13 attorneys, the witnesses and on you. My third job is that
14 I am the sole judge of the law and you must take, accept
15 and apply the law as I charge it. If you will recall that
16 I ask one of my questions was could you do that, that you
17 are required now that you are on the jury under oath,
18 under your oath to take and accept and apply the law as I
19 charge it. This is true even if you think I charge the
20 law in error or even if you think I charge or even if you
21 think t the law should be different. Your oath requires
22 you to take and accept and apply the law as I charge it.

23 You are not to infer from anything I say or do during
24 this trial as being an opinion of mine on the facts. Our
25 law does not allow a trial to formulate or express to a

1 jury any opinion on the facts; that is solely your job.
2 It is solely up to you to examine the evidence and give to
3 the evidence the effect, the value, the weight, the truth
4 you believe it should have. In doing this you may believe
5 one witness as opposed to several, several witnesses as
6 opposed to one. You may believe all, part or none of a
7 witness's testimony. Use your common sense, your sense of
8 logic, your sense of reason, use your experiences in life
9 as you analyze the evidence. As judges of the facts you
10 necessarily must judge the credibility, that is the
11 believability of the witness's who testify. In assessing
12 credibility use the things I just mentioned, use the
13 things that you in your day to day life find as being
14 indicative of the truthfulness and you can use certain
15 evaluators. How a witness acts on the stand, are they
16 hesitant or straight forward. Consider the opportunity a
17 witness had to know those things to which they testified.
18 You can consider any bias and prejudice a witness may
19 have, that is whether they wish to help or hurt one side
20 or the other. And look at consistencies or
21 inconsistencies in a witness's testimony. These sort of
22 things sort of help you to determine credibility.

23 Now in this case we will have testimony from
24 individuals who are quailed as what we call experts.
25 Generally an individual can only testify as to something

1 they've observed with one of their five senses. Usually
2 something somebody has seen or heard but it could be
3 taste, touch or smell. However where an individual has
4 certain qualifications, experience, education, that person
5 can qualify, give opinions. They can render an opinion,
6 these opinions are for your assistance, they are not
7 binding on you and they are allowed into evidence for your
8 consideration. You may accept or reject -- The example I
9 use sometimes is if I have a child and the child appears
10 to be sick, hot to the touch, it appears to be
11 uncomfortable I can tell the child is sick but I couldn't
12 diagnose what's the matter with the child. However I can
13 take that child to a physician and a physician could see
14 the exact same things that I've seen, a physician could
15 based on their experience and knowledge and training, they
16 could render an opinion. That is they could give a
17 diagnoses and say the child's got the flu, the child is
18 down with the chicken pox or something like that. So
19 that's basically what an expert does, they take facts and
20 from those facts reach an opinion. It's not always about
21 diagnosis but that's just by way of example.

22 You do not need to take notes. Just pay close
23 attention. You are not to discuss the case among
24 yourselves or make up your own mind until we reach the
25 point in the trial where I instruct you to jointly

1 deliberate and return a unanimous verdict. Prior to that
2 time you are not equipped with all the tools you need to
3 make a fair and reasonable decision. Do not let anyone
4 discuss this case with you outside the courtroom. If
5 anyone tries to discuss this case with you tell them you
6 cannot as you are serving on the jury and report back to
7 me if anyone tries to discuss the case with you.
8 Hopefully giving me that person's identify because I will
9 have to take action against anyone trying to talk to a
10 seated juror.

11 I do not know that this case will receive any news
12 coverage but if it does don't let yourselves be exposed to
13 it. Don't watch anything, read anything or listen to
14 anything that can remotely deal with this trial. Now in
15 our modern times we now have access to the world. Cloud
16 and other things that we can find out anything we want
17 about anybody and about any situation by simply going on
18 line. That's improper, do not do that, do not do any
19 research concerning anything about this case, no research
20 anything about the lawyers, about Mr. Sexton, about the
21 doctor and about the procedure, about where this took
22 place, about me, about anything. You must base your
23 verdict solely on the law and the evidence that is
24 presented here in the trial.

25 We take breaks about every hour and a half. That

1 seems to be a good comfort level but if any of you need a
2 break at any time please let me know and we will take a
3 break. Its hard to pay attention if you are not
4 comfortable. I will take a break if I feel like I need
5 one and you certainly have the same prerogative. And I
6 extend that to counsel and their clients. We wish to move
7 the case along with promptness but we're not in such a
8 hurry that we will not take a break if we need one. If
9 you can't see or you can't hear let me know. Cup your
10 ear, give me a voice raising gesture, a nudging gesture
11 and I will try to correct whatever the problem is. It's
12 not fair to ask you to resolve this issue; the issues you
13 will be presented, and then not let you have a full
14 opportunity to see and hear those things which you need to
15 see and hear.

16 I'm now going to turn the case over to the attorneys.

17 (PAUSE.)

18 THE COURT: All right. I'm going to let you first go
19 into the jury room to get familiar with it and get
20 comfortable. We have some matters to take up before we do
21 that - before you hear from the attorneys.

22 (JURY EXITS COURTROOM AT 11:42 AM.)

23 THE COURT: Yes, sir.

24 MR. MCGOWAN: Your Honor, initially we would like to
25 offer into evidence Exhibits One through Thirty-three and

1 I think that these are for lack of a better term Joint
2 Exhibits. Everybody's agreed to them but we have them all
3 in a notebook and are offering those into evidence at this
4 time.

5 (WHEREUPON: PLAINTIFF'S EXHIBIT ONE THROUGH THIRTY-
6 THREE IDENTIFIED AND MARKED, RECEIVED INTO EVIDENCE.)

7 MR. KING: No objection, Your Honor.

8 THE COURT: All right. Without objection. I presume
9 that's this?

10 MR. KING: That's correct. And we have agreed also
11 with the Court's agreement to give copies of that notebook
12 to each juror.

13 THE COURT: That's good.

14 MR. KING: Now there are twelve hundred pages of
15 medical records. We have tried to reduce what's going to
16 be in evidence to what's there but I want to ---- to the
17 court that we may have to resort to records that are not
18 there; other medical records that are not there. And
19 there's also -- There's a CT Scan, there's diagnostic
20 studies and X-rays and CT Scans coming into evidence that
21 are not in there.

22 THE COURT: What else while the jury's out?

23 MR. ANDREWS: We have a motion to exclude any
24 deposition experts of the Doctor Denenberg. Doctor
25 Denenberg is a treating physician in this case; I was

1 notified by Mr. King about a month ago that he planned to
2 call Doctor Denenberg at trial therefore I noticed his
3 deposition and took his deposition according to Rule 30 J,
4 I believe 30 and 30 J as a treating physician, I don't
5 plan to use it. Mr. King plans to use it and I'll let him
6 discuss this with you, but he believes that he's fine
7 testifying as an expert witness on standards of care
8 approximate cause. He never identified him as an expert
9 witness Number One, because I don't think that's proper.
10 And Number Two, I don't think it's proper to use excerpts
11 from depositions they've never been designated and he's in
12 town, Your Honor, and he's available.

13 THE COURT: That would be the first question is
14 whether or not it falls under the -- I'm trying to find
15 the rule now.

16 MR. ANDREWS: It's Rule 30, Rule 32 and Rule 30 in
17 conjunction with one another, Your Honor. And I think
18 it's 30 I.

19 THE COURT: Thirty-two. You said 30 J, that didn't
20 look like it.

21 MR. KING: 30 I.

22 MR. ANDREWS: It's 30 I and Rule 32.

23 MR. KING: Your Honor, can I approach? I have a
24 Memorandum.

25 THE COURT: You can just hand it to the Clerk.

1 MR. ANDREWS: And, Your Honor, if I can just make one
2 more, say one more thing. 30 I may in fact allow
3 testimony regarding his treatment of that patient. I
4 don't think it allows expert testimony unless he's been
5 designated as an expert witness. And I would also submit
6 to you that Doctor Denenberg did not treat this patient
7 until after the initial surgery which is the reason why we
8 filed this law suit, the initial surgery.

9 THE COURT: Well I think -- Let's look at 30 I first
10 and actually I've never had looked at this one that
11 closely but just quick reading it looks to me that it is
12 for the use of a person who takes deposition because it
13 required that the notice I don't -- It doesn't appear that
14 Doctor Espinal's counsel did the notices by plaintiff, it
15 says the notice shall specify that the purpose of the
16 deposition is pursuant to this rule so that's one hurdle
17 that I think the use has got to get over. If that doesn't
18 apply then you flop over or over to Rule 32 33, A 3 about
19 the unavailability and trying to secure the witness and
20 that sort of thing.

21 MR. KING: Your Honor, first off my interpretation of
22 the rules anybody can use any deposition that's been taken
23 if he otherwise qualifies.

24 THE COURT: Well I agree with that but then he falls
25 under certain other hurdles.

1 MR. KING: He is a treating physician. That's my
2 first argument. Second off he said he was not available
3 in his deposition. Now I have sent a subpoena to him for
4 tomorrow. But in his deposition Mr. Andrews ask him he
5 said he would not be available.

6 MR. ANDREWS: Can I clarify that, Your Honor. He's
7 seeing patients, he's here. That doesn't qualify as non-
8 available.

9 THE COURT: He's subject to subpoena. But going back
10 let's look at 30 I again first. The deposition of any
11 physician may be taken by any party in which the physician
12 may be called as a witness on notice that each party is
13 provided a rule a evidence deposition otherwise -- See,
14 here's where we get into the language, and evidence
15 deposition otherwise admissible may be received into
16 evidence at a trial or hearing. Skipped a sentence and
17 then it says a notice shall specify that the purpose of
18 the deposition is for evidence. So we're not dealing with
19 discovery depositions we're dealing with evidentiary
20 depositions. And in fact you go down before the evidence
21 deposition, any party may obtain discovery committed under
22 Rule 26.

23 It appears to me you've got to get -- It's got an
24 evidence deposition that falls under 30 I and if it's not
25 then you go back to 32 and that throws them into the un-

1 availability. Just have to see, that's where I am but
2 I'll be glad to hear from you.

3 MR. KING: As I said I got a subpoena, he's been
4 served with a subpoena but he said he was not available.

5 THE COURT: Well that's not his decision to make
6 unfortunately. May be fortunate. I don't know. Him
7 unfortunately, the Court fortunately, that he's under
8 subpoena and we've got a sheriff, we can go find somebody
9 to help him get here but I don't want to embarrass him in
10 front of his patients. Now when he gets here as to what
11 kind of testimony about the standard of care we'll worry
12 about that at that point.

13 MR. ANDREWS: I just want to put the Court on notice.
14 Mr. King knows that if he does show up and he does plan to
15 get from him expert opinions I have an objection to that.
16 He never had been designated as an expert witness, never.

17 THE COURT: We'll cross that when he gets here.

18 MR. ANDREWS: Yes, sir.

19 THE COURT: When he gets there.

20 MR. KING: Your Honor, rather than bringing him here,
21 can you hear us on that? I don't want to take him away
22 from patients and probably not testimony.

23 THE COURT: I'll be glad to hear you now but if he
24 was not listed as an expert, we got these rules and
25 sometimes the purpose of a rule -- First the evidence rule

1 it talks about, the evidence rule -- We're talking about
2 civil rules not, the scope of the rules is to bring
3 fairness and that's what we want to do. But we've got to
4 follow rules as close as we can or we have not structure.
5 So the purpose of the interrogatories and the request to
6 list expert witnesses is just for that purpose so that the
7 opposing party will now know who the experts are and who are
8 not going to be called as experts.

9 MR. KING: Your Honor, I called him as a fact
10 witness.

11 THE COURT: Well that's - -

12 MR. KING: I designated him as a fact witness. I
13 think under Rule 701 he can testify as to the facts in
14 this case as he knows them. And then one, conclusions and
15 opinions that came from his examinations? Mr. Andrews is
16 correct, he sees Mr. Sexton on the 8th of March the day
17 after the first procedure. I'm not asking him about
18 standard of care. He's a pulmonologist, he's not a
19 surgeon. My questions to him would be what exactly did he
20 take, what history and physical did he do on the 8th?
21 What conclusions did he reach? And what treatment did he
22 render?

23 MR. MCGOWAN: Can I give a little bit of fact
24 background so Your Honor can -- This surgery occurred - -

25 THE COURT: Well when I was talking about rules a

1 minute ago usually under the rules we have one person for
2 each side present unless you have any objection, Mr. King?

3 Mr. McGowan?

4 MR. MCGOWAN: Doctor Denenberg - -

5 THE COURT: He's - -

6 MR. MCGOWAN: He was going to be my witness that's
7 why I was doing that.

8 MR. ANDREWS: I'll be glad to argue.

9 THE COURT: I hate to be calling the rules on one
10 person and not call them on the other. Go ahead.

11 MR. ANDREWS: Your Honor, he needs to be designated
12 as an expert witness. He wants to bring him in as a fact
13 witness and then get expert opinions from him. That's
14 what he's trying -- I think that's what he's trying to do.

15 MR. KING: I don't think what I've ask, Mr. Andrews
16 is expert testimony.

17 MR. ANDREWS: Okay.

18 THE COURT: If he appears - -

19 MR. ANDREWS: Well here's a question.

20 THE COURT: Mr. Andrews, wait just a minute. If it
21 appears we might have to have an in camera to see where we
22 are because we can sit here and argue for a couple of
23 hours as to what he is and is not. Until I can actually
24 hear him on the hoof I don't know that I can make a
25 ruling.

1 MR. ANDREWS: Okay.

2 THE COURT: So get him here we'll do an in camera.
3 If it looks like -- I mean we're not going to start with
4 an in camera we'll go ahead and start with the testimony,
5 we get into an area that the plaintiff thinks is
6 objectionable we'll stop and have an in camera.

7 MR. KING: Your Honor, would you consider reading his
8 deposition and see if I can go through with Mr. Andrews as
9 to what I was wanting to ask him?

10 THE COURT: I don't have any problem with that. I
11 don't know if that is going to move us any way forward but
12 yeah I'll look at that and we can revisit it.

13 MR. KING: We can do that tomorrow morning. That
14 determines whether or not we can get him over here.

15 THE COURT: All right.

16 MR. ANDREWS: That's fine.

17 MR. KING: I have one other matter.

18 THE COURT: Anything else, Mr. Andrews?

19 MR. ANDREWS: We just need a few minutes to set up
20 before the jury comes back. About five or ten minutes.

21 MR. KING: I have one other matter. This has not
22 been filed with the Clerk as of yet. It's a motion in
23 limine. By way of background, Your Honor, on the morning
24 of March 7th Mr. Sexton was to have a polyp removed from
25 his colon. The plaintiff has witnesses who will testify

1 that they were told by unnamed parties that this surgery
2 was not going forward due to low oxygen saturations and
3 the levels of the '60's. Now the only people that can
4 stop a surgery are the anesthesiologist Doctor Lupo who is
5 a witness here, going to be a witness here; and the
6 surgeon Doctor Espinal. So this is factually not correct
7 and the blood alcohol of the oxygen saturations were never
8 60. The lowest they were, were 85 pre-surgery. But what
9 is more significant is we have no idea who this person is.
10 We've described it as the anesthesiologist; the
11 anesthesiologist is Doctor Lupo. But again there is
12 really no description of this person. The Sexton family
13 they don't know who the person is. And there's obviously
14 no way we can find that person we can talk to them, we can
15 examine them, or do anything cause it's strictly hearsay.

16 THE COURT: I kind of got lost there. If they are
17 identifying the person, and they said is the
18 anesthesiologist, that would be admissible. But now
19 you're saying they don't know how it was.

20 MR. KING: They don't know who it is, they've talked
21 about a anesthesiologist, they've talked about a CR aid,
22 they've talked about several people. Now again I would
23 agree, if they say it's the anesthesiologist but I don't
24 think they know who the anesthesiologist is. Now if they
25 say the anesthesiologist, then I have to accept that.

1 THE COURT: Counsel, this looks like hearsay to me.

2 MR. MCGOWAN: Well it's not, Judge. What the witness
3 said is clearly a medical person who told him that and
4 it's not hearsay under the Fields vs. Regional Medical
5 Center, Orangeburg case because it goes to show the effect
6 of the statement on the listener and that says it's not an
7 exclusion to hearsay. It says it is not hearsay because
8 what matters is what they did as a result. And secondly,
9 even if it is hearsay under 803 1 it is a present sense
10 impression. And that exception to the hearsay rule states
11 a statement describing or explaining an event or condition
12 made with - made while the declarant was perceiving the
13 event or condition or immediately thereafter. That is
14 what this medical person came out, it was before the
15 surgery they are describing the events or condition and it
16 is at the time or immediately thereafter. And Mr. King
17 can go after the credibility of the witness, whatever he
18 prefers to do, but that means that it is Number One, not
19 hearsay because it's offered to show the effect on the
20 listener. And Two, it is a present sense impression 803
21 Sub. 1.

22 MR. KING: Your Honor, both those rules would apply
23 to actions by the hearer. And I submit to you the
24 Sexton's and the Sexton family witnesses did not act upon
25 that information. That would be information if it was

1 given to Doctor Espinal or Doctor Lupo or one of the
2 medical staffing that would be a type of hearsay that the
3 rules that Mr. McGowan posed would be applying to. Again
4 we've got an unknown person that we have no idea who they
5 are. Again if they say - -

6 THE COURT: Let's do this. 803 talks about declarant
7 perceiving a condition, the event or conditions. That's
8 different from having, restating something someone else
9 stated. Receiving means, I mean when someone came out and
10 said -- I read this and the testimony was, I just looked
11 at the oxygen saturation level and it was 60, that might
12 be a little different here. We don't know where this
13 information came from. If it's just a nurse or somebody
14 in scrubs, maybe not, I don't know that it falls under 803
15 1. What was the other rule you were talking about? 70
16 --

17 MR. MCGOWAN: It is in - Let's parse this down.
18 There's two statements going on here. One is, the surgery
19 is cancelled. The second part is because the O2 SATs are
20 too low. Now the surgery is cancelled part is a verbal
21 act that says there is no surgery, its done. That's not
22 hearsay that is a verbal act and it is not a hearsay
23 statement. So are we debating that part or the whole
24 thing?

25 THE COURT: No I don't think they object. All they

1 talk about is -- Well they say the surgery is not going
2 forward due to oxygen saturation levels.

3 MR. KING: What I'm objecting to is that Ms. Sexton,
4 I believe, is going to testify that Doctor Espinal told
5 her the surgery was not going forward. He's a party I
6 don't challenge that. That goes strictly to credibility.
7 Doctor Lupo is not a party. She says that she will
8 testify that the surgery was never considered to be
9 cancelled. Anybody else, first off couldn't cancel the
10 surgery. Second off the hearsay doesn't fall within any
11 exceptions Mr. McGowan has made reference to.

12 THE COURT: Let me look at that case before I make a
13 decision on this. I imagine I will know by this afternoon
14 because it looks like after opening statements now I ask
15 counsel to stay away from that particular part of the
16 equation so to speak since I haven't ruled on it.

17 MR. MCGOWAN: Well there are also a lot of phone
18 calls that were going among the family and we intend to
19 talk about those because those were clearly present sense
20 impression. For instance Chuck Beard, the brother in law
21 of Ricky, was told the surgery is cancelled. He called
22 his wife, Glynnis who is Ricky's sister and says don't be
23 in a hurry to come to the hospital they just cancelled the
24 surgery. Glynnis gets a call from Ricky, Ricky says yeah
25 the surgery's cancelled. He's coughing and then he says

1 oh they're here to get me to do the surgery.

2 THE COURT: If they are going to testify they can
3 testify what was related to them by those individuals. If
4 they are going to be subject - -

5 MR. MCGOWAN: We intend to talk about that in opening
6 and I just wanted you to know so that we weren't stepping
7 on Your Honor's toes.

8 THE COURT: The person making the call is going to
9 testify.

10 MR. MCGOWAN: Both ends of both calls, both ends of
11 both calls are going to testify.

12 THE COURT: All right.

13 MR. MCGOWAN: Thank you, Judge.

14 THE COURT: Bring in the jury.

15 MR. MCGOWAN: Can we get - -

16 THE COURT: Clyde, they need a couple of minutes,
17 about five minutes to set up and then after openings we'll
18 break for lunch.

19 (PAUSE AT 12:05 PM.)

20 (JURY ENTERS COURTROOM AT 12:07 PM.)

21 THE COURT: There is no assigned seating other than
22 for the alternate and the Foreperson. Everybody else just
23 kind of lite where you are.

24 Madame Forelady, you will preside over the
25 deliberations and sign the unanimous verdict when it's

1 time. And also be the liaison between myself, the jury
2 and myself.

3 MADAME FORELADY: Yes, sir.

4 THE COURT: All right. Counsel.

5 MR. ANDREWS: May it please the Court.

6 THE COURT: Yes, sir.

7 MR. ANDREWS: Good afternoon. I want to apologize to
8 you all first, as you all can tell my voice doesn't sound
9 real good. I've been struggling with some infection over
10 the weekend and frankly I couldn't talk until yesterday
11 and if it bothers you in any way I'm sorry, I'm doing the
12 best that I can. Thank you.

13 I imagine that being on a jury and being on a jury
14 for a medical mal-practice case is new to each of you. I
15 can assure you though that this is not a difficult
16 process. And Your work here is relatively straight
17 forward. This case like all legal cases is about rules.
18 This is a medical mal-practice case and the rules of
19 health care are vitally important to make sure that
20 patients do not get injured. We all know that health care
21 is a big business, a big and dangerous business at times.
22 If things go well we get treatment or like in this case we
23 get a certain surgery we go home and we're better for it.
24 If things go bad we're liable to be wheeled out the back
25 in an ambulance dead or in the hospital for months with

1 unnecessary pain and bills.

2 Doctors especially know how dangerous health care and
3 surgery can be. That is why they are taught from the very
4 first day of medical school that they must follow these
5 patient safety rules or that things can happen. Only if
6 the doctor strictly follows the rules can patients be
7 safe. And it's really that simple.

8 Let's talk about Your job as a juror. We think that
9 there are four, we submit to you that there are four
10 questions in this case that you need to decide. Number
11 One: What are the rules as they apply in this case?
12 Number Two: Did the defendant, Doctor Espinal, break one
13 or more of these rules? What did it cost? And Number
14 Four: What are you the jury going to do about it to make
15 it right and to make sure that this doesn't happen again?

16 The first three questions are really simple.
17 Everyone agrees with what the rules are. You will hear
18 testimony, you will hear testimony from Doctor Espinal,
19 everyone agrees what the rules are. How they were broken
20 and what the break of the rules caused. The open end
21 question is what are you going to do about it. Let's talk
22 about the rules. The rules are simply and everybody
23 agrees what they are. This includes the defendant Doctor
24 Espinal who has already gone on the record, we took his
25 deposition testimony and you will see that, and testified

1 about what the rules are. The rules going from general to
2 specific and as they apply here are the following. Number
3 One: A surgeon is never allowed to needlessly endanger a
4 patient. That makes sense. Number Two: A surgeon must
5 be fully informed of his patient's condition before
6 surgery. Makes sense. Number Three: You should never do
7 an elective surgery when its not emergent, not necessary
8 at this time on a patient that comes in with pneumonia.
9 And Number Four is if you choose to do any of the above
10 that we just talked about, the three, you must fully
11 inform the patient and get them to sign off on the
12 increased risk. That's called informed consent. And
13 you've got to talk about the increased unnecessary risk
14 cause and ger them to sign off on it. Those are the
15 rules. A violation of any one of these rules is enough.
16 Those are all common sense rules. And Doctor Espinal as I
17 said to you earlier has already sworn that they are true.
18 It must be followed. We will show you that as this trial
19 progresses but everyone will agree to those rules.

20 You can well see why these are the rules, medicine in
21 the best of circumstances is dangerous. Needless danger
22 has to be avoided. And when a surgery is elective and can
23 wait you must not take any unnecessary changes. And if
24 you take those chances it is always the patient that
25 suffers, not the doctor. So the doctor has to be

1 extremely careful when deciding to do an elective surgery
2 whether or not its appropriate at that time. So we've
3 been over what the rules are.

4 Next step. Did the defendant, Doctor Espinal, and
5 his medical corporation break the rules? You got to break
6 one, you break one or more, one is enough, all right. In
7 order to evaluate whether or not any of these rules are
8 broken you have to know what happened in this case.

9 Let me tell you about this case. On February 16th,
10 2007, Mr. Sexton, sitting right here, our client, we call
11 him Ricky and I'm gonna call him Ricky, he had a
12 colonoscopy performed by Doctor Richardson here in town.
13 He was fifty years old and everybody knows that when you
14 get to be fifty they say you need to get a colonoscopy so
15 he did that. Doctor Richardson is a specialist, he does
16 colonoscopies every day all day. Doctor Richardson
17 located several polyps within the colon and he removed all
18 but one. That's not unusual. You can't always remove all
19 the polyps. And in fact it happens all the time.

20 On February 23rd, a week later, 2007, Ricky and his
21 wife, Tricia or Tricia Sexton meet with Doctor Richardson
22 and Doctor Richardson informs them that he's going to need
23 to get that polyp that's about two to three centimeters,
24 he's going to need to get it surgically removed and he
25 needs to refer him to Doctor Espinal who is a general

1 surgeon to do the surgery. The polyp was flat. They
2 call it sessile; it not upon a stalk so it wasn't easy to
3 get and that's the reason why he had to get a surgeon to
4 do it and that's not uncommon it happens all the time.
5 Again Doctor Espinal is a general surgeon, practices in
6 Rock Hill, he does all his surgeries at Piedmont Medical
7 Center. Nine days later after getting a referral to
8 Doctor Espinal which is March 2nd Doctor Espinal sees Mr.
9 Sexton, Ricky, and his wife in his office. Doctor Espinal
10 briefly examines Ricky tells him the surgery will be done
11 on March the 7th; that would be simple and he would be
12 back to work the following Monday. He's going to operate
13 on him on a Wednesday, he's going to recuperate for a
14 couple of days in the hospital; go home, have the weekend
15 to recuperate and be back at work on Monday. And that was
16 very important to Ricky because Ricky's a pipe fitter and
17 there was a planned outage at the plant that he was
18 working at and he was going to be extremely busy. You
19 will hear that Ricky didn't want to do the surgery in the
20 first place because of this. That's where he works the
21 hardest, works the most and makes the most money and he
22 didn't want to be out. But they assured him he would be
23 back in time Monday to go to work.

24 So having heard that from Doctor Espinal, Ricky
25 signed off, they had to agree to it. During this time on

1 March 2nd Doctor Espinal does a brief examination. One of
2 the things he checks on Ricky is he checks his lungs as to
3 whether or not their clear or not. And this, whether his
4 lungs are clear or not, will become important later and
5 we'll talk about it. But during the examination on March
6 the 2nd his lungs are clear, Ricky has no trouble
7 breathing, and he's feeling well. In fact as part of
8 Ricky's job as a pipe fitter he has to pass those
9 respirator test. He's been doing it for years and he's
10 never had any problem passing those test. Never
11 complained of any difficulty breathing or anything. Never
12 been diagnosed with any lung disease at all.

13 At that time Doctor Espinal does not take any measure
14 of Ricky's oxygen levels during the physical. It's going
15 to play in and this will be important later and I'll show
16 you why it's important. The oxygen level is measured by a
17 red light placed on the finger. It is not invasive and it
18 only takes about thirty seconds and it's very common. The
19 highest oxygen level is a hundred percent. Anything
20 ninety-five or greater is considered to be normal.
21 Anything below ninety is bad and it needs to be
22 investigated. Again Doctor Espinal did not measure
23 Ricky's oxygen level in the office so he had no idea what
24 his base line oxygen level was. Based on what Doctor
25 Espinal had done on March the 2nd, his lungs were clear,

1 he was breathing normally, and thus his oxygen level most
2 probably now in the high nineties would be normal and
3 consistent with Ricky's long history of yearly lung test.

4 Doctor Espinal schedules the surgery for March the
5 7th, started about Seven o'clock in the morning; Ricky's
6 supposed to come in at Six. The day prior to the surgery,
7 March 6th, because he wanted to get it done on March 7th,
8 Ricky's ill. He's coughing terribly and he has a fever of
9 a 101 degrees. Simply put, he was sick the night before
10 the surgery. He had a bag cough and he had a fever.

11 Trisha, his wife, called Ricky's older sister Glynnis and
12 said Glynnis, he's sick, I don't know what to do. What do
13 you think we should do? Glynnis says well, you know they
14 probably won't do the surgery but call them anyway and let
15 them know and see what they think. So Trash calls and
16 they say, come on in, in the morning and we'll see what
17 it's like, we'll let the doctor make that call. So they
18 wake up, actually Ricky wakes up about Three o'clock in
19 the morning on the 7th, he's a little nervous, and guess
20 what? He still thinks -----. He's coughing, he's not
21 breathing very well, and he feels warm. As instructed
22 though he and Tricia drive over to PMC. And they arrive
23 at the hospital at 6:00 am. Trisha tells the nurses about
24 Ricky's fever and the fact that she thinks he has the flu.
25 Shortly after they get there Trisha will tell you that she

1 speaks with Doctor Espinal and the anesthesiologist about
2 Ricky's condition. She will testify that they told her
3 they were going to put off the surgery and let him get
4 well. The surgery is cancelled and she is to go get
5 breakfast and come back in an hour and Ricky will be ready
6 to go home.

7 At the same time, Ricky's brother in law, the husband
8 of Glynnis his older sister, takes a day off from work to
9 come to be with his brother in law as some support. Prior
10 to this scheduled time of this surgery Chuck gets on his
11 cell phone and calls Glynnis, who's right down the road
12 getting ready and says, Glynnis, the surgery is cancelled,
13 no need to hurry down here. He's too sick. Glynnis
14 shortly after that gets a phone call from Ricky in the
15 hospital from his cell phone. And you will hear him
16 testify and her testify as to what happened during that
17 conversation. Glynnis -- Ricky told Glynnis on the
18 telephone they're not going to do the surgery. Glynnis
19 will testify that he was coughing terribly. Could barely
20 understand him, had to make him repeat himself because she
21 couldn't understand him. Was relieved that they weren't
22 going to do the surgery and at the same time Ricky goes
23 well they're here for the OR, they're taking me back to
24 surgery. Glynnis goes, let me -- She didn't get to talk
25 to him and she gets ready and she rushes up to the

1 hospital. She calls Trash they get there about the same
2 time, they get up there and he's in surgery. And they're
3 shocked. They're absolutely shocked. Ricky spent about
4 two hours in the recovery room. Things weren't going well
5 in the recovery room. He wasn't able to breath. He spent
6 about two hours back there; his oxygen saturation range,
7 his oxygen levels had dripped horribly low, dangerously
8 low. They were at deadly levels. And we'll show you
9 that.

10 When they came up they were upset but they figured
11 that well their the doctors and they know best. Then
12 while it was unusual to have surgery cancelled with a guy
13 in that type condition, they know what they're doing, then
14 it must be safe. Over the next couple of days it would be
15 proven that the surgery was not safe at all. Again,
16 Ricky's oxygen levels after surgery were dangerously low,
17 he's placed on a respirator, he goes to the ICU. Three
18 days after the first surgery he's taken back to surgery to
19 fix a massive infected leak of his colon caused by the
20 hole in the colon not healing properly. And you know why
21 it didn't heal properly? I submit it did not heal
22 properly because Ricky was not getting enough oxygen in
23 his blood because he had those low oxygen rates and he was
24 sick.

25 Also, and Doctor Espinal admitted this in his

1 deposition, he had pneumonia prior to the surgery. All
2 right, Ricky stays in the hospital for almost five weeks.
3 Medical bills run in the amount of about Three Hundred and
4 Fifty Thousand Dollars. He misses six months of work.
5 Remember, he was going back to work on Monday. This was a
6 simple procedure, nothing to it. He misses six months of
7 work, has terrible scarring, pain to this day, and
8 limitations. And you'll hear him tell you what those are.
9 More than once during this process, he and his family were
10 told that he probably was not going to make it.

11 All right, so what did Doctor Espinal do wrong? How
12 did he break these basic rules? During the course of the
13 treatment of Ricky, Doctor Espinal told Glynnis, his older
14 sister, who was irate and very concerned about her baby
15 brother, he told Glynnis that he should have never done
16 the first surgery and it was his fault. She will testify
17 to that. You will have to judge the credibility of what
18 she's saying. He said, let's get past that. We need to
19 focus on getting him well. And despite his admission, he
20 never tried to make it right by Mr. Sexton. He never has.
21 He's never taken responsibility for it. In other words,
22 Doctor Espinal's words were it's my fault but his actions
23 are well, not really, you're on your own. So Mr. Sexton
24 fearing he would never be able to work again and to
25 provide for his family contacts us, me and Mr. McGowan.

1 And what do we do? We talk to him. Okay, let's go look
2 at the medical records. And what do those medical records
3 show when we get them? Just prior to the surgery along
4 with feeling like he has the flu, and had a temperature of
5 a 101 the day before, Ricky's oxygen saturation rates are
6 83 or 85. It's hard to read that -- which is low, very
7 low. This is measured by the nurse and it's highly
8 abnormal and this is new for Mr. Sexton. The nurses exam
9 prior to the surgery so the nurse listens to the lungs,
10 finds that the breath sounds were diminished, reduced,
11 he's having difficulty breathing. That's new. Because
12 remember Doctor Espinal a few days later every things
13 fine. Evidently after seeing this the anesthesiologist,
14 Doctor Lupo, orders a chest X-ray. And the chest X-ray
15 just prior to surgery on the 7th shows abnormalities of
16 both lungs. What doctors' call anelectosis. This means
17 that in both lungs the air sacs are collapsed and not
18 working properly. It's an early sign of pneumonia along
19 with other documented medical abnormalities. The
20 anesthesiologist's job is to make sure that the patient
21 can manage the anesthesia safely. It's the surgeon's job
22 to make sure that the patient can go through the surgery
23 properly and he doesn't harm the patient. According to
24 Doctor Espinal, now, after this case is filed, he says he
25 never looked at the chart. He didn't see the abnormal

1 oxygen levels, the diminished breath sounds, the abnormal
2 chest X-ray. Nor did he lay a finger, examine Mr. Sexton
3 in any way. So, the family -- and you all will hear from
4 them and you will judge their credibility -- says that the
5 surgery was cancelled and then abruptly uncanceled.
6 Doctor Espinal says he doesn't remember that happening.
7 It wasn't cancelled. But then he says I never looked at
8 the chart to know the problems. Either way Doctor Espinal
9 broke the patient safety rules. On the one hand if Doctor
10 Espinal did cancel the surgery he would have knowingly
11 exposed this patient to unnecessary danger. He saw it,
12 cancelled it and say no let's go ahead with it he would
13 have knowingly exposed this patient to unnecessary danger.
14 That breaks rule number one. On the other hand if he did
15 not inform himself of the patient's condition prior to
16 cutting him open and proceed anyway, he breaks rule number
17 two. Either way he broke rules number three and four. He
18 did an elective procedure on a person who had pneumonia.
19 And you will see it, we'll show you his deposition, he
20 says he had pneumonia based upon the chest X-ray. Take a
21 look at it. And he certainly didn't get any sign off on
22 the increased risk. Remember we talked about Rule Number
23 Four, the informed consent. He didn't get him to sign off
24 on that, he didn't tell him anything about that. That's
25 recklessness. That's recklessness. For this type of

1 procedure that was being done on Ricky, the lungs are
2 vitally important. Their supported for two reasons.
3 First, is that would have enough oxygen in the blood
4 stream the colon -- he had to get a polyp removed from his
5 colon and we'll talk about that in a second -- the colon
6 won't heal. The tissue itself will not heal normally and
7 you will get what's called a leak from where they put it
8 together. It's not -- it won't heal. A leaky colon
9 inside your body is one of the most deadly tissues around
10 and you must do everything to make sure that this does not
11 happen.

12 The second reason the lungs are so important is that
13 this procedure is started through scopes, or laparoscopic.
14 You make small incisions. When you do that though it
15 compresses the abdomen and the chest like the balloon with
16 compressed air so you could see what's going on.
17 Inflating the abdomen though puts a lot of pressure on the
18 lungs. If there's something already wrong with the lungs
19 inflating the abdomen only makes it worse. Despite the
20 rules according to Doctor Espinal's most recent story, he
21 says he's not aware of the low oxygen saturation rate, the
22 diminished breath sounds, or the abnormal chest X-ray.
23 How do we know that? He told us so. I'm going to show
24 you on Page 23 of his sworn testimony, he says he was not
25 aware of that. Why was he not aware of that? He didn't

1 look at the chart. He didn't look at the chart before he
2 operated on his patient. That's what he says now at
3 least. Because you remember back when he told Patricia
4 the surgery was cancelled he came back later. He also
5 told the family it was his fault and he should not have
6 done it. In any event, Doctor Espinal's excuse for the
7 purpose of this case is on Page 23 of his sworn testimony.
8 We ask him about the medical record where this information
9 appears about the breath sounds and all that, the chest X-
10 ray. We ask him have you ever seen this document before?
11 His answer, no. He never looked at the chart. We will
12 show you that testimony in black and white on Page 23 of
13 his testimony.

14 The rule is that the surgeon must inform himself of
15 the condition of his patient prior to beginning a
16 procedure. Makes sense doesn't it? Doctor Espinal again
17 admits this is his obligation. He will tell you that is
18 his obligation to do that. And his duty as a surgeon to
19 do that. He says so on Page 28 of his deposition
20 testimony. Despite this duty and this obligation that he
21 has, Doctor Espinal says he never looked at the chart. Is
22 this sufficient proof that a single violation of the stand
23 of care? All right we've talked about the rules, the
24 breaking of the rules and what it cost. Excuse me, we
25 haven't got to what it cost.

1 The polyp that needed to be removed is about two to
2 three centimeters. Its sitting on the transverse colon,
3 the descending colon comes up the transverse colon comes
4 across, it's right there. He removes the polyp and about
5 ten centimeters. That's how much he takes out the colon
6 and he sends it off to get it tested. And I'm not going
7 to get into all what he does but basically what he does is
8 he loops it around and he staples it together. It's like
9 a hose. That procedure and you'll hear it called is an
10 anastomosis. Immediately after the surgery Ricky develops
11 a leak where the two ends are stapled. His family says
12 that he's starting to get big, descended, contents from
13 his digestive tract because of the leak begins to flow
14 into his peritoneal cavity which causes a terrible
15 infection in the abdomen of Mr. Sexton. Shortly after the
16 surgery that was done on March 7th it's obvious that Ricky
17 has a leak. Ricky becomes extremely hypoxic, hypoxia is a
18 condition in which the body is deprived of oxygen. He was
19 already deprived of oxygen. He also developed a fever.
20 And his belly continues to swell. Not only that, his
21 heart rate increases well over a hundred beats per minute.
22 That's called tachycardia. And he develops what's called
23 rapid breathing. These are all tell tale signs that Ricky
24 has a leak and needs immediate surgery to fix it.

25 Three days later on March 10th Doctor Espinal finally

1 does an open procedure, discovers a leak and repairs it.
2 Ricky spends about another additional thirty days in the
3 hospital and again his family is told on more than one
4 occasion he's not going to make it. It was during this
5 time when Glynnis the big sister who looks after baby
6 brother who quite candidly is upset with Doctor Espinal,
7 he admits to her and you will hear her testify, he admits
8 to her that he shouldn't have done the surgery. But we
9 got to move on from there. Ricky's then released to a
10 Health South Rehab Hospital, spends about a week there.
11 Then he went home on April the 16th 2007. Because of the
12 complications associated with his stay at the hospital and
13 this unnecessary surgery, Ricky doesn't return to work for
14 six months. This cause of all of this was that his lungs
15 were in no shape for the surgery. And he had pneumonia.
16 The main problem was the low oxygen rate from the
17 pneumonia made it impossible for the colon to heal. How
18 do we know that? Doctor Espinal says so on Page 87 of his
19 deposition testimony. And we'll show you that. He said
20 the reason why it didn't heal because he had low oxygen
21 saturation rates.

22 Last, we talked about the three things, last is what
23 are you going to do about it? And that brings us to how a
24 trial like this is put together and how things work from
25 here. This is -- Again this is a medical mal practice

1 case. Essentially it says that the doctor did not provide
2 the minimum level of care the law requires and someone got
3 hurt. Under our law this is a civil case and only money
4 and future conduct can be affected by it. Medical license
5 are never an issue in these cases. So how do you prove a
6 case like this?

7 Well, there is a period of months of investigation
8 before a case like this is even filed. You have to first
9 obtain all the medical records. It takes a long time.
10 You will get to see those medical records, they've been
11 admitted into evidence and we'll have a notebook. Not all
12 of them but what we the defense lawyers agree are the
13 relevant ones. The records show what was done and what
14 was not done for Mr. Sexton. And after we investigate
15 those records ourselves, which again is time consuming, we
16 send them out to acknowledged experts in the field. This
17 field is called the field of surgery, general surgery.
18 These experts in the field are provided the entire medical
19 record. Here, tell me what you think. In this case you
20 will hear from Doctor Robert Solymvari, he's a surgeon
21 that has more than twenty-three years of experience. He
22 performs surgeries just like what Doctor Espinal does
23 every day. He trained at Johns Hopkins one of the most
24 preeminent hospitals not only in the country but in the
25 entire world. He speaks three languages, and has much

1 experience in the Charlotte area. So the experts we sent
2 these records to they reviews the records and they tell us
3 that the doctor's did or did not meet the minimum standard
4 of care. If they tell us they did not, end of story;
5 we're done. If they tell that they did then you have to
6 get what's called an affidavit sworn testimony from him
7 and that's how this case starts. It takes about two and a
8 half, sometimes two to three years to get from that
9 process to where we are today so it's a long process. And
10 during those three years the other side produces witnesses
11 and we get to take testimony from the witnesses. You know
12 that we've deposed Doctor Espinal because I've read from
13 that several times today. We've also deposed their
14 experts, they've deposed our experts. They hire their own
15 experts who will support their case. Generally these are
16 experts that have some connection with the defendant. You
17 will have to consider how easy it is to find one doctor to
18 support another in a case like this. You will have to
19 judge the credibility of other witnesses. Again this case
20 is about whether or not medical rules were followed. If
21 this was a tragic case, if somebody ran a red light that's
22 pretty easy. We all know the rules. Medical case are a
23 little bit different and the rules are made by medical
24 professionals. And that makes sense. The last thing we
25 need is some person with the government telling doctors

1 what they're supposed to do. We need doctor's to
2 determine what the rules are. But there is also another
3 important factor. We need you to hold, juries just like
4 you, to hold doctor's to their own standards and rules.
5 Without that there would be death and destruction
6 everywhere. That is why you are here to make this right
7 and to make sure this doesn't happen again. What do we
8 have to prove? This is a simple negligence case. What
9 that means is that we have to prove to you one and only
10 one deviation from the standard of care. I said that
11 before. And we'll prove all four of them but all we got
12 to do is prove one. We then have to prove as a result of
13 that deviation from the standard of care that someone was
14 hurt. What's different about this and the car wreck is
15 this involves medical care. And under our law that means
16 we have to bring in a specialist and that's to prove this
17 kind of case. You will hear from Doctor Solymvari and you
18 will learn everything you know to make a good decision.
19 Just because this is medical does not mean it's
20 complicated. What is our burden of proof? Perhaps you've
21 heard people say the plaintiff has the burden of proof.
22 They have to prove their case. And the burden of proof in
23 a civil case is a relatively low burden. If you imagine
24 the scales of justice, you've seen the lady scales of
25 justice, all we have to do with the evidence that we

1 present, is tip the scales ever so slightly in our favor
2 and we win. This is not a criminal trial where you have
3 to prove something beyond a reasonable doubt. That's not
4 the burden here. You don't have to be absolutely sure
5 that we've proved our case. Just more likely than not.
6 And that's what the law says and that's what you have to
7 follow. And we'll do that and we'll exceed as well. You
8 must issue a verdict for or against according to the law
9 and the evidence in this courtroom. Who are we suing and
10 why? Well we're suing Doctor Espinal and his medical
11 corporation. Why? He violated the first medical rule.
12 Never expose your patient to unnecessary risk. Doctor
13 Espinal performed an elective surgery that should have
14 been rescheduled. Whether he cancelled it and then
15 uncanceled and never looked at the chart, either way,
16 doing this elective procedure when Ricky had pneumonia and
17 the other conditions that he had was just wrong. It
18 should have never been done.

19 The second reason that we're suing Doctor Espinal and
20 his medical corporation he was not informed of the
21 patients condition prior to operating. He simply did not
22 inform himself of Mr. Sexton's oxygen levels, diminished
23 breath sounds, and his chest X-rays. That assumes that
24 his testimony in his deposition that his odds with
25 everybody in the family that says that it was canceled.

1 And they left. Think about that. They get up and ride up
2 there at Six o'clock in the morning and I guess I don't
3 know what the testimony is maybe they decided to leave.
4 They left for a reason and the reason why - surgery and
5 that's what they were told. So he was wrong to proceed
6 with the surgery after he cancelled it. Or he was wrong
7 in ignoring the lung issues that would have lead to a
8 cancellation. Either way is wrong. He broke the rule,
9 Ricky got hurt.

10 The third reason we're suing Doctor Espinal and his
11 medical corporation is that Ricky had pneumonia. The only
12 person to testify that he had pneumonia do you know who it
13 is? Is Doctor Espinal. He testified that in looking at
14 the chest x-ray he had pneumonia. The chest x-ray again
15 was ordered by the anesthesiologist just prior to the
16 surgery. Did he look at it? No. Not prior to the
17 surgery. Again this is an elective procedure. You know
18 why they wanted to remove the polyps; right? They think
19 they might be cancerous. They may not be, just as an
20 abundance of caution. He can wait. This isn't something
21 that needs to be done a week, five days later, ten days
22 later. He can wait longer than that. You can't do an
23 elective procedure on somebody in this type of condition.
24 It's just too dangerous, it's too risky.

25 So, the forth thing, if you chose to ignore the other

1 three that we just went over then you have to get the
2 patient to sign off on the increased risk. That's the
3 informed consent. That didn't happen. That's the forth
4 reason that we're suing Doctor Espinal. You might be
5 wondering to yourself well why would Doctor Espinal do
6 this? Was he sloppy? Not paying attention? Motivated by
7 money? We don't know. And the judge will never tell you
8 that we have to prove what his motivation was. We don't
9 know what his motivation was. We don't know for sure why.
10 We do know that if the surgery was cancelled then the OR
11 would have been lost and then Doctor Espinal would lose
12 that valuable OR time. With no OR time operating room a
13 surgeon cannot bill. Again we don't know for sure why.
14 May not ever know and we don't have to prove that. What
15 do we want? This is a civil law suit and the only thing
16 that we can ask you for is money. That's unclassified,
17 that's undignified, when you -- it's hard to put into terms
18 the pain, the injuries, but that's all we can ask for. As
19 you heard earlier from the judge we're in civil court.
20 You can't put him in jail. And we're asking for a
21 substantial sum of money. I have to read it. It's One
22 Million, Nine Hundred and Twenty-Nine Thousand, Three
23 Hundred and Thirty-three Dollars, and Forty-three cents.
24 That is a specific number and I will never be able to
25 fully explain to you why that specific number. But that

1 is what we seek. It does include a specific sum for the
2 medical damages, about Three Fifty. Loss wages: Those
3 damages total up to Four Hundred Thousand Dollars. He
4 also has some residual problems, things that will be with
5 him for the rest of his life as a result. So the
6 remainder is what the law allows and further than that I
7 don't think I can explain it to you much more.

8 Ultimately though the amount of money is up to you.
9 The money is designed to do two things. First to make it
10 right for Ricky and Trisha. Secondly, to hold Doctor
11 Espinal accountable for his actions, to make sure that
12 this does not happen. If we don't hold the doctor
13 accountable, then negligent conduct is encouraged and it
14 will be repeated. Folks will watch what happens here and
15 thus we ask you to be the safe guard for safe, good
16 medicine in this community. I assure you that doctor's
17 watch patients like this -----, what you do or not do will
18 determine health care, whether health care gets better or
19 worse in this county. In many ways your verdict will
20 effect the next patient as much as Mr. Sexton. It will be
21 one question on the verdict form, when you go back to
22 render your verdict you will get a verdict form. And
23 there will be on question down a little way, and I will
24 ask you if Doctor Espinal was reckless. Doctor Espinal
25 knew the dangers and proceeded anyway. That's reckless.

1 We'd ask you to check reckless when you get to that
2 verdict form.

3 Ultimately you have to decide whether or not to let
4 Doctor Espinal slide. The whole reason that we have this
5 tort system to what we do here is to protect public safety
6 and you play a huge role in that. We can never undo what
7 happened to Ricky and what they've been through. We can
8 only try to do right by him and we can try to make sure
9 that Doctor Espinal gets the message and other people get
10 the message and this doesn't happen any more. Thank you.

11 THE COURT: Mr. King.

12 MR. KING: May it please the Court.

13 Good morning, or afternoon. I'm Spencer King, this
14 is my law partner John Rogers with me and we are defending
15 Doctor Espinal and his - -

16 MADAME COURT REPORTER: Mr. King.

17 THE COURT: You're not coming in good.

18 MR. KING: I'm sorry.

19 MADAME COURT REPORTER: That mic, would you please.

20 MR. KING: Let me first thank you all for leaving
21 your jobs and your families and your homes and coming down
22 here and this vast amount of money that York County pays
23 you for your services. The good news, this case will
24 probably not last more than three days. You have a very,
25 very important role. You may say I don't know anything

1 about law and I don't know anything, so how did I get
2 picked to be on this jury. Well you got picked to be on
3 this jury because you bring your collective experience and
4 wisdom and education and meet eleven other people and you
5 are going to decide after you review the evidence and
6 listen to the witnesses in this case, what the truth is.

7 Now, it does involve medicine which is a technical
8 science and there will be a number of medical providers,
9 some physicians, some expert witnesses who are physicians
10 in the field of surgery, who have been employed by the
11 plaintiff or by the defendant to come testify and help you
12 understand what the standards are.

13 Your role is to decide who is most accurate in
14 describing the facts that occurred to you. The medical
15 providers will tell you about the medicine. We have
16 agreed with the Plaintiff's to give you an extracted
17 record of the medical records involving Mr. Sexton's care
18 in hopes that they will be beneficial to you. Each of
19 you will have a set of those records and then we will give
20 you sometimes about the time you start hearing testimony.

21 Now, at the conclusion of the case your role is to go
22 out and reach a verdict based upon the instructions that
23 Judge Hayes gives you as to the law. You judge
24 credibility, you judge the evidence. The medical
25 providers will tell you what the medicine is. Judge Hayes

1 tells you what the law is.

2 Now, we lawyers are advocates. We try to interpret
3 the facts as they are favorable to our side. Now I'm not
4 going to set up here and waste your time and tell you how
5 many places I disagree with Mr. Andrews and Mr. McGowan as
6 to who said what and what the facts are in this case. I
7 don't want to bore you and I don't want to waste your time
8 because you're going to hear that from the witnesses. And
9 then you're going to decide whether Mr. Andrews accurately
10 reflected or told you what the facts are in this case or
11 whether or not he twisted them.

12 Now, let's go back to the beginning. Mr. Sexton goes
13 to see digestive disease and sees a Doctor Scot Richardson
14 for a colonoscopy. Now a colonoscopy is a procedure where
15 the physician looks with a tube into the colon looking for
16 polyps. The colon is also called the large bowel. It's
17 right here.

18 (ATTORNEY KING INDICATED TO HIMSELF.)

19 MR. KING: And the colon has a propensity to grow
20 polyps. Polyps are fatty growths that adhere to the walls
21 of the colon. Now some of them are like mushrooms or like
22 on a stalk. And the gastrointestinal physicians now have
23 the capacity that when they're doing the colonoscopy, they
24 can snare, they can snip the mushroom like polyps off the
25 wall. Now there are other types that are -- that adhere

1 to the side of the wall and the gastrointestinal people do
2 not have the ability to remove those. They have to be
3 surgically removed. Any of these can be cancerous. Any
4 of these can grow to be a blockage. Polyps in the colon
5 grow very rapidly, often times without symptoms. Colon
6 cancer is the second largest cause of cancer deaths in
7 this country. They can also cause blockages. They cannot
8 be ignored. So after having removed the ones that the
9 gastrointestinal people were able to do, there was a polyp

10 ---

11 (ATTORNEY KING INDICATING TO DISPLAY.)

12 MR. KING: --- the ascending colon. Look at this,
13 this is like this. So it's the right hand side of the
14 colon, coming up it is, this is coming up, this is the
15 transverse. And the polyp that has to be removed is right
16 here.

17 (ATTORNEY KING INDICATING TO DISPLAY.)

18 MR. KING: You're going to hear testimony about the
19 mesentery. Now the mesentery is this tissue in here that
20 supplies blood to the colon. Now, after the digestive
21 disease did the colonoscopy they send Mr. Sexton to Doctor
22 Espinal's office. And Doctor Espinal does first, he
23 examines Mr. Sexton and he takes a history. And Mr.
24 Sexton for whatever reason is not a good historian. He
25 doesn't tell him about several medical conditions and

1 procedures that he has had in the past that may have
2 relevance to this case. He does not tell Doctor Espinal
3 that he is a smoker, a heavy smoker, forty pack a year, or
4 a forty year smoker with amounts that vary depending upon
5 who he was talking to from zero to Doctor Espinal up to
6 two packs a day as he is going to tell the
7 anesthesiologist and he still smokes. But he neglects to
8 tell Doctor Espinal about his smoking history.

9 Doctor Espinal discusses with Mr. Sexton with his
10 wife present, they have no question what the risk and
11 complications are with this surgery. All surgeries -- Now
12 I'm gonna tell you, there ain't no little surgery -- All
13 surgeries carry risk and complications. The standard was
14 of bleeding, infection. A complication that come about in
15 this case and can come about not necessarily because of
16 negligence, it can just happen, is an anastomotic leak.

17 Now the procedure that was done in this case is to
18 remove about two or three inches of the colon in this
19 area.

20 (ATTORNEY KING INDICATING ON DISPLAY.)

21 MR. KING: Which will then you will have this section
22 missing and they have to be rejoined. Now that can leak.
23 And that is explained to Mr. Sexton and he has no
24 question. Now my friend Mr. Andrews says that Mr. Sexton
25 didn't sign off, he didn't sign the consent form to this

1 procedure. Well, I'm going to ask you when you look in
2 your medical notebooks, it's there. Not only is there one
3 for the first surgery but there is one for the second
4 surgery which is clearly an emergency surgery.

5 Now, on the morning of March 7th, as scheduled Mr.
6 Sexton reports to Piedmont Hospital. Now there will be
7 testimony of the Sexton family members that he had the
8 flu. Well, ladies and gentlemen, that is not born out in
9 the records at Piedmont. He has no temperature. The only
10 thing abnormal that he does have is he has what you will
11 hear about are low oxygen saturations or low oxygen in the
12 blood. It can be caused by many things. One thing that
13 causes it is a heavy smoker.

14 Now, surgeons are not the first line to decide
15 whether or not to go forward with a surgical procedure.
16 The first line is to decide whether or not that patient
17 can undergo a general anesthesia and that is the
18 anaesthesiologist. And the anesthesiologist in this case
19 is Doctor Lupo. And Doctor Lupo after meeting with Mr.
20 Sexton, having the information about the low oxygen
21 saturations, there is no fever, does a chest x-ray; orders
22 a chest x-ray. And that is, again, that is in the records
23 that you will have. And, ladies and gentlemen, there is
24 no acute, there is no pneumonia presurgery. Pneumonia
25 does develop no question later on after the first surgery

1 but at this point there is no pneumonia. Now, Doctor Lupo
2 is faced with is that she's got a patient that has low
3 oxygen saturations, COPD. He's got a polyp in his colon
4 that may be harboring a cancer, the COPD is not going to
5 get any better. We know that Mr. Sexton is active, has a
6 tough hard job and has, regularly has oxygen test so he's
7 able. So she concludes after she does the chest x-ray or
8 has the chest x-ray done, that he is a suitable candidate
9 and she clears him for surgery and proceeds with surgery.

10 Now there is nothing in the first surgery to remove
11 the polyp. Doctor Espinal goes in removes about two or
12 three inches and reconnects. Mr. Sexton does require a
13 stay in the recovery room a little longer than normal. He
14 then goes to the floor and pretty well day one which is
15 the 7th, I'm going to refer to Day One as the first day,
16 first day in the hospital. It is March the 7th. Things
17 are about as you would expect with most surgical patients.
18 Day Two because of the oxygen saturations Doctor Espinal
19 calls in a pulmonologist, Doctor Denenberg. Then again
20 things are going as appears no problems with the surgery
21 procedure. Then on Day Three which is the 9th of March,
22 Mr. Sexton starts generating, goes as high as a 104, he
23 get tachycardia, fast heart beat. These are all signs and
24 symptoms of an anastamotic leak where you have contents in
25 the colon that is leaking into the abdominal cavity.

1 So, confronted with this Doctor Espinal then takes --
2 Generally if you have an anastomotic leak a surgical
3 procedure in the colon is not going to manifest itself
4 within a matter of hours, immediately or in a matter of
5 hours or even a matter of days, it's going to take some
6 time. So Doctor Espinal then moves him into a higher
7 skill level of the hospital and orders a CT contrast.
8 Puts the contrast into the colon and observing or had a
9 radiologist observe it to see if it's leaking. And that
10 is attempted on the afternoon of the 9th.

11 For whatever reason the contrast does not get far
12 enough into the colon that it's really definitive of
13 what's going on so it has to be redone on the morning of
14 March the 10th. It's done with Doctor Espinal being right
15 there. He's not the radiologist but he's right there and
16 you will be able to see the CT. You can see the contrast
17 and you can see that it was leaking. This is an
18 emergency. This is a true emergency and you have to got
19 to go in and suture up and stop the material that is
20 leaking into the abdomen and that is what is done. And in
21 so far as sealing up the leak that's done. What is
22 significant -- maybe because there is two surgeries in two
23 days or underlying health issues, Mr. Sexton goes into
24 respiratory distress. He has a bad result. Now no
25 physician wants his patient to have a bad result.

1 Physicians spend their entire life training to heal
2 people, not hurt people.

3 Mr. Sexton is to be commended. He has a rough row,
4 he is several months out before he is able to go back to
5 work but he goes back to a job as a pipe fitter which he
6 tells me is tough as hell and I don't doubt that one bit,
7 and misses no time from work after that, so he has made a
8 good medical recovery and I commend him for it.

9 Now, ladies and gentlemen, we don't argue that this
10 is a bad result. The bad results do not necessarily mean
11 medical negligence. The issue in the case, the first
12 issue you need to reach is whether or not Doctor Alec
13 Espinal was medically negligent. Did he breach the
14 standard of care? That's the first issue. And then the
15 second issue, did that approximate cause that result of
16 any damages to Mr. Sexton? I tell you that it did not. I
17 thank you for listening to me. I want to close with one
18 thing. No, government should not tell physicians how to
19 practice medicine. And let me tell you who else shouldn't
20 tell them how to practice medicine. Plaintiff lawyers.

21 MR. MCGOWAN: Objection, Judge, that's entirely
22 inappropriate. It ought to be stricken -

23 THE COURT: Disregard that last statement. That was
24 argumentative.

25 MR. KING: Can you hear me on that?

1 THE COURT: I told them to disregard the last.

2 All right, we're gonna break for lunch until 2:30.

3 You report back to the jury room by 2:30. Not to the
4 courtroom, have a pleasant lunch and remind all my
5 admonitions about not discussing the case. We'll see you
6 back at 2:30.

7 (JURY EXITS COURTROOM FOR LUNCH AT 01:10 PM.)

8 THE COURT: I would like to see the case you
9 mentioned. Anything before we break for lunch?

10 MR. ANDREWS: Yes, Your Honor. Mr. McGowan made the
11 objection but I'd like an admonition to counsel. I
12 thought that was extremely underhanded. To make comments
13 that we tell doctor's what to do in front of a jury. I
14 almost want to move for a new -- a mistrial. I mean it's
15 just so wrong.

16 THE COURT: I told them to disregard it.

17 MR. KING: Your Honor, you've ruled and I'm not
18 questioning that. Mr. Andrews in my judgment went further
19 than that when he basically tells that jury they decide
20 they get the information, they sent the records to their
21 expert and if it's not an breach of the standard of care,
22 the case goes away. Now I'm not sure how I said anything
23 other than counter exactly what Mr. Andrews just said. He
24 spent much more time telling that jury that than what I
25 did. And I don't think that what I did was improper, Your

1 Honor. I was told to disregard it and that's clear
2 instruction.

3 MR. ANDREWS: That's a disingenuous argument.

4 THE COURT: Well I think, you know, we've gone a long
5 way when I started practicing law we took five minutes to
6 tell them what was in the complaint. We now allow rather
7 more substantial opening statements, they do almost border
8 on closing arguments. I can't find the rule real quick
9 but I believe the opening statements have the word in them
10 non argumentative so I think possibly those, there was
11 some arguably argumentative statements and nobody objected
12 to them. That's where I have some concern. I think we're
13 okay where we are now. I'm not - nobody made a motion for
14 a mistrial, I told the jury to disregard that and we'll
15 move on.

16 MR. MCGOWAN: That case cite, Your Honor, I can have
17 somebody run the case over.

18 THE COURT: I can get it.

19 MR. MCGOWAN: Okay.

20 THE COURT: Just give me the cite and let me write it
21 down.

22 MR. MCGOWAN: Yes, sir. It's *Field's versus Regional*
23 *Medical Center*, 609 S.E. 2d 506, 2005 Supreme Court case.

24 THE COURT: All right. I can get it.

25 I don't have a clerk but I do have West Law. Thank

1 you.

2 (COURT IN LUNCH RECESS AT 01:15 PM.)

3 (COURT BACK IN SESSION AT 02:35 PM.)

4 THE COURT: Thank you. Take your seats.

5 Anything from the Plaintiff before we get the jury
6 back in?

7 MR. MCGOWAN: No, sir.

8 THE COURT: Defense?

9 MR. KING: No, sir.

10 THE COURT: Let me just ask, Mr. McGowan, I read that
11 Field's case over lunch and I didn't see, I thought you
12 said it had something to do with the motion in limine and
13 the impact on the error of the comment. I didn't find
14 anything like that in the case.

15 MR. MCGOWAN: Oh, yeah, it was in there.

16 THE COURT: All right.

17 MR. MCGOWAN: It had to do with the effect on the
18 listener and the issue was whether the reported expert
19 could testify why he wasn't board certified.

20 THE COURT: Well I was looking at the right case but
21 I did not see that part.

22 MR. MCGOWAN: It said that his testimony was going to
23 be "counsel told me it was a conflict of interest for me
24 to take the board exam because I was the one that wrote
25 it" and that wasn't allowed in. And they said that that

1 was not -- it was objected to on the basis of hearsay and
2 kept out on the basis of hearsay and the court said that
3 was not hearsay because it went to go to show the effect
4 on the listener.

5 THE COURT: Well let me, while you all, let me bring
6 my computer in here then I can kind of look at that
7 without --

8 MR. MCGOWAN: I'll give you a pinpoint cite.

9 THE COURT: I got it.

10 (PAUSE.)

11 MR. MCGOWAN: If the Court is citing CJS Evidence?

12 THE COURT: All right. You had a chance to look at
13 it?

14 MR. KING: No, sir, I have not had a chance to look
15 at the case.

16 THE COURT: Can you go ahead with some witnesses or
17 do we need -

18 MR. MCGOWAN: Oh no we can go ahead.

19 THE COURT: Okay.

20 MR. MCGOWAN: We have an expert that will take about
21 an hour or two.

22 THE COURT: Okay. All right, well let's do that and
23 I'll -- I did not see that in there but I will, you say it
24 is I'll find it and then I'll let Mr. King.

25 All right, bring in the jury.

1 (JURY REENTERS COURTROOM AT 02:40 PM.)

2 THE COURT: All right, call your first witness.

3 MR. MCGOWAN: Thank you, Your Honor.

4 The Plaintiff calls Doctor Robert Solymvari.

5 MADAME CLERK: Doctor, if I can have you stop right
6 here. If you'll place your left hand on the Bible and
7 raise your right please.

8 (WHEREUPON: DOCTOR ROBERT
9 SOLYMVARI, BEING FIRST CALLED AND DULY SWORN, TESTIFIED AS
10 FOLLOWS:)

11 MADAME CLERK: Thank you. You may have a seat
12 please, sir.

13 DIRECT EXAMINATION

14 DOCTOR ROBERT SOLYMVARI BY MR. MCGOWAN:

15 Q. Doctor, let's start off with introducing you to the
16 jury. Can you tell the jury where you're from?

17 A. I'm Doctor Robert Solymvari. I'm from Thomston,
18 Georgia. I reside in Pike County in Georgia and I'm a
19 general surgeon.

20 Q. Now, tell me about your educational background. How
21 is it, what education do you have to become a surgeon?

22 A. I was born in Europe, I grew up in Germany, finished
23 high school in Germany. Completed medical school in
24 Munich, Germany. After I moved to the United States after
25 completing my examinations to qualify for a United States

1 residency program I had spent two years at John's Hopkins
2 in general surgery residency and finished my residency in
3 three years, an additional three years in Charlotte, North
4 Carolina at Carolinas Medical Center.

5 Q. So you had medical school and then after that there's
6 a five year surgery residency that you went through?

7 A. That's correct.

8 Q. All right, tell the jury a little bit about what a
9 residency is? What is that work environment like for a
10 surgeons to be?

11 A. A residency is where you basically work under a
12 supervisional or the working surgeons testing components
13 to what you call more of a diccative component. That's
14 some of the lesser part and you still attend conferences
15 and some theoretical teachings, maybe one or two hours a
16 day. And most of the day you basically work, surgeons
17 performing operations, taking care of patients, and you
18 have increasing responsibilities as you're experience and
19 knowledge grows during the residency.

20 Q. So there is some class room learning and the rest is
21 hands on tutelage of the supervision of other surgeons?

22 A. That is correct.

23 Q. And then as you progress in the residency, do you
24 become more of a teacher and less of a student?

25 A. That is correct. Usually by the time you are a four

1 or fifth year resident usually you run your own service
2 with some board level residence and then you become what
3 sometimes it's called the teaching assistant and so you
4 actually start to teaching the lower level residence as
5 that time.

6 Q. Now do you, how many hours a week of residency, how
7 much are were you working there?

8 A. When I came through it was a hundred to a hundred and
9 twenty hours a week. Right now it's limited to eighty.

10 Q. Now, as part of the residency program, were the cases
11 that you all working on reviewed sort of as a group in M&M
12 conferences I think you called them?

13 A. Yes. Every time we had a complication Thursday
14 mornings from 7:30 to Eight o'clock we had what's called
15 morbidity mortality. Morbidity means disease or
16 complications from the surgery and mortality if somebody
17 died. So any bad complication or death related to a
18 surgical case of a patient we took care of had to be
19 discussed in open forum with the entire surgical
20 department.

21 Q. And that would be held every Thursday morning during
22 your residency?

23 A. Every Thursday morning.

24 Q. And you may or may not have the case at issue, but
25 any issues that came up among the service would be

1 discussed during that Thursday meeting?

2 A. That's correct.

3 Q. Okay. Now, let's talk about your work background
4 since the end of your residency, you finished your
5 residency here in Charlotte; is that right?

6 A. That's correct.

7 Q. And then tell me what your work environments been.

8 A. I joined the private practice called Dillard Surgical
9 Specialist in Charlotte which I was at that practice until
10 2004. In addition to working as a private practice
11 surgeon, I also participated as an instructor and teacher
12 at the residence program with Carolinas Medical Center.
13 And I also participated on the Level One Trauma Center as
14 a Level One Trauma attending usually weekend shifts, you
15 know, where we cover the trauma center as an attending
16 surgeon, meaning we supervise the service.

17 Q. So not only were you working as a private practice
18 surgeon, you were also teaching residence?

19 A. That's correct.

20 Q. Okay. And since 2004 you been in Thomston, Georgia.
21 Right?

22 A. Yes. I moved to a smaller town and work at one
23 hospital there.

24 Q. And you're the only surgeon for what, four counties I
25 think?

1 A. Right now my partner just left town so I'm the only
2 person for four or five counties.

3 Q. Are you board certified in any medical speciality?

4 A. General surgery.

5 Q. Now, what does it take to become board certified?

6 A. You have to go to medical school, you have to
7 complete an approved general surgery residency in the
8 United States. You have to pass a written and oral
9 examination on separate, you know, time lines and then at
10 that point you're board certified. In addition to that
11 there is what they now call a maintenance of
12 certification. Its not just board certified so I can just
13 move on with my life now, you're required to periodically
14 submit your cases to boards so they can review it and make
15 sure you have a good experience and good results. And
16 also you have to take interment examinations that you're
17 up to date on your surgical knowledge theoretically.

18 Q. So do you have to prove before you get to take the
19 exams that you have certain level experience and certain
20 number of cases and things of that nature?

21 A. Yes. You have to submit your surgical log from your
22 residency and make sure you have enough -- There is a
23 requirement for each case. You have to do a certain
24 amount of colons surgeries, you have to do a certain
25 amount of appendectomies, you have to do a certain amount

1 of different operations for the board to approve you based
2 on your operative experience and then you have to prove
3 your theoretical knowledge by taking the two different
4 boards, a written component and then an oral component.

5 Q. And what is the oral exam like? Is that a board of
6 physicians asking you --

7 A. Oral examinations usually consist of three, I think,
8 half hour exams during the day in front of professors.
9 Basically they are surgical board members. They are
10 usually professors who are very well established in the
11 science of surgery and they basically examine you making
12 sure that, you know, give you case presentations. They
13 say I have a patient who has a two centimeter polyp, tell
14 me how you're going to handle this case. And you have to
15 present the case and they will assess if you are safe or
16 unsafe to you at that point have to be board certified.

17 Q. Is what is tested on the exam what is taught to
18 surgeons generally applicable? In this case is what we're
19 going to be talking about generally headed and applied by
20 all general surgeons in the country?

21 A. Yes.

22 Q. Okay. So tell us what general surgery is? That's a
23 specific medical speciality but what does it deal with?

24 A. General surgery is actually a very specific
25 speciality. People that are a little bit lost they say oh

1 it's general. Its not really general, its just a term
2 applied more that it has a very wide scope. General
3 surgeons perform just about every operation inside the
4 abdomen, operating on the intestines, stomach, make gall
5 bladder, pancreas, occasional blood vessels. We do
6 operate on the skin, removing skin cancers and other
7 things. We operate on the neck, head neck area, removing
8 tumors. Some general surgeons like myself they also do
9 vascular surgery. So general means that we are pretty
10 widely trained as taking care of just about as much of a
11 human body as possible except brain, chest, and maybe
12 bones.

13 Q. Okay. Have you ever in your practice dealt with
14 colon surgery?

15 A. Yes.

16 Q. How common is that in the bag of surgeons, surgeries
17 that you would do?

18 A. Very common. Certain colon problems are very common.

19 Q. Okay. And how many colon surgeries would you say
20 you've done?

21 A. I've done at least five hundred if not a thousand.

22 Q. And what about in this particular case, a polyp
23 resection or a resection the part of the large colon.

24 Have you done that?

25 A. I would say at least a hundred if not more. I would

1 say hundreds.

2 Q. Okay. Now tell me what you have looked at in
3 connection with your work in this particular case? What
4 materials have you reviewed?

5 A. I was supplied medical records from Mr. Sexton's
6 admission and first admission, and then hospital reports
7 and his rehabilitation records and of course depositions
8 of people participating in this law suit and experts.

9 Q. How do you approach an issue like this? When you're
10 presented medical records what is it that you go through
11 to determine whether somebody did or did not meet the
12 standard of care?

13 A. I start like I would start working up a patient. I
14 try to, you know, I try to evaluate the, you know, what
15 was the presenting problem, what was the basic chief
16 complaint, what test have to be done to come to conclusion
17 of his diagnoses, go through his medical history, his
18 medications, his risks, his current condition; then I
19 basically, you know, if it's a surgical case I will review
20 the operation to make sure that -- and of course paying
21 attention what was actually the question where did
22 something go wrong. Usually when I read a case something
23 went wrong there was a complication. And of course then
24 you had to review the patient's postoperative reports to
25 see how he was treated, how his outcome was, and did he

1 recover and what I could assess from his discharge was his
2 residual condition. You know some of it I cannot because
3 I cannot reexamine the patient after they leave the
4 hospital but pretty much get the full picture to see
5 what's going on.

6 Q. Is there a difference between a complication and an
7 injury that's caused by negligence?

8 A. Very much so. We have complications every day, that
9 is hopefully a very rare occurrence.

10 Q. All right. Are you prepared in this case to give us
11 your professional opinions?

12 A. Yes I am.

13 MR. MCGOWAN: Your Honor, at this point we move
14 Doctor Solymvari as an expert in the field of general
15 surgery.

16 THE COURT: Any voir dire?

17 MR. KING: Doctor Solymvari, you do laparoscopic
18 partial colectomies?

19 A. Yes I do.

20 Q. And how often do you do those?

21 A. I do about twenty to thirty a year.

22 Q. And how many, do you do open procedures also?

23 A. Yes.

24 Q. And how many open procedures do you do?

25 A. During the year?

1 Q. Yes.

2 A. It's less and less. I would say I do maybe about a
3 total of sixty to seventy colon cases a year. And it's
4 getting less and less, you know, as far as clearly open.
5 But there's continuing to between laparoscopic assisted or
6 open.

7 Q. Have you reviewed the records of Digestive Disease
8 Associates, Doctor Pennington?

9 A. I cannot recall right now.

10 Q. The group that actually did the colonoscopy, removed
11 the first polyp?

12 A. Yes.

13 Q. You have reviewed those records?

14 A. Yes.

15 Q. You've looked at the Piedmont records?

16 A. Yes.

17 Q. Have you not seen the surgical consents signed on
18 March the 6th?

19 A. I haven't found the surgical consents in my notebook.

20 Q. Okay.

21 A. I remember there was a question at the time of the
22 deposition.

23 Q. But your testimony is you haven't seen it?

24 A. Yeah that's my testimony.

25 Q. Okay.

1 THE COURT: Any objection to his qualifications?

2 MR. KING: Other than that no, sir.

3 THE COURT: I find he is qualified as a general
4 surgeon.

5 MR. MCGOWAN: Thank you, Your Honor.

6 Q. Doctor Solymvari, may we assume that all your
7 opinions are to a reasonable degree of medical certainty
8 and held to a standard of more probably than not unless
9 you tell us otherwise?

10 A. Yes.

11 Q. Based upon your review did you find one or more
12 deviations from the applicable medical standard of care by
13 Doctor Espinal?

14 A. Yes.

15 Q. And did one or more of those deviations cause or
16 substantially contribute to the injuries and
17 hospitalization of Mr. Sexton?

18 A. Yes.

19 Q. All right. Now let's start from the first
20 principles. What is a surgeon's fundamental job?

21 A. I would say when you encounter a patient it's
22 evaluate the patient, diagnose his condition and assure
23 that he safely gets through the point of healing.

24 Q. Is there danger involved with every surgical
25 procedure?

1 A. Yes there is.

2 Q. Is some danger avoidable?

3 A. Yes.

4 Q. And some danger is unavoidable; is that fair?

5 A. That's correct.

6 Q. Is a doctor, a surgeon, ever allowed to subject his
7 patient to needless or avoidable danger?

8 A. No.

9 Q. Why is that?

10 A. Because basically surgery is dangerous and we have to
11 weigh the risk and benefits of the procedure for the
12 patient. If the patient's risk from the surgery is higher
13 than the benefit he can obtain from it, then we should not
14 be doing the procedure at that point.

15 Q. Okay. Now can you give us some examples of surgical
16 dangers that are needed or necessary and some that are
17 unnecessary?

18 A. An unnecessary would be let's say we require our
19 patients to be what you call ANPO prior to an operation.
20 Don't eat or drink anything eight, eight hours before an
21 elective operation because basically at the time of
22 anesthesia induction the patient can aspirate and get
23 pneumonia and get real sick. So if you do an elective
24 procedure and the patient comes in the morning and says oh
25 I forgot I had a doughnut, we'll stop, come back tomorrow,

1 stay NPO, there's no reason to proceed with the operation.
2 The patient is in no danger at that point of dying or
3 disease progressing for one more day or who knows when to
4 reschedule the surgery. Somebody got shot in the abdomen,
5 bleeding to death, and they just had a hamburger prior to
6 that regardless we'll take the patient to the operating
7 room and evalu -- and do the surgery because his risk of
8 dying from bleeding or end up dying of injuries is a lot
9 higher than his risk of aspirating or aspiration of
10 pneumonia. But even then we take precautions trying to
11 avoid the pneumonia.

12 Q. Is there a difference between an elective procedure
13 and an emergent or emergency procedure?

14 A. Very much so.

15 Q. What is that difference?

16 A. The elective procedure is something that you can do
17 just about any day. The patient is in no danger at that
18 moment of time from his disease process. It can be done
19 today or tomorrow, next week, or depending how fast the
20 disease can process. Emergency procedure is usually
21 within hours or at that time depending if somebody is
22 bleeding to death that can kill them within minutes, it's
23 that fast. If somebody is in an infectious process
24 usually within four to five hours we want to operate on
25 them so there is an urgency to the operation.

1 Q. In this case, the first surgery on March 7th, was
2 this an elective or an emergency procedure?

3 A. This was purely an elective procedure.

4 Q. Which means what in this case?

5 A. It was not emergence, the surgery could have been
6 halted with no harm to the patient any time.

7 Q. All right. Before we get into the particulars of Mr.
8 Sexton's case, what part of the body are we dealing with
9 here? What part of the abdomen?

10 A. We're dealing with the large intestine. That's the
11 intestine that's kind of like at the end of the digestive
12 track, after the food has been ingested and they contents
13 of the intestine and from the large intestine, the large
14 intestine usually removes water from the remaining
15 material from the food and turns it into the stool that
16 eventually gets expelled from the rectum.

17 Q. What was Mr. Sexton's problem in this case that led
18 to that March 7th surgery, the first surgery?

19 A. He had a polyp as it was pointed out previously
20 sitting in his large intestine that from the records I
21 take what they call the hepatic flexure which is the cone
22 here, the liver. And this could not be removed by a
23 colonoscopy and so since some polyps can turn into cancer
24 we try to remove these polyps, you know, so they don't
25 turn cancerous as long as they are still benign and does

1 not cause any problem.

2 Q. Was there any indication in this case that Mr. Sexton
3 had cancer in that polyp?

4 A. No.

5 Q. Did any record that you see ever state that Mr.
6 Sexton had colon cancer that needed to be addressed
7 immediately?

8 A. No.

9 Q. Was this procedure to remove this flat polyp an
10 emergency that couldn't wait a day, a week, or six weeks?

11 A. No.

12 Q. Did the nature of this procedure, the particular
13 medical condition that he had, did that allow any needless
14 risk to be taken for Mr. Sexton? Was it such an emergency
15 that they had to move forward regardless of the
16 circumstance?

17 A. Absolutely not.

18 Q. Have you ever referred patients referred to you
19 examined patients referred to you by a gastroenterologist.

20 A. Yes.

21 Q. What is a gastroenterologist?

22 A. Usually medical doctors who train in the disease of
23 the digestive tract and they are usually ones who
24 diagnose, they do a lot of scoping like in this case.
25 They will enter either the mouth or the rectum with a

1 scope and evaluate the tract to find out if there is any
2 tumors, lesions in them.

3 Q. And is it routine for a general surgery practice, and
4 in fact your practice to give referrals from
5 gastroenterologist for polyps and things?

6 A. Currently I don't have a gastroenterologist in town
7 but that was routine in Charlotte and the doctor who does
8 most of the scoping in town he is as far as I guess an
9 endrologist but he's not board certified, he does most of
10 the scoping so I would say for intensive purposes yes it's
11 routine.

12 Q. But you have been in exactly the same shoes as
13 Doctor Espinal that is patients were referred to you by
14 someone who did a scope and said there is something in
15 there we need to address it surgically?

16 A. Exactly.

17 Q. All right. Tell me how this process works. You get
18 the appointment set up with the patient who's been
19 referred by another doctor for an issue in the colon.
20 What is it that's your job and obligation at that point as
21 the surgeon?

22 What do you do?

23 A. I break it down in two components which I would call
24 evaluate and treat. Evaluation phase is usually starts at
25 the office. The patient comes in, I'll ask a patient if

1 they know why their in my office and usually they know and
2 sometimes they don't. I read the medical records from the
3 referring physician like in this case I would obviously
4 when the colonoscopy was performed, what he found, did he
5 take any biopsies of the polyp to tell me, you know, is it
6 cancerous, non cancerous. Sometimes even if you cannot
7 remove the polyp you know you can biopsy it. And then of
8 course you do a history and physical to assess the
9 patient's risk and fitness for surgery which includes a
10 history. Does he have any symptoms from this polyp,
11 bleeding, any other issues. I would assess, you know,
12 past medical history, heart disease, lung disease,
13 diabetes, other risk factors that could affect him. What
14 medication he's on, what allergies he has, what is his
15 social history as far as smoking and drinking, drug use
16 and other risk factors. Family history especially in
17 colon cancer. Some families have clusters or colon cancer
18 that they are very high risk of colon cancer so you ask if
19 anybody in the family had colon cancer or other family
20 history of diseases. And I perform an examination
21 including vital signs, heart rate, blood pressure, lungs,
22 heart, abdomen; in most cases most likely a rectal exam to
23 evaluate the patient, is there any blood in his stool.
24 And then skin and legs and I will basically make -- I have
25 an impression what the diagnoses is if I can observe the

1 digestive disease or guess the diagnoses and then I
2 discuss with the patient what I recommend which in this
3 case let's say we do surgery and then I discuss the risk
4 and the benefits of the surgery with him. And then if he
5 agrees to it we schedule the operation.

6 Q. All right. So it starts out you taking a history of
7 the patient and as reviewing the medical records provided
8 and talking with the patient; is that right?

9 A. That's correct.

10 Q. And then you do a physical examination.

11 A. That's correct.

12 Q. And the purpose of the physical examination is what?

13 A. Just assess any risk that may be evident from his
14 history. Let's say someone could have a heart murmur that
15 he doesn't know about. Somebody who's a smoker can have
16 decreased breath sounds, you know, or some kind of noises,
17 bronchi, or sneezes in this chest that indicate an
18 underlying disease that we don't know about that could
19 constitute a risk at the time of surgery.

20 Q. Does it also provide you a comparison point for later
21 so that you know the way his lungs as far or et cetera or
22 in your office that you can then compare that to what may
23 be down the road?

24 A. Yes.

25 Q. All right. So after you've discussed everything with

1 the patient, and the patient consents to and agrees to the
2 surgery and it gets set up, what happens next from the
3 surgical standpoint?

4 A. Set up the surgery and you know like in this case we
5 have an elective surgery so you set it up usually several
6 days away depending on the patient's and your schedule.
7 The patient usually will get a bowel prep the day before.
8 In case of colon surgery they had to drain to clean them
9 out so everything is clean inside. The patient shows up
10 in the morning and gets assessed by the nursing team and
11 anesthesiologist to go back to surgery. We are required
12 to go by check the patients prior to his moving back to
13 the operating room to -- If his history and physical is
14 more than twenty-four hours from the time of presentation
15 to the surgery, we are required to what's called updating
16 and sign off on the history and physical to make sure that
17 nothing has changed in that week or a few days that went
18 in between, that the patient is still fit for surgery,
19 that the criteria be set at the time of discussion with
20 him.

21 Q. All right. Well let's talk about that for a second.
22 So your job as the surgeon is to make sure that nothing
23 significant has changed with the patient since the last
24 time you saw him?

25 A. That's a requirement.

1 Q. What is the anesthesiologist have to do with this?
2 What is the anesthesiologist's job?

3 A. The anesthesiologist will focus on the patient's
4 fitness for surgery but more from his point of view as far
5 as heart, lungs and other things but, you know, we look at
6 the whole patient. They look at more like is this patient
7 going to survive an actual two hours on the table. You
8 know I have to look at the whole picture from start to
9 finish.

10 Q. Who is it that has the ability, the medical power
11 let's say, to call off a surgery? Who can do that?

12 A. The anesthesiologist or the surgeon.

13 Q. So is it fair to say that both have to agree and sign
14 off on the surgery?

15 A. I think it's -- Yes. Yes.

16 Q. So -

17 A. Either one can stop it. So basically one cannot over
18 rule the other. The anesthesiologist says I'm not going
19 this is too high risk it's not going.

20 Q. And by the same token if the surgeon says -

21 A. The surgeon says we're not going, we're not going.

22 Q. Is the ability of that surgeon to perform an
23 independent evaluation of the patient is that a duty
24 that's owed to the patient?

25 A. It is.

1 Q. I'm the surgeon I have to make sure this is safe
2 regardless of what anybody else says?

3 A. That is correct.

4 Q. Is there an obligation and duty, is it a medical rule
5 that the patient and the physician, the surgeon, has to be
6 aware of his patient's condition prior to the surgery?

7 A. That's an obligation yes.

8 Q. And why is that an obligation?

9 A. Because I am responsible for that patient. When that
10 patient puts his trust into me to get them through an
11 operation I am responsible for his well being. Every
12 other health care team member who encounters that patient
13 just about will be there for a certain point of time. You
14 have your pre-op nurse that will be there for a while.
15 You have an anesthesiologist who is going to be there for
16 a certain extent. There may be even let's say certain
17 hospital consultants but I'm the one who takes the patient
18 from the get go, from the door when they walk into my
19 office to once he's healed or he's dead for sometimes if
20 it's a major problem I'm responsible for the entire course
21 of the patient so I pretty much have to be informed at all
22 times what's going on with that patient.

23 Q. Can you safely practice surgery without knowing the
24 condition of your patient before the procedure?

25 A. No.

1 Q. Is it fair to say that that's in fact a patients'
2 safety rule is that you need to know the condition of your
3 patient before the procedure?

4 A. Yes.

5 Q. And what happens if you don't follow that basic rule?

6 A. Patient's get hurt or something is going to get
7 missed.

8 Q. All right. So let's just go down the track for a
9 minute that the surgeon is fully informed about this
10 patient's condition and everything looks good to go for
11 surgery. How does -- What's the process supposed to look
12 like from there?

13 A. Once you sign off and the patient looks ready to go
14 and everybody agrees then we'll take the patient into the
15 operating room. Usually there is another safety step
16 where everybody pauses and has to say stop to avoid wrong
17 side surgery or operating on the wrong patient and
18 everybody is required to stop and say okay this is Mr. So
19 and So and we'll be doing this, everybody in the room.
20 Once we have that then the patient gets put to sleep under
21 an anesthesia, the appropriate body part gets prepped,
22 draped, and then we basically make an incision and do what
23 we need to do at that time.

24 Q. All right. When you have a patient that needs an
25 elective surgery, is it an obligation and duty of the

1 surgeon to evaluate that patient's fitness with that
2 procedure at that time?

3 A. Yes.

4 Q. And what do you look for? What kind of things does a
5 surgeon supposed to evaluate to make sure that this
6 elective procedure will be done safely at this time?

7 A. Well basically you have to evaluate the patient --
8 several things. I mean has the patient been MPO, basic
9 situation. Had he taken any prep, a time of colon
10 surgery. Is he going to be clean enough. You have to
11 assess his cardio risk. Surgery is a major stress on the
12 body and people how have an underlying cardiac risk they
13 can have heart attacks during the surgery. You have to
14 assess their respiratory risk basically for post op
15 pneumonia, oxygenation and also are they going to be able
16 to be ventilated safely throughout their general
17 anesthesia. There is multiple levels to it so basically
18 those I would say are the most basic, you know,
19 principles.

20 Q. Should you -- Let's talk about the lungs because
21 that's what this case is about. Should you continue with
22 an elective procedure on a patient that has an O2 set of
23 85 with diminished breath sounds and pre op analyctisis
24 without a full investigation and try to improve that
25 situation?

1 A. No.

2 Q. Why not?

3 A. Because if you proceed you run the risk of several --
4 of complications for the patient and they are not
5 necessary at that time because the patient is in no
6 danger. Basically they can have post-op pneumonia that
7 can become serious and life threatening. They can have
8 low oxygenation that can impair wound healing and since
9 this is an elective procedure the risk of the procedure
10 basically is higher than the risk of the disease at that
11 point to the patient. Everything is like it's what is the
12 risk. Everything in surgery is risk. The way I would
13 describe it let's say let's compare elective versus
14 emergency in layman terms. If there is a snow storm out
15 there with ice on the road and I get into my car and I got
16 to Walmart to get medicine for my sick child who is
17 running a fever of 104 and I get into an accident that's a
18 justifiable accident to some extent. I had to go, the
19 child was going to die or get hurt by me not going there.
20 Same scenario. I go get a six pack of beer,
21 irresponsible. And that's why we compare in layman's
22 terms elective versus an emergent surgery. If you have to
23 go because the patient is dying in front of your eyes or
24 in the next two hours and suffer consequences for not
25 operating you are going to have to go and do the surgery.

1 If there is no consequences at that point or we can
2 foresee in the future for the patient that can be
3 deleterious to their health, you stop and you do what you
4 need to do to improve the patient's condition to undergo
5 the procedure or take a different alternative approach.
6 Sometimes we say no we don't need surgery under these
7 circumstances we'll apply medical therapy. We can come
8 back and rescope you in three months; is the polyp is
9 still there. Is everything sure that, you know, what's
10 going on. So that's pretty much the basics of it. It's
11 very logical.

12 Q. So for an elective procedure like this would there
13 have been any harm to Mr. Sexton by putting this off a
14 day, a week or two weeks or some other amount of time?

15 A. None at all.

16 Q. Let's talk about the role of oxygen in wound healing.
17 Now what role does oxygen play in the healing of like the
18 colon, anastomosis or a connection like this here?

19 A. Healing is basically occurs by once you cut into
20 tissue there is certain cells that move into the area and
21 your reaction to that injury and those cells produce
22 materials to heal the wound. Basically saying cells move
23 into the area that can produce the glue and matrix to
24 connect the tissues back again so the scar forms and the
25 healing occurs. Those cells need a lot of oxygen to

1 perform their jobs. If there is not enough oxygen
2 supplied that's their fuel to do their jobs to repair the
3 injury. If there is not enough oxygen in that area the
4 cells cannot perform their function, healing will not
5 occur and the wound will fall apart.

6 Q. Does every surgeon supposed to know this?

7 A. Yes.

8 Q. Now what do you know what your patient's oxygen level
9 is at any given moment?

10 A. You can either get an O2 stat or you get the blood
11 gas.

12 Q. Now O2 stat is an O2 saturation?

13 A. O2 saturation means it's usually a machine that
14 measures to what level the blood is oxygenated in the
15 body. And a blood gas measures more what's the level of
16 the oxygen in the blood, not in the cells but around the
17 cells. But it also usually gives you a O2 saturation.

18 Q. Now the O2 stat, it's a little clippy thing you can
19 put on your finger; is that right?

20 A. Yes.

21 Q. Is that an evasive test?

22 A. No.

23 Q. Is it painful?

24 A. No.

25 Q. Is it expensive?

1 A. No.

2 Q. Is it time consuming?

3 A. No.

4 Q. So what are you looking, what's a good O2 stat for a
5 patient? What's something as a surgeon you would not be
6 concerned about?

7 A. My cut off is Nine to Four, Nine to Three, to Nine to
8 Four percent.

9 Q. And the best is a hundred percent; is that correct?

10 A. Yes that's correct.

11 Q. And so normal is 93, 94 or above?

12 A. Yes.

13 Q. Is an O2 sat of less than 90; in this case 85, would
14 that be of concern to a surgeon preoperatively to an
15 elective procedure?

16 A. Very much so.

17 Q. Why?

18 A. Because at this point you assume that specific to
19 this case based on the history and physical evaluation
20 performed by Doctor Espinal's office this patient did not
21 have any former arrest or problems and no reason, so he
22 should be expected to have an O2 sat in the normal range.
23 I would say 94 percent plus, within 94 to a Hundred. So
24 if you have an O2 saturation that's in the 80 range that's
25 pretty serious. Immediately red flags have to go up to

1 say we are missing something here, something's not right
2 we have to investigate this.

3 Q. Let's assume that you have a patient that has and
4 needs an elective surgery when they can be put off. And
5 after you check you have done an evaluation in your office
6 and everything otherwise appears normal, when you check
7 the chart or examine the patient preoperatively before the
8 procedure you notice that there is an O2 sat of less than
9 90 and in this case it's 85, and this is news to you, what
10 is it that to be safe for this patient what is required of
11 the surgeon in those circumstances?

12 A. To stop and think.

13 Q. All right. Now let's speak particularly about Mr.
14 Sexton's case and we're going to be looking at some of
15 these records in this book and what not. What caused Mr.
16 Sexton to end up, the go to Doctor Espinal?

17 A. A gastroenterologist found a polyp and could not
18 resect.

19 Q. Now when you say could not resect, what does that
20 mean?

21 A. As the defense counsel described in the -- I was
22 sitting here and I may have mentioned it, I don't know, in
23 the opening statement polyps can be like little mushrooms
24 that have a stalk and they can usually be resected because
25 you can go around with a snare and not enter or cut into the

1 wall of the colon which is pretty thin in some areas
2 almost paper thin.

3 Q. Does resect mean take out?

4 A. Remove.

5 Q. Remove?

6 A. Yeah remove. Now if you have what you call a sessile
7 polyp that's flat and sitting on the wall, if you try to
8 get around it or cut too deep you can actually poke a hole
9 into the wall of the colon and the patient can leak. So
10 they are not safe to be resected with colonoscopy. They
11 need to be resected by the surgeon with a formal operation
12 where the surgeon can take the polyp out and then close
13 the intestinal wall or resect that area and close it.

14 Q. All right. So in this case do the records show that
15 Mr. Sexton had some of these polyps on a stalk and were
16 removed by the gastroenterologist?

17 A. Yes.

18 Q. But there was one that's flat that we're talking
19 about; is that right?

20 A. Yes.

21 Q. Now, are these things fast growing such that if you
22 put the surgery off a month, six months, that Mr. Sexton
23 is going to get cancer and die?

24 A. No.

25 Q. What is it that you're -- that's the recommendation

1 for colonoscopy repeats? If you have a clean colonoscopy
2 when are you supposed to have another one?

3 A. It usually changes but I would -- at the current time
4 it's five years.

5 Q. So if you're clean day one, five years from now you
6 should have another one to make sure that you don't have
7 any of these stalks growing?

8 A. That's correct.

9 Q. Is it generally accepted in the surgery field that
10 you can't develop colon cancer, generally, if you're clean
11 from day one, within five years? That you're going to
12 catch any of those polyps before they turn to cancer?

13 A. Yes.

14 Q. Now, - -

15 A. Now let me put something in. There is a certain risk
16 involved in different polyps. There can be hyperplastic
17 polyps which are low risk. There can be tubular adenomas
18 which Mr. Sexton had which are also low risk. There are
19 certain polyps called tubulovillous adenomas that are a
20 higher risk of developing cancer and they are faster
21 growing. So there is a certain range but we're not
22 talking days; we're not talking weeks, we're talking
23 months as far as developing cancer in them.

24 Q. So Mr. Sexton's polyp was a low risk, a very slow
25 growing polyp to begin with. Right?

1 A. That's correct.

2 Q. But even if it was a more aggressive kind, you would
3 still have months to address it?

4 A. At least weeks.

5 Q. All right.

6 A. I mean several weeks.

7 Q. All right. Well let's start off with Doctor Espinal
8 and his exam. I'm going to put it up on the screen. It's
9 Exhibit Number One in the book.

10 Have you reviewed this, Doctor?

11 A. Yes.

12 Q. And it starts with the patient presents to discuss
13 polyp not colonoscopically resectable. The main symptoms
14 include no symptoms. Recent colonoscopy showed
15 unresectable polyp at hepatic flexure. What does that
16 talk about; the flat thing in his colon?

17 A. Yes.

18 Q. And then we have the active problem being colon
19 polyps. Surgeries: It says none. Medications: He's
20 taking Nexium. What kind of drug is Nexium?

21 A. It's a drug for gastro acid reflux disease which
22 means heart burn, acid coming up into the esophagus.

23 Q. And then we have a Review of Systems. Is that
24 another word for history or is that different.

25 A. It's different. History is usually related to the

1 process we're dealing with. What is your history? I mean
2 say for example a colon tumor, we have constipation, we
3 have diarrhea. We have rectal bleeding, you know, you
4 have abdominal pain. That's more of taking a history. A
5 Review of Systems is you just look over, you examine the
6 patient, you ask them do you have any other problems so
7 you to through their systems in their own words. Do they
8 have any complaints. It's like, do you have a headache,
9 do you have visual changes, do you have numbness, do you
10 have cough. I mean you go through the different systems
11 in the body. Neurological or either, you know, so that's
12 a Review of your Systems.

13 Q. All right. So let's concentrate on the lungs because
14 that's kind of what we're here about. According to this,
15 Lungs: It says, "Denies cough dyspnea orthopnea or
16 hemoptosis.

17 A. Hemoptosis.

18 Q. Hemoptosis. All right. Cough, everybody knows what
19 that is. What's dyspnea?

20 A. It's shortness of breath, difficulty breathing.

21 Q. So that would have been where the patient was ask do
22 you have any problem breathing, coughing, shortness of
23 breath, anything like that he would have said no.

24 A. No.

25 Q. And what's the next one, Orthopnea?

1 A. Orthopnea is the patient gets short of breath by
2 moving; like standing up or changing positions or
3 sometimes you can even go as far to say there if there is
4 any activities, you know, so sometimes at rest the patient
5 can have normal breathing but as soon as he changes
6 positions, stands up, you know, he has difficulty, you
7 know, it's basically changing the position he's got a
8 problem.

9 Q. And then the last one, Hemoptosis.

10 A. Hemoptosis is coughing up blood.

11 Q. So what can we gather from this record?

12 A. According to this record he had no respiratory
13 problems or complaints.

14 Q. So when ask Mr. Sexton said my lungs are fine.

15 A. No problem.

16 Q. And then we have a section for Vital Signs but there
17 do not appear to be any. Is that fair?

18 A. No vital signs.

19 Q. And we don't have in here a base line, even under
20 Physical Exam: Vital signs there is no temp, no pulse, no
21 respiration rate, no blood pressure, no height or weight
22 according to the chart. Right?

23 A. Yeah.

24 Q. Now without going through all of this stuff, let's go
25 through the lungs. Now in the physical exam is this

1 supposed to record what Doctor Espinal would have actually
2 physically done, his own medical findings?

3 A. Yes. You describe what he heard when he listened to
4 the lungs.

5 Q. All right. Well let's just start with, let's get to
6 the lungs. Lungs: Auscultation-Abn not detected. What
7 does that mean?

8 A. I have no idea.

9 Q. What is auscultation?

10 A. To listen to the lungs.

11 Q. And that's where the doctor puts the stethoscope on
12 the lungs and listens?

13 A. Yes.

14 Q. And if that means abnormal, abnormalities not
15 detected?

16 A. Well it either means that abnormal finding or not
17 detected, that he had no breath sounds which means there
18 was no breath sounds.

19 Q. Which would be highly abnormal?

20 A. Yeah he mostly like would be dead at that point.

21 Q. Oh.

22 A. I mean if it's on both sides. If it's one side it
23 would be one sided.

24 Q. All right.

25 A. But I don't know what to do with that. If that

1 medical note comes to me from a different physician I
2 don't know, I don't know what that means.

3 Q. Well, let's assume that there were no problems with
4 his lungs.

5 A. Okay.

6 Q. Respirations: Nothing abnormal. Chest: Palpation
7 nothing detected. Lungs: Percussion, nothing detected.

8 A. Okay.

9 Q. All right, because I think that's what the testimony
10 is. If you have this patient, I mean we have down below
11 the Impression, Surgical Treatment Plan. In looking at
12 this record, what kind of a candidate, just based upon if
13 this is your patient admitted before he goes to procedure.
14 What kind of a risk is your patient for in a elective
15 procedure?

16 A. Low risk.

17 Q. It's okay to take him?

18 A. Perfectly fine.

19 Q. All right. Was there an O2 saturation recorded in
20 the office?

21 A. I didn't see one.

22 Q. And if you have this sort of record, and there is no
23 abnormalities found, what can a reasonably prudent surgeon
24 believe about his patient's lung condition prior to
25 elective surgery if he reports no symptoms and he has no

1 abnormalities detected?

2 A. For his age he should have a normal risk lung and
3 normal risk acceptance for surgery or extended surgery.

4 Q. So based upon what's found in this first exam there
5 was no problem with scheduling a procedure; is that fair?

6 A. Yes.

7 Q. Let's move on to the day of the surgery. You have
8 seen Exhibit Number Three which is in evidence. And this
9 is a Piedmont Medical Center form and it says the Patient
10 Admission Data Base or Patient Admission Assessment Date
11 Base.

12 A. Yes.

13 Q. Now tell me what you take from this form. What's the
14 purpose of a form like this?

15 A. It's usually the pre-op nurse assesses the patient
16 from the nursing standpoint and they will go through a --
17 they will do a risk assessment and prepare you know what
18 kind of medical problems do they have. Any allergies to
19 the medications, what medications they take, take their
20 vital signs, assess their, you know that morning we assess
21 them before they go back to surgery.

22 Q. Are charts like this available for surgeons to look
23 at?

24 A. Yes it's on the chart.

25 Q. And I'm gonna turn to -- It seems to go through a lot

1 of different things here, health history, hospitalization,
2 nutritional issues, abuse and neglect screen, and so on.
3 Then there is this page which is Page 4 of 6, PMC 00843.
4 That's down here on the lower right hand corner. There's
5 General Admission Information. You've reviewed that,
6 Doctor?

7 A. Yes.

8 Q. All right. And I've highlighted this so I won't have
9 to be fumbling around, but it says an oxygen saturation of
10 eighty-five percent at admission. What do you make of
11 that?

12 A. That it's low.

13 Q. And it says here apparently placed two liters O2
14 Nasal. Right?

15 A. Yes.

16 Q. Is that the normal standard everyday thing to do for
17 an elective procedure when a patient gets admitted is to
18 immediately put them on two liters of oxygen?

19 A. The anesthesiologist may want a patient preoxygenated
20 for their own purposes but this was done for a clear
21 indication that the O2 saturation was too low.

22 Q. All right. Was this -- Does this present -- Does
23 this number present a different picture of the patient,
24 predetermining anything else in the one that we've seen in
25 the office nine days before?

1 A. This is highly abnormal.

2 Q. What should a surgeon do when they see this number?

3 A. They need to stop and say everybody stop. They need
4 to figure out what's going on with this patient. First of
5 all you need to assess, is this really a true oxygen
6 saturation that exist. So you go and tell the nurse put
7 it on him again. You look at the way formatrics or
8 representatively symbol and if it is then I would say the
9 next step would be I would order a lung gas before we go
10 back to the operating room and I would summons the
11 anesthesiologist to discuss this with him to see this is
12 not safe to proceed what are we going to do about this.

13 Q. All right. Now on the next page there is a nursing
14 examination that's done, in this case of the respiratory
15 system. Do you see that?

16 A. Yes.

17 Q. And the nurse examines the patient and says breath
18 sounds are diminished bilaterally. What does that
19 indicate to you as a surgeon?

20 A. That the patient is very shallow breathing or there
21 is an infiltrate in the chest from something.

22 Q. Is this note of diminished breath sounds in contrast
23 to what Doctor Espinal found in his office visit --

24 A. We assume that the abnormal detected means that there
25 was a normal exam done. It's a sharp contrast to that.

1 Q. So if you have a surgeon who looks at this record and
2 says all right we have an eighty-five percent O2 sat and
3 we have diminished breath sounds, and I have an elective
4 procedure; what does a reasonably careful prudent surgeon
5 do?

6 A. You cancel the surgery.

7 Q. All right. Now I understand -- Do you understand
8 there was a chest x-ray done?

9 A. Yes I saw a report on that day.

10 Q. And here is a -- This is Exhibit Number Sixteen and
11 it's dated 3/7/07. Do you see that?

12 A. Yes.

13 Q. And you've seen this document before?

14 A. Yes.

15 Q. All right. Tell the jury what an imaging report
16 like this is. What's going on with a record like this?

17 A. You want me to read it?

18 Q. Well I just want to know that -- A radiologist is a
19 different physician in the hospital; is that right?

20 A. Yes.

21 Q. And then you as a surgeon order a film and then the
22 radiologist reads it; is that right?

23 A. Yes.

24 Q. And then they have to give you their opinion or their
25 impression of what they see somehow and it ends up in the

1 record as one of these; is that right?

2 A. That's correct.

3 Q. All right. So this is the radiologist read of the
4 film; is that fair?

5 A. Yes.

6 Q. All right. What did this radiologist read on the
7 film on the morning of the 7th?

8 A. That the patient had accotolactisis means collapsed
9 areas of the lung. Patient had collapsed areas in his
10 lung. Without consolidation meaning that's like a true
11 what you call infiltrate. Should I explain?

12 Q. Yeah. Let's just do this sentence by sentence. This
13 says, "Impression: Patient does demonstrate mild
14 prominence of the interstitium." What does that mean to
15 you as a surgeon?

16 A. When you look at a lung, a lung is like a collection
17 of tiny bubbles. The interstitium and the lung is
18 basically mostly air, over ninety percent is air.
19 Interstitium is the solid material like what we would
20 think the walls of the little bubbles; that's the
21 interstitium, that's the lung tissue itself. And so there
22 was a mild prominence of that tissue which can come from
23 what we call infiltrate. There can be cells there that
24 indicate inflamation or it can be fluid in there from
25 whatever reason; heart problems or edema from again

1 pneumonia or an infectious process.

2 Q. But a prominent interstitium is not normal?

3 A. No its not normal.

4 Q. And then the doctor says, "I do not have any prior
5 studies to know if this is related to chronic changes or
6 acute changes.

7 A. Yes.

8 Q. Do radiologist sometimes look at prior film to figure
9 --

10 A. Yeah it's important to establish a time line. I
11 mean somebody who has a normal chest x-ray last week and
12 now has this it could indicate that there is a process
13 going on that's developing like pneumonia or something.
14 If you have somebody who has had industrial exposure to
15 certain toxins or is a heavy smoker and they have an
16 established chronic inflammation of lung from smoking then
17 they could have, you know, they could say well there's no
18 change so its most likely the patient is at this base
19 line.

20 Q. So in this case though if you don't know if it's
21 chronic or acute, and if the only evidence is that this is
22 something that's new, what should a reasonably prudent and
23 careful surgeon do for an elective procedure reading
24 something like this?

25 A. If you put -- I mean if that is the only abnormality

1 and the patient is sating at a hundred percent it may be
2 meaning less, I would proceed with the operation.
3 Q. But what if -

4 A. Even in light of a significant decreased O2
5 saturation this has meaning, this is a new finding so you
6 need to stop and potentially investigate the lung with
7 additional studies or get chest x-rays later. I mean it
8 basically is the bottom line is you stop.

9 Q. So if we have an O2 sat of eighty-five percent and as
10 far as we know new, if you have diminished breath sounds
11 bilaterally and if you have this prominent, mild
12 prominence of the interstitium, all those three things
13 together in a patient for an elective procedure.

14 A. I think the more important finding is the
15 atelectasis.

16 Q. All right.

17 A. Atelectasis means collapse of the lung tissue. Again
18 imagine tiny bubbles all over the lung, atelectasis is
19 when those bubbles collapse. The bubbles is not inflated,
20 it's a deflated tiny balloon and they can just be
21 temporarily but they can also be the first step to
22 pneumonia. It has collapsed, it is starting to fill up
23 with fluid, its going to fill up with bacteria, it can be
24 the first step towards pneumonia. So that most likely a
25 chronic, the prominence of the interstitium most likely

1 will not give a decreased breath sounds but a collapsed
2 lung by I know air traveling in the collapsed little
3 bubbles will cause decreased breath sounds. And that is
4 significant because now you can correlate a physical
5 finding by a nurse with the chest x-ray that there was
6 indeed a correlation between two modalities, exam and x-
7 ray.

8 Q. Should you proceed on with an elective procedure in
9 the face of these sort of lung for lack of a better term
10 questions at minimum?

11 A. Not if it's no diagnoses.

12 Q. All right. Was there any evidence that Mr. Sexton
13 prior to going into the hospital for this day and
14 diagnosed lung illness of some kind?

15 A. Not to my knowledge.

16 Q. Have you reviewed the deposition testimony of Doctor
17 Espinal?

18 A. Yes in some detail I did.

19 Q. Do you hold the opinion that it is required by the
20 surgeon in a circumstance like this to inform himself of
21 the patient's condition?

22 A. Yes.

23 Q. And Doctor Espinal agrees with that doesn't he?

24 A. According to what I can remember. That's a long
25 document, it lulls back and forth but as I can remember

1 the document said that he agreed that the surgeon should,
2 you know, obviously has our standard as we are taught the
3 surgeon should, you know, assert himself of the patient's
4 condition prior to surgery.

5 Q. All right. I'm going to publish this to the jury,
6 this is Doctor Espinal's deposition. It starts on Page 27
7 and it says that,

8 " Again that wasn't my question. Do you
9 believe that you have an obligation to inform
10 yourself

11 of the condition of your patient prior to beginning a
12 procedure?"

13 And he said, "Yes" according to his testimony.

14 You and he, you would respond to that; right?

15 A. Yes.

16 Q. Did Doctor Espinal according to his own testimony,
17 and the facts of the case, inform himself of the O2 sat,
18 the atelectasis, the diminished breath sounds and the
19 prominence of the interstitium prior to performing this
20 elective procedure on Mr. Sexton?

21 A. At that position it's going back and forth. Again my
22 impression of the deposition is that he did not inform
23 himself.

24 Q. And in fact -- I'm going to quote another portion of
25 his deposition on Page 26, I believe you read also,

1 Doctor.

2 "And did you know, before you decided to do --
3 continue with this procedure that, Mr. Sexton had an
4 eighty-five percent O2 sat -

5 "No.

6 --- upon -

7 --- I didn't."

8 --- admission?"

9 "Why not?"

10 "Because I'm just not made aware of this
11 information."

12 Is it the obligation of the doctor to make himself
13 aware?

14 A. Yes.

15 Q. How could Doctor Espinal have informed himself of
16 these facts? Is it a difficult process?

17 A. No. I'm kind of puzzled because the O2 sat of
18 eighty-five percent, I mean, it certainly it's something
19 that, you know, you to see pneumonia show up to assess
20 your patients, the nurse immediately points your attention
21 to it. I mean it's something you have to, I mean that's
22 not going to be just sweep under the rug at no hospital.
23 I mean when you go there to do your update on your patient
24 history and physical that's going to be one of the parts
25 that's gonna be left up to your knowledge.

1 Q. Did you ever see in these medical records an update
2 to the history and physical by Doctor Espinal?
3 A. No.

4 Q. And doing such an update would be required by the
5 standard of care?

6 A. It is a JACO requirement at hospitals. JACO is the
7 National Hospital Association that credit, credits
8 hospitals.

9 Q. So the rules are you gotta do this updated exam?

10 A. Yeah that's it. It's a constant fight that my
11 hospital between doctors and nurses because my nurses will
12 not even move the patient back to the operating room until
13 we showed up and sign off on the chart.

14 Q. Well I'm not going to read the part of Doctor
15 Espinal's deposition to you, I just want you to comment on
16 it because it starts with the top of Page 91, Line 2 I
17 guess it is.

18 "All right. That -- Did you do a physical
19 examination of the patient before the
20 procedure?"

21 He says, "Yes. And I did not find any.

22 Q. On the day of the surgery?

23 A. Not a complete physical examination.

24 Q. Where would that be recorded?

25 A. What?

1 Q. A physical examination of the patient before
2 --

3 A. On my history and physical?
4

5 Before the one that you did in the office?
6 Yes.

7 Five days before?
8 Yes.

9 All right. So did you do another physical
10 examination of the patient before the procedure?"
11 He says, "No."

12 If he did not do an updated history and physical on
13 the patient, would that be below the standard of care?
14 A. Yes.

15 Q. And would a doctor be expected to listen to the
16 lungs of his patient while doing an updated history and
17 physical?

18 A. Yes.

19 Q. Would he be expected to see something like an eighty-
20 five percent O2 sat if he does an updated history and
21 physical?

22 A. Yes.

23 Q. Would he be expected to review an x-ray report that
24 had been done?

25 A. Yes. Actually I would add that I think you should go
look at a chest x-ray yourself. As defense counsel

1 pointed out, when the patient was in trouble Doctor
2 Espinal himself as he did saw, went and looked at the
3 second CAT Scan himself because it was such an important
4 situation and not just the word of the radiologist word
5 for it. I think it's the same should occur in this case.

6 Q. Well let's talk about after this procedure. We know
7 that it's been done, it's March 7th. What -- Just
8 generally describe Mr. Sexton's course over the next two
9 to three days.

10 A. Surgery was done, operation performed as was pointed
11 out before he continued to have respiratory problems,
12 fever, decreased O2 saturations. It was what we call
13 becoming more and more septic which means an oral
14 infectious, infectious evaluation and it is fair to assume
15 that he was, you know, at that point had pneumonia or
16 getting pneumonia which then later as appropriately was
17 done they also investigated, you know, the CAT Scan and it
18 showed that he had a leak and then they proceeded back to
19 repair the leak and the resection of the intestine.

20 Q. What role did Mr. Sexton's oxygen levels or his lung
21 condition play in causing or substantially contributing to
22 the leak?

23 A. A crucial role.

24 Q. How so?

25 A. If there is not enough oxygen as I pointed out

1 earlier, wound healing is impaired. The cells have to
2 repair the tissues don't have enough oxygen. There is no
3 fuel, like you imagine a machine with no gas in it or no
4 diesel in it, you know, it's not running. And so
5 basically the two ends that are sowed together they are
6 not held together by staples or sewn; you just put them
7 together and the body repairs it over the next few days by
8 itself and actually the healing goes on for a long time.
9 But basically if there's a low oxygen level then those
10 cells have no fuel to repair the damage and it leaks.

11 Q. Now, some more from Doctor Espinal's deposition on
12 Page 87. You read this I trust where he says or he was
13 ask, "In this case you said oxygen was important for
14 healing and he said absolutely. And then I ask him,

15 "Do you believe that the lack of oxygen contributed
16 substantially to the lack of healing at the anastomosis?"

17 Now anastomosis is that connection. Right?

18 A. Yes.

19 Q. And he says, "yes, that the lack of oxygen did
20 contribute substantially to lack of healing of the
21 anastomosis is what he says. Right?

22 A. Yes.

23 Q. So you and he agree on that as well?

24 A. Yes we agree.

25 Q. What did this leak then cause? Take us down the road

1 a little bit. We have a leak, we have a sepsis, we have
2 the pneumonia that's fully set in. What was Mr. Sexton's
3 general course from that point on?

4 A. He was very sick. Basically he had what I would call
5 he was getting more sepsis. You know his system have
6 started failing, his lungs have failed, his GI tract has
7 failed, he was running a fever and that's pretty much or
8 it takes the whole body and at that point, you know, he
9 required a second surgery to repair the damage which
10 again, blood loss going through all the problems. Having
11 to stay on a ventilator because he couldn't breath for
12 himself and then slowly as the body repaired itself, you
13 know, those supports you draw on you can't sit on the
14 fence. He fortunately went to the healing side at that
15 point of which he took a long time.

16 Q. So was it fair to say that the leak was caused by the
17 lack of oxygen that led to the infection which led to the
18 organ problems which led to his stay in the hospital and
19 his rehab; is that fair?

20 A. Let's put it the other way. If you would have an
21 uncomplicated colon resection, let's say at an appropriate
22 time, then you most likely in my practice or most
23 practices you would have stayed in the hospital I would
24 say about five days, five to seven days to recover over
25 about maybe two to four weeks. Even if it's done

1 laparoscopically. Or the surgery would have been halted
2 and they would have never had the surgery under the
3 circumstances and you know they would have figured out a
4 different way. So that would have been the alternative.
5 You can compare the alternative that he went through which
6 is caused by the leak and the prolonged hospitalization.

7 Q. And the leak was caused by the lack of healing?
8 A. Yes.

9 Q. Which was caused the lack of oxygen?
10 A. Yes.

11 Q. Now, we're going to hear I'm sure that the
12 anesthesiologist signed off on the procedure and therefore
13 it was good to go and then the surgeon's job was done.
14 What is your view as a board certified surgeon of such a
15 position that if the anesthesiologist signs off you're
16 fine?

17 A. That I vehemently disagree with that. I'm very proud
18 of my profession and where I was trained we are always
19 told there are forty trained medical doctors before become
20 surgeons and I take pride of taking full responsibility
21 for my patients. I disagree that having that
22 responsibility of different, you know, medical
23 professional. I strongly disagree with that assessment.

24 Q. Is it the standard of care to defer all decision like
25 that to an anesthesiologist if you're the surgeon in

1 charge of the patient?

2 A. No. You certainly consult with them sometimes, you
3 know, and you defer to their opinions but in this case I
4 would not have deferred to the anesthesiologist.

5 Q. Now, you've looked at Exhibit Number Twenty-seven
6 which is already in evidence I believe, and that's the
7 statement of medical bills, summary of the bills. It's
8 already in evidence but were the medical bills here caused
9 by this surgery? This was started in March '07 and went
10 through Piedmont and HealthSouth. And the wages we're not
11 going to ask you to comment on but the first three items
12 about Doctor's Espinal's bill, the PMC bill and then the
13 Health South Bill. Was that caused by the leak and the
14 infection and what not?

15 A. Well some of it was caused by the surgery but the
16 magnitude of it is caused by the leak. I mean the initial
17 surgery uncomplicated would have caused some of this cost
18 but obviously its magnified by the factor of most likely I
19 would say -

20 Q. But if that surgery was cancelled you wouldn't have
21 had any of those bills. Right?

22 A. No.

23 Q. All right. Now characterize for me in your view,
24 we've been through sort of the facts in all of this. Are
25 these minor sort of technical violations of the standard

1 of care? Or are they significant safety issues?

2 A. In my opinion it's a significant safety issue.

3 Q. And why is that?

4 A. Because you cannot take a patient to the operating
5 room with low oxygen level when it's not necessary. It's
6 just not something I think there is no reason to go to
7 operation. That's why I think this case pretty much
8 stops.

9 Q. If you had a resident that you were teaching and you
10 were back here in Charlotte and they decided to do a
11 procedure on a patient, this procedure on this patient,
12 what kind of comments would you have for that resident?

13 A. I cannot repeat that in the courtroom.

14 Q. Okay.

15 A. Without being extremely critical.

16 Q. Now, are surgeons supposed to know these rules about
17 no unnecessary danger, informing yourself of the condition
18 of the patient and things like that before they can get
19 into the surgery business?

20 A. Yes throughout. I mean the first rule of any medical
21 profession is basically the hypocritical oath is to do no
22 harm, it's your number one rule. You always have to keep
23 in mind, do no harm.

24 Q. And are board certified surgeons aware of the
25 consequences if they choose to move forward with elective

1 procedures with they shouldn't?

2 A. Oh yes.

3 (SIRENS GOING OFF OUTSIDE OF COURTROOM MAKING HEARING
4 DIFFICULT.)

5 Q. Now, based upon the fact that surgeons are supposed
6 to know the rules and know the consequences -

7 THE COURT: You might ought to wait.

8 (SIRENS GOING BY COURTHOUSE.)

9 Q. Let me start over. Based on the fact that surgeons
10 are supposed to know the patients safety rules and know
11 the consequences if they chose to violate those rules,
12 would you say that based upon the facts in this case, that
13 do you have an opinion whether Doctor Espinal's actions in
14 this case, proceeding when he did in the face of the
15 evidence that was available, was reckless?

16 A. Yes.

17 MR. KING: Your Honor, this calls for a conclusion by
18 the jury after you make a determination of whether
19 reckless is approbative in this case. It's a legal issue
20 --

21 THE COURT: I'm gonna let the jury go to the jury
22 room just a minute. I'm having trouble hearing but I need
23 to take this up outside your presence. Leave your books
24 here.

25 (JURY EXITS COURTROOM AT 03:45 PM.)

1 THE COURT: All right. The question is whether or
2 not the expert testified not only to the standard of care,
3 the reasonable standard of care but whether or not the
4 testimony would go further beyond the simple breach of the
5 standard of care, testified to the conduct. Is that where
6 we're are?

7 MR. KING: Yes, sir.

8 THE COURT: I'll hear from you.

9 MR. KING: At the appropriate time in this case, Your
10 Honor, you will have to decide whether or not there is
11 evidence of recklessness and you will instruct that jury
12 on the definition of reckless and it will go to that jury
13 for a determination, so I do not believe this witness is
14 qualified to speak as to the -- to his opinion as to what
15 the definition of recklessness is or whether there was
16 recklessness in this case. It's beyond his
17 qualifications, he is a surgeon.

18 THE COURT: Mr. McGowan.

19 MR. MCGOWAN: I respectfully, Judge, Mr. King said
20 that its your job to determine if there was evidence of
21 reckless and that's what we're trying to provide to Your
22 Honor for consideration is evidence of recklessness.
23 Frankly I've had judges go both ways on these sorts of
24 questions. What I don't want to have happen is that Your
25 Honor say there is no evidence of recklessness because no

1 witness testified to it when I could have gotten him to
2 testify to it. And so if Your Honor doesn't require that
3 then I still want to get the questions in but I'm trying
4 to provide the evidence of recklessness.

5 THE COURT: Well the definition of recklessness,
6 conscious failure to do care.

7 MR. MCGOWAN: In other words knowing the rules,
8 knowing the consequences if you don't, proceeding anyway;
9 that's that recklessness is.

10 MR. KING: He's already ask those questions.

11 THE COURT: Yeah. While I think it's up to the jury
12 to determine the facts whether or not that was
13 recklessness conduct I don't believe you need to ask him
14 whether he considers that to be reckless. I think it
15 would be an issue that would be submitted to the jury. Is
16 that your position?

17 MR. KING: Yes, sir.

18 MR. MCGOWAN: What I intend to ask this witness,
19 Judge, is do you believe, do you have an opinion Doctor
20 Espinal knew or should have known the rules and
21 consequences and yet proceeded anyway.

22 THE COURT: While we got the jury out I know all of
23 them want to take their break so we'll take a break for
24 about ten minutes.

25 You can step down, Doctor, and to use the facilities

DOCTOR ROBERT SOLYMVARI: DIRECT BY MR. MCGOWAN

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1 or whatever you need. Take about a ten minute break. I
2 know once they get in there they all want to use the
3 facilities.
4

5 (COURT IN RECESS AT 03:47 PM.)

6 (COURT BACK IN SESSION AT 04:00 PM.)

7 THE COURT: Take your seats.

8 Bring in the jury.

9 Mr. King, we been informed by the jury you are not
10 vocalizing loud enough.

11 MADAME COURT REPORTER: I agree, Judge.

12 (JURY REENTERS COURTROOM AT 04:02 PM.)

13 THE COURT: You may proceed.

14 MR. MCGOWAN: A few more questions, Doctor, then I'll
15 turn you over to Mr. King.

16 DIRECT EXAMINATION - CON'T

17 DOCTOR ROBERT SOLYMVARI BY MR. MCGOWAN:

18 Q. In your view would a board certified surgeon, general
19 surgeon, know the patients safety rules we been talking
20 about in terms of no unnecessary danger, knowing the
21 condition of your patient, such as that that we've been
22 talking about, would a board certified surgeon know those
23 rules?

24 A. Yes.

25 Q Would a board certified surgeon know the consequences
of not following those rules; what bad things can happen

1 to a patient?

2 A. Yes.

3 Q. And in this case did Doctor Espinal know those rules
4 and proceed anyway?

5 A. Yes.

6 Q. All right. Is this sort of thing capable of being
7 repeated?

8 A. Yes.

9 Q. Could this happen again?

10 A. Yes.

11 Q. And when you do this sort of thing can patients be
12 injured?

13 A. Yes.

14 Q. Can they even die?

15 A. Yes.

16 Q. Is it restricted to just colon surgery patients or is
17 broader than that?

18 A. In general.

19 Q. Is it restricted to just males like Mr. Sexton or is
20 it broader than that to include older people, younger
21 people, females, kids, the whole gambit?

22 A. Every human.

23 MR. MCGOWAN: Thank you.

24 CROSS EXAMINATION

25 DOCTOR ROBERT SOLYMVARI BY MR. KING:

1 Q. Good afternoon, Doctor Solymvari. How are you?
2 A. Good afternoon. Great.

3 Q. Doctor, how much are you charging for your testimony
4 here?

5 A. Well there is the travel expenses involved. Usually
6 -- I drove here so it's fifty-one cents a mile. There is
7 preparation where we review the transcript and
8 complexities, one to three hundred dollars an hour. Usual
9 testimony like for a full court case like today runs
10 between two to three thousand dollars.

11 Q. I'm sorry.

12 A. Two to three thousand dollars for a full day.

13 Q. And how active are you in medical legal matters such
14 as this?

15 A. How do you define active?

16 Q. Do you review a number of cases on the annual basis
17 more than five or six?

18 A. Not more than five or six.

19 Q. Okay. How many would you say?

20 A. Two or three.

21 Q. Okay. And primarily for patients?

22 A. Yes. So far I've never testified to defendant
23 doctor.

24 Q. Okay. Doctor, an astigmatic leak in the colon is a
25 known complication of that surgery, is it not?

1 A. That is correct.

2 Q. And a leak in the colon into the peritoneum or into
3 the abdominal cavity cause for emergency surgery.

4 A. A leak does yes.

5 Q. Okay. We talking about a procedure that was done on
6 the 10th.

7 A. Yes.

8 Q. Okay. And would you agree that an astigmatic leak in
9 the colon from surgery such as this can occur without
10 there being medical negligence?

11 A. Yes I agree.

12 Q. Okay. And you can have bad result in medicine
13 without there being negligence?

14 A. That is correct.

15 Q. And you yourself have had bad results in surgical
16 cases even though you did everything that you thought you
17 could do humanly possible?

18 A. That is correct.

19 Q. Would you agree that most anastomotic leaks in colon
20 surgery are delayed, that there is several days before
21 they are detected?

22 A. Yes.

23 Q. And signs and symptoms are elevated white count?

24 A. Yes.

25 Q. Distended abdominal pain into the abdomen?

1 A. Yes.

2 Q. Tachycardia, rapid heart beat?

3 A. Yes.

4 Q. Your criticism of Doctor Espinal primarily is that he
5 did not do an adequate pre-op evaluation and risk
6 assessment.

7 A. That is my main criticism.

8 Q. Okay. And you have not seen the informed consent
9 form signed by Mr. Sexton the day before surgery?

10 A. No I have not.

11 Q. Okay. Doctor Solymvari, you may have only seen
12 extracts. I'm gonna hand you what is marked as Exhibit
13 Twenty-nine. Now, is that a documentation of the patient
14 signing off that he has been advised of the risk and
15 complications and that he consents to the surgery?

16 A. If you will give me one minute to read through it?

17 Q. Certainly

18 A. Thank you.

19 (PAUSE.)

20 A. Yes, sir.

21 Q. Okay. So that's the form that you've never seen
22 before?

23 A. No.

24 Q. So that is a form that is required to be utilized in
25 surgery procedures, is it not?

1 A. Yes it is. Informed consent is required.

2 Q. All right. And that's precedent?

3 A. It's consent but I'm not sure if it's fully informed.

4 Q. Okay.

5 A. It's not very detailed.

6 Q. Okay. But if you go back, if you look at Doctor

7 Espinal's HP when he sees Mr. Sexton initially, he

8 discusses, according to his notes, risk of complications,

9 does he not?

10 A. May I look at that too?

11 Q. Sure. That's I believe -- You've got that notebook.

12 A. What page would that be on?

13 Q. I think its under Tab 1.

14 A. Okay.

15 Q. Let me see if I can get another notebook, Doctor, so

16 I can stay with you.

17 A. That is correct.

18 Q. So he -- at the bottom which is actually it says

19 PalmettoSurgery -003. It's the second page of the initial

20 evaluation. He talks about surgical treatment plan.

21 "Laparoscopic right colectomy. Risks discussed included

22 chances of anastomotic leak, colostomy, conversion to open

23 procedure, infection, bleeding, DVT, bowel obstruction,

24 and lieus. The patient understands and agrees to

25 proceed."

1 A. Yes.

2 Q. Correct? And the patient also said in looking at the
3 form and signed the day before the surgery at the hospital
4 that the risk and complications had been explained to him.

5 A. Yes.

6 Q. Correct? And would you agree that in discussing risk
7 and complications with your patient, you may not just rely
8 on the written word. Your discussion with the patient may
9 be verbal in addition to that.

10 A. That's correct.

11 Q. What you want to do is you want to do two things.
12 You want to insure that you have told the patient what the
13 procedure is going to be, what the risk are, what the
14 complications and that the patient understands.

15 A. That's correct.

16 Q Two parts. Correct? Now, does the physician has to
17 depend upon the accuracy and honesty of the patient in
18 telling him about what his past medical history is, does
19 he not?

20 A. To a certain extent he has but it's also a physicians
21 duty to elicit certain responses that the patient does not
22 or does not think it's important.

23 Q. Okay.

24 A. A patient walking in off the street will not
25 understand that certain details of his health history may

1 be better relevant to the procedure. So it has to be more
2 of an active process as opposed to a passive process on
3 the physician's part on eliciting certain risk factors and
4 histories.

5 Q. Okay. And smoking was an issue in this case, was it
6 not, Doctor?

7 A. Yes.

8 Q. All right. And if you look at Tab 33, which is
9 called Intake Forms with Mr. Sexton would put first to see
10 Doctor Espinal.

11 A. Can I have -- I only have to Tab 31, nothing in this
12 book.

13 MADAME COURT REPORTER: Mr. Blackwell, will you hand
14 him my book? This is in evidence, this is what he's
15 reading from.

16 Correct? Correct, Mr. King? I don't want to hand
17 this client something -- this witness something wrong.

18 MR. KING: He should have 33.

19 MADAME COURT REPORTER: He says he does not.

20 MR. KING: I don't know where that one came from
21 then. That was an old one.

22 DOCTOR SALYMVARI: Let me look at it.

23 MR. KING: That may be his.

24 THE COURT: Wait. Let him keep it.

25 DOCTOR SALYMVARI: Okay. I go to Tab 33. I'm sorry.

1 It just wasn't marked at the end of the book.

2 MR. KING: May we approach? I want to make sure that
3 we have marked ...

4 This is the Court's Exhibit?

5 MADAME COURT REPORTER: Yes, sir.

6 MR. KING: That's the one we're sure of?

7 MADAME COURT REPORTER: Yes, sir.

8 MR. KING: Okay. Thank you.

9 Q. Now, Doctor, you do have Exhibit 33?

10 A. Yes I do have it.

11 Q. And if you look at the second page it says tobacco or
12 alcohol use, there is nothing checked?

13 A. Yes.

14 Q. All right. And if you look at Tab 28, do you have
15 that?

16 A. Going there. Yes. Uh-huh.

17 Q. And that is Digestive Disease's Chart?

18 A. Tab 28. Yes.

19 Q. And I'm looking at DDA-15, has to do with Medical
20 History Update.

21 A. DDA-15?

22 Q. Yes, sir, DDA-15, Bates stamped at the bottom.

23 A. Yes.

24 Q. Okay. And it ask the question about do you smoke and
25 the answer is yes. And the qualification if yes, how

1 much? And the answer is very low?

2 A. Yes.

3 Q. Doctor, would you agree that in forty-five years if
4 someone between one and two packs a day doesn't - isn't
5 very little?

6 A. No it's not little. It's significant.

7 Q. All right. And would that amount of smoking cause a
8 patient to have COPD?

9 A. It can yes.

10 Q. And COPD is what?

11 A. That's called Chronic Obstructive Pulmonary Disease
12 and it's due to chronic irritation of the air ways in the
13 lung. Patients develop basically a lung disease that
14 restricts their breathing.

15 Q. And would that account for low oxygen saturations?

16 A. Well there's a wide variation of COPD.

17 Q. Okay.

18 A. It can or it cannot but the earliest stage of COPD
19 there is correlation, you can make a general statement
20 like that.

21 Q. Okay. And when Mr. Sexton went to Piedmont on the
22 morning of the 7th for the surgical procedure, the only
23 thing that was abnormal was that he had low oxygen
24 saturations.

25 A. He had diminished breath sounds.

1 Q. Okay.

2 A. He had abnormal chest x-ray.

3 Q. Okay. Temperature was normal?

4 A. Yes.

5 Q. Okay. Respiration is normal?

6 A. Yes.

7 Q. Blood pressure normal?

8 A. Yes.

9 Q. Okay. Temperature?

10 A. Temperature?

11 Q. Temperature when he got there?

12 A. I don't understand.

13 Q. Temperature?

14 A. I think it was normal.

15 Q. Okay. And he wasn't complaining of shortness of
16 breath?

17 A. According to the chart he had cough and shortness of
18 breath.

19 Q. Okay. And you know that he has a hard job that he
20 requires physical labor out, physical labor?

21 A. Yes.

22 Q. And you know after he reported and the low oxygen
23 saturations were found, that the anesthesiologist ordered
24 a chest x-ray?

25 A. That is correct.

1 Q. Okay. And that chest x-ray does not show anything
2 that is acute?

3 A. No. It does show anything acute. It says
4 actolactisis. That's not a normal finding in a patient
5 walking off the street.

6 Q. That's not pneumonia is it, Doctor?

7 A. But its abnormal. You can't say it was normal.

8 Q. Okay. But that's -

9 A. Pneumonia can be actelectosis. There is findings of
10 interstitial prominence, mild.

11 Q. Okay.

12 A. There's -- that is not a normal chest x-ray.

13 Q. But that is mild and it is not pneumonia?

14 A. You don't know that. Chest x-ray does not diagnose
15 pneumonia. Chest x-ray is one modality in the diagnosis
16 of pneumonia. There is pneumonia the chest x-ray is
17 completely normal and the changes will develop six to
18 twelve hours after the chest process like ARDX. Chest x-
19 rays are completely normal in the early phase. So the
20 diagnoses of pneumonia it can be a radiological
21 description but the diagnoses is made by evaluating the
22 whole patient. History, physical exam, O2 sats, chest x-
23 ray.

24 Q. All right. But the anesthesiologist, Doctor Lupo, is
25 the medical doctor who ordered the chest x-ray?

1 A. Yes. As far as I know yes.

2 Q. All right. And the anesthesiologist and the surgeon,
3 either can stop a surgical procedure?

4 A. Yeah either one of them can.

5 Q. Now, you have testified that in your opinion the
6 surgery should have been delayed?

7 A. Yes.

8 Q. Now, we know that Mr. Sexton has a polyp in the colon
9 that may carry with it, may have with it a cancer.

10 A. No, you don't know that.

11 Q. Well it's possible and without removing that polyp
12 you're not going to know it's not cancerous, is that not
13 correct, Doctor?

14 A. But that polyp does not have to be removed on that
15 day. That polyp may have been sitting there for months.
16 That polyp could become completely benign. You do not
17 know.

18 Q. And that's correct. You don't know whether it is or
19 whether it isn't?

20 A. Yeah. Okay.

21 Q. True?

22 A. Go ahead.

23 Q. True?

24 A. You don't. True.

25 Q. All right. And you would agree that you're going to

1 have to remove that polyp?

2 A. No I do not.

3 Q. I'm not saying that day. I'm just saying you gonna
4 have to remove that polyp?

5 A. No I do not.

6 Q. That -

7 A. There can be in a different patient who has severe
8 lung disease, let's take one, or prohibited heart problem.
9 I think that polyp being as small as it is and as it turns
10 out later being just a tubular adenoma could have been
11 followed clinically with colonoscopies. It could have
12 been biopsied, not removed, but biopsied and indicating
13 that it is a polyp that has a low, lower risk of malignant
14 transformation and could have been followed. It all comes
15 down to risk assessment. While you assess the risk of the
16 polyp versus the risk of the surgery that day or ever, if
17 the risk of the surgery out weighs the risk of the polyps
18 turning into cancer and causing him any further problems
19 then basically the waiting, the lesser risk wins which is
20 not to do anything about that polyp. At that point or
21 sometimes even never.

22 Q. But would you agree it's a judgment call?

23 A. Yes but there can be good judgment and bad judgment.

24 Q. But it may be judgment without maybe being medical
25 negligence?

1 A. No. No. It can be a judgment call. I don't think
2 there can be a judgment about assessing the risk of a tiny
3 two centimeter polyp versus operating on somebody who has
4 unexplained O2 saturation at 85. That's not a judgement
5 call. That is as clear as it is. You could discuss
6 judgment call on the choice of the operation we had which
7 I also disagree with. But I don't think there is a
8 judgment call on him deciding that day if you needed to
9 proceed to surgery or not. That's not a judgment call to
10 me.

11 Q. But the anesthesiologist cleared Mr. Sexton for
12 surgery after being aware of the O saturations?

13 A. Obviously they took the patient to the OR but that's
14 -- I don't know if he cleared it or not. I didn't see a
15 note from the anesthesiologist. Obviously he didn't
16 because he took him to the operating room.

17 Q. Okay. You don't deny that?

18 A. No.

19 Q. Okay. Now, the procedure that Doctor Espinal did was
20 to go in the ascending colon and --

21 Can you see that?

22 A. You want me to step down?

23 Q. Yeah. Sure.

24 (WITNESS LEFT WITNESS STAND.)

25 Q. You tell us, Doctor, not me try to tell you. What

1 was the procedure that Doctor Espinal did?

2 A. He resected -- it appears from the note to me he
3 resected a segment in about this area which is called the
4 hepatic flexure. The liver sits right here and he went in
5 with what you call laparoscopic procedure. He didn't open
6 the patient completely, went in with just little holes
7 with TV camera and he resected the two -- like a segment
8 that involved the polyp and then took the two ends and put
9 them side to side and did like a staple and most of the
10 staples is inside the abdomen.

11 Q. Okay. And the mesentery which is that -

12 A. Right here.

13 (WITNESS INDICATED TO DISPLAY.)

14 Q. - - - yellow colored, red, lines in it and the red
15 is a medical illustration for blood; is it not, sir?

16 A. That is correct. The mesentery is kind of like a fat
17 plain or wrapping that carries these blood vessels that
18 supply the oxygen to the intestine.

19 Q. Okay. And the blood vessels in the mesentery are
20 circulatory. In other word if one was blocked and cut off
21 the blood would continue to circulate down through another
22 one would it not?

23 A. In some areas yes. In some areas no.

24 Q. Okay. And you are not critical of the procedure that
25 Doctor Espinal used to remove the colon are you, Doctor?

1 A. Yes I am.

2 Q. When I took your deposition I thought you told me it
3 was a judgment call?

4 A. It is a judgment call but that's a true judgment call
5 where I can be critical of it but you may not consider it
6 as -- you can consider it as a contributing factor but not
7 the main problem. The main problem basically is this
8 patient should have never been operated on that day.

9 Q. Okay.

10 A. But there was a contributing factor because this is
11 an operation that disturbed the blood supply of the colon
12 without reliably knowing where the blood supply comes, you
13 know, as opposed to two other procedures that could have
14 been used.

15 Q. But -- We'll get your deposition and read it if you
16 like, did you not tell me that it was a judgment call that
17 medical literature would support the way he did it?

18 A. I did tell you but I was also critical of it.

19 Q. But you don't -- you're not -- You're telling this
20 jury it breached the standard of care?

21 A. No.

22 Q. You would have done it differently?

23 A. Yes.

24 Q. Okay. And your procedure would have been just to
25 remove the polyp?

1 A. That's correct.

2 Q. Now a polyp was based upon what the digestive disease
3 physician's tell us it was roughly adhering to one half or
4 one third of the side of the wall?

5 A. It came back two or three centimeters and the colon
6 is at least pretty much ten centimeters around so I would
7 say maybe ten or twenty percent of the wall.

8 Q. But if you removed it in the fashion that you're
9 suggesting wouldn't you not have a bottle neck?

10 A. No. Uh-huh. To remove it basically on a transfer
11 incision. When you close the transfer you basically fold
12 it over. Same fashion Doctor Espinal did the
13 adenomatosis. If you go side to side adenomatosis you do a
14 side to side closure. If you would resect the polyp with
15 a longitude incision and you sewed it up longitudely then
16 you have a bottle neck. What you do is you resect it
17 transversely and close it transversely but it actually
18 loops the bowel on itself and that does not create a
19 bottle neck.

20 Q. And if I understood your testimony, you are opining
21 that the leak occurred because of oxygenated blood to the
22 surgical site?

23 A. The leak occurred because there is not enough oxygen
24 to the anastomosis.

25 Q. Okay. Do you know how much of the mesentery -- The

1 mesentery contains the blood supply?

2 A. Yes.

3 Q. Do you know how much mesentery was removed?

4 A. No I cannot take that from the pathology report?

5 Q. You can't tell?

6 A. No I can't tell. That description to me is fairly
7 unreliable. I would have to see it myself.

8 Q. Okay. Now, you can go back up. Thank you.

9 (WITNESS RETURNED TO WITNESS STAND.)

10 Q. And you understand that a pulmonary consult was
11 ordered and done by Doctor Denenberg the next day?

12 A. Yes.

13 Q. And, anything in Doctor Denenberg's report that was
14 not known prior to his being called in?

15 A. Well Doctor Denenberg elicited more of the smoking
16 history, history of asthma in the past and more, you know,
17 pulmonary problems that may have occurred earlier in life.

18 Q. Okay. And over the next several days when you've
19 told us that an anastomotic leak may take days to develop?

20 A. That's correct.

21 Q. And over the next several days, actually on the 9th,
22 is the day that Mr. Sexton gets sick?

23 A. Yes.

24 Q. Fever of a 104. Tachycardia. Correct?

25 A. Yes.

1 Q. And that's the day that Doctor Espinal ordered the
2 CT?

3 A. Yes. As I recall yes.

4 Q. With contrast?

5 A. Yes.

6 Q. Okay. And you now know that actually the first CT
7 that was run on the afternoon or evening of the 9th, the
8 contrast could not get into the colon and it had to be
9 redone the morning of the 10th.

10 A. Yeah I heard that during the opening statements.

11 Q. Okay. You know that now?

12 A. Yes.

13 Q. So, are you critical of Doctor Espinal's procedure on
14 the 10th of repair the leak?

15 A. Not at all.

16 MR. KING: Excuse me just a minute.

17 (PAUSE.)

18 MR. KING: I want to make sure I'm not stealing your
19 exhibit notebook. I didn't want to take a juror's
20 notebook.

21 Q. Would you agree with me, Doctor, COPD is not
22 reversible?

23 A. Treatable.

24 Q. But not reversible?

25 A. But can be improved upon.

1 Q. Doctor, do you still have the exhibit notebook?

2 A. Yes.

3 Q. Would you look at Exhibit Five.

4 A. Yes.

5 Q. And if you'll look, and it's very, very small print,
6 but if you'll see there is Pre-Op Checklist that we're
7 looking at.

8 A. Yes.

9 Q. And if you'll look up on the upper right hand side.

10 A. Uh-huh.

11 Q. It says "History and physical on chart updated."

12 A. Yes.

13 Q. You see that?

14 A. Yes.

15 Q. Okay. And you've told us that the surgeon needs to
16 do an update on the morning of surgery to insure that
17 there has been no changes in his patient's condition from
18 the time that he did the initial?

19 A. Yes.

20 Q. And according to this nurse's notes it was done.

21 A. I don't see a check mark in that box.

22 Q. You don't see initials with a check in that box?

23 A. I don't know. My eyes are not the best but I don't
24 see a check mark in there. It seems to be an empty box.

25 (SIDE BAR BETWEEN ATTORNEYS.)

1 Q. Doctor, what I have found, I was going to mark this
2 by the court reporter as an Exhibit for Identification.

3 (WHEREUPON: DEFENDANT'S EXHIBIT NUMBER ONE,
4 PREMARKED FOR IDENTIFICATION.)

5 BY MR. KING:

6 Q. Doctor, does that make reference to a H/P, updated
7 H/P?

8 A. It states that he didn't notice any changes in the
9 patient's condition.

10 MR. KING: Thank you, Doctor. Nothing further.

11 THE COURT: Any redirect?

12 Is this in evidence?

13 MR. KING: I marked it for identification only.

14 MR. MCGOWAN: I moving that into evidence right now,
15 Judge. I think it's gonna be Number Thirty-four.

16 THE COURT: Any objection?

17 MR. KING: That's fine.

18 THE COURT: In without objection

19 MR. KING: With consistency, Your Honor, at some
20 point we probably ought to make multiple copies of that.

21 MR. MCGOWAN: We're gonna give that to the Court
22 Reporter so she can remark it.

23 DOCTOR SOLYMVARI: Okay, sir.

24 MADAME COURT REPORTER: Did you say Thirty-four, Mr.
25 McGowan?

1 MR. MCGOWAN: Yes, ma'am.

2 (WHEREUPON: DEFENDANT'S EXHIBIT NUMBER ONE PREMARKED
3 FOR IDENTIFICATION, REMARKED AND RECEIVED INTO EVIDENCE AS
4 PLAINTIFF'S EXHIBIT NUMBER THIRTY-FOUR.)

5 REDIRECT EXAMINATION

6 DOCTOR ROBERT SOLYMVARI BY MR. MCGOWAN:

7 Q. Let's look at this, Doctor. I believe this came
8 about, correct me if I'm wrong, Doctor, because it is the
9 standard and the obligation that the physician reexamine
10 the patient before the procedure. Right?

11 A. As I said before yes.

12 Q. And that's what Doctor Espinal said in his
13 deposition. Right?

14 A. Yes. National standard.

15 Q. All right. So what we have here is this document
16 signed by Doctor Espinal and it says the attached history
17 and physical has been reviewed and the contents accurately
18 reflect the patient's condition today without any
19 additions or revisions to the original document. That's
20 what it says right there. Right?

21 A. Yes it does.

22 Q. If Doctor Espinal had actually examined the patient,
23 would you have expected him to see and note an eighty-five
24 percent O2 sat?

25 A. Yes I would have.

1 Q. Would that have been an addition or revision that
2 would have been needed?

3 A. Yes. I would have checked that box.

4 Q. If Doctor Espinal had actually examined the patient,
5 would you have expected him to make note of diminished
6 breath sounds bilaterally?

7 A. If you agree with the nurse yes.

8 Q. Would that have been an addition or revision required
9 given it was a change from his history and physical?

10 A. That is correct.

11 Q. If he had examined the patient before the procedure,
12 would you have expected him to make note of the
13 atelectasis and the mild prominence of the interstitium?

14 A. That -- If he had that information but certainly yes.

15 Q. All right. So, if this is a legitimate record of a
16 real examination by Doctor Espinal, if he actually did
17 what this record claims he did, how can we explain his
18 testimony where he says that he did not do another
19 examination of the patient before the procedure?

20 A. I don't know.

21 Q. Is it wrong in a deviation from the medical standard
22 of care for a physician to make a medical record that
23 claims he did an updated history and physical on the
24 patient when he did not even examine the patient?

25 A. That could be considered fraudulent.

1 Q. Is there ever a time when a physician is allowed to
2 say he did something to make a medical record that to the
3 outside public would claim he did when he didn't actually
4 do it?

5 A. No.

6 Q. Have you ever in your career, you've been a surgeon
7 nor for some twenty odd years, run across a time when a
8 physician swears under oath that he never did a physical
9 examination of the patient before the procedure in the
10 middle of a law suit, knowing that we'd be asking
11 questions about his testimony, and yet present a document
12 like this which reports to claim that he did such an
13 examination and there were no changes? Have you ever run
14 across this kind of situation in your career?

15 A. No.

16 Q. If you had a resident when you were teaching that
17 didn't do an updated physical and examination yet created
18 a record to try to convince the world that he did, what is
19 the proper response of a reasonably and prudent surgeon in
20 that circumstance?

21 A. He would have been disciplined.

22 Q. Is this sort of fraudulent document ever -

23 MR. KING: Objection, Your Honor, to
24 characterization.

25 THE COURT: I sustain the objection. Refer to it as

1 something else.

2 BY MR. MCGOWAN:

3 Q. Is this sort of document which is -- would you agree
4 that it is at odds with this sworn testimony in his
5 deposition?

6 A. Yes I do.

7 Q. Is it ever acceptable for a physician to create
8 documents that report to show that he did something when
9 he really didn't?

10 A. No.

11 Q. Let's talk about his consent form for just a minute.
12 Does a patient ever consent to a doctor's negligence?

13 A. No.

14 Q. Does a patient consent to a doctor putting things in
15 the records that aren't true?

16 A. No.

17 Q. Is there any evidence in the record of a consent, an
18 informed consent of Mr. Sexton after the 6th but before
19 the procedure? IN other words once the lung issues were
20 evident did you see any consent of that kind?

21 A. No. I mean the consent was pertaining to the day of
22 the examination. But it appears that the risk has changed
23 for the patient so I think that initial consent was
24 inadequate on the day of surgery because it did not
25 explain the increased risk of pulmonary complications

1 because of his low O2 saturations.

2 MR. MCGOWAN: Thank you, Doctor.

3 That's all I have, Your Honor.

4 THE COURT: Any recross?

5 MR. KING: Yes, sir.

6 RECROSS EXAMINATION

7 DOCTOR ROBERT SOLYMVARI BY MR. KING:

8 Q. You have Doctor Espinal's deposition?

9 A. Which page would that be?

10 Q. I'm looking at Page 91. I don't think you have his
11 deposition.

12 A. No I don't have that here.

13 Q. Let me walk up there and see if we can read on it
14 together.

15 Let's look at Page 91 of Doctor Espinal's deposition.

16 And the question, this is Mr. McGowan on examination.

17 All right.

18 "Did you do a physical examination of the patient
19 before the procedure? Doctor Espinal's answer was?

20 A. The day of the surgery?

21 Q. Yes, sir.

22 A. "Yes. And I did not find that."

23 Q. Question, "On the day of the surgery?"

24 A. "Not a complete physical examination."

25 Q. Question, "Where would that be recorded?"

1 A. "What?"

2 Q. "A physical examination of the patient before ---

3 a. "On my ---

4 Q. --- you --

5 A. --- history and physical."

6 Q. "The one that you did in the office?"

7 A. "Yes."

8 Q. "Five days before?"

9 A. "Yes."

10 Q. "All right. So did you do another physical
11 examination of the patient before the procedure?"

12 A. "No."

13 Q. "So -- "

14 A. "There is a preoperative note that's checked. I
15 don't know where it is in this -- as part of the
16 preoperative process that we are required to reevaluate
17 the patient from a generic standpoint to see if there's
18 anything that's changed significantly since we've seen him
19 in the office. Of course -- and that's why we have
20 certain -- and H&P, or history and physical, can only be
21 acceptable for 30 days. Once you get beyond 30 days,
22 things can change; then you have to redo another physical
23 examination. You don't have to redo a physical
24 examination ten times in a week.

25 So the basic second examination is to come in to make

1 that.

2 Sir, you're too close to that mic.

3 A. I ain't never talked in one like that.

4 MADAME COURT REPORTER: That's all right. Just calm
5 down.

6 A. Sorry.

7 MR. ANDREWS: Ricky, just relax. I know you're
8 nervous. Okay.

9 A. Okay.

10 Q. State your name.

11 A. John R. Sexton.

12 Q. John R. Sexton.

13 A. Call me Ricky.

14 Q. Okay. And you go by Ricky; is that right?

15 A. That's right.

16 Q. Now, Ricky, everyone here noticed that you talk a
17 little different; is that right?

18 A. That's exactly right.

19 Q. Okay. Do you have a speech impediment?

20 A. Yes I do.

21 Q. Is that something that you've had since you been
22 born?

23 A. Yes I have.

24 Q. Okay. And I think it's -- What is it known as?

25 A. I got a hole in the roof of my mouth.

1 Q. Something like a cleft palate?

2 A. Uh-huh.

3 Q. Okay. Just want to make sure everybody understood
4 that and I'm going to repeat some of the things that you
5 say as I understand them and if I repeat something that's
6 not what you said, you let me know, because I don't want
7 --

8 A. She'll let you know.

9 (WITNESS INDICATED TO COURT REPORTER.)

10 Q. Yes she will. You go by Ricky. Right?

11 A. Uh-huh.

12 Q. And how old are you, Ricky?

13 A. Fifty-one.

14 Q. Fifty-one.

15 A. Sixty-one.

16 Q. Sixty-one?

17 A. Correct.

18 Q. And where do you live?

19 A. 1830 Autumn Lane Drive, York.

20 Q. Where is that?

21 A. York.

22 Q. York. In York County?

23 A. York, South Carolina. Right down the road.

24 Q. Okay. And who lives there with you, Ricky?

25 A. Me and my wife.

1 Q. And your wife is here and her name is Tricia; is that
2 right?

3 A. Yeah.

4 Q. And how long have you all been married?

5 A. Six years.

6 Q. And you said you -- Did you grow up in York?

7 A. No I grew up in Rock Hill.

8 Q. Okay. What kind of education do you have, Ricky?

9 A. Not a lot.

10 Q. How far did you go in school?

11 A. Went through the twelfth grade.

12 Q. Okay. Did you receive your --

13 A. No I did not.

14 Q. Did you ever get your GED?

15 A. No I did not.

16 Q. Okay. So you quit school around the eleventh or
17 twelfth grade; is that right?

18 A. Around there yeah.

19 Q. Okay. And what did you do after that?

20 A. I went to work for a lumber company.

21 Q. And so you're about seventeen, eighteen years old
22 then?

23 A. Yeah.

24 Q. And you're sixty-one today?

25 A. Uh-huh.

1 Q. So for the last forty-three years you been working
2 full time?

3 A. Everyday of the week a lot of times.

4 Q. And basically you're a pipe fitter?

5 A. That's a fact.

6 Q. Is that right?

7 A. Yeah.

8 Q. Kind of like a plumber. Tell us how that's
9 different?

10 A. A little bit higher up.

11 Q. A little bit different isn't it. And where do you
12 currently work?

13 A. Mid-Atlantic and do all of Duke Power's work, nuclear
14 plant.

15 Q. And how long have you been working?

16 A. It'll be thirty years next month.

17 Q. Are you working today, Ricky?

18 A. No I'm here.

19 Q. Well not today.

20 A. I would be.

21 Q. I caught myself before I finished. Are you still
22 employed?

23 A. Yes, sir.

24 Q. And who are you employed with?

25 A. Mid-Atlantic.

1 Q. And you are a pipe fitter?

2 A. Yes, sir.

3 Q. Okay. I want to go back and talk about your medical
4 history prior to March of 2007. Okay?

5 A. Okay.

6 Q. Ricky, did you smoke during your life?

7 A. Yes I did.

8 Q. When did you start smoking?

9 A. I have no idea.

10 Q. Ten -

11 A. Seventeen, eighteen. No it wasn't that early.

12 Q. Okay. And you smoke today; is that right?

13 A. That's exactly right.

14 Q. And - -

15 A. But I ain't -- I ain't about dead like everybody
16 said.

17 You know there wasn't nothing wrong with me. There ain't
18 nothing wrong with me today.

19 THE COURT: Wait. He's gonna ask you some questions.

20 A. Okay.

21 THE COURT: Just answer what he ask. Don't go off.

22 A. All right. I apologize.

23 Q. Ricky, did you smoke more when you were younger than
24 you did today?

25 A. I don't smoke a whole lot. I never have. Not a lot.

1 Q. What did you use to smoke? How much did you smoke?

2 A. I ain't never smoked a pack a day.

3 Q. Okay.

4 A. Maybe not even a half. Not working no way.

5 Q. Have you had any major illnesses that you can
6 remember? Not talking about this, going back prior to
7 March of 2007.

8 A. Yeah I been sick. You know how you get the flu.

9 Q. What about any major operations? Didn't you have an
10 appendix?

11 A. I had an appendix out and my tonsils out. Nothing
12 major.

13 Q. Anything else that you can recall?

14 A. Nothing I know of. I had a rupture in my stomach.

15 Q. You had an ulcer?

16 A. Yeah that's what it was. And I drank a lot of liquor
17 too. I sure did.

18 Q. Okay. And how long have you not? Do you drink
19 today?

20 A. No I do not.

21 Q. When's the last time that you took a drink?

22 A. Maybe twelve years ago.

23 Q. Congratulations. Now we're talking about March of
24 2007. Okay. And I'm asking you about your medical
25 history.

- 1 A. Okay.
- 2 Q. Were you taking any prescription medication at that
- 3 time?
- 4 A. I take Nexium.
- 5 Q. Nexium?
- 6 A. Acid reflux.
- 7 Q. For your acid reflux?
- 8 A. That's it.
- 9 Q. All right. And you went to see a digestive disease
- 10 doctor by the name of Doctor Richardson?
- 11 A. Yeah.
- 12 Q. Back in February of 2007?
- 13 A. That's all them guys at work that talked me into it.
- 14 Q. The guys at work talked you into it?
- 15 A. Yeah. Into a colonoscopy.
- 16 Q. Okay. You went there just to make sure everything
- 17 was okay?
- 18 A. Yeah.
- 19 Q. All right.
- 20 A. Good idea.
- 21 Q. And he did a colonoscopy on you on February 16th,
- 22 2007.
- 23 A. That's correct, yeah.
- 24 Q. And he found some polyps in your colon. Right?
- 25 A. Yeah.

1 Q. And he removed a couple.

2 A. Uh-huh.

3 Q. But one was flat and was about two to three
4 centimeters and he couldn't remove it?

5 A. About.

6 Q. When did you learn that he couldn't remove that? Was
7 that about a week later?

8 A. Well I went back for the return visit and he told me.

9 Q. Okay. And he told you at that point what? Did he
10 tell you he was going to refer you - -

11 A. Yeah he referred me to Doctor Espinal.

12 Q. Okay. Now you met with Doctor Espinal on March 2nd,
13 2007. Right?

14 A. That's correct.

15 Q. And did Trash accompany you on that?

16 A. Yes, sir.

17 Q. Okay. And right now I'm not talking about the entire
18 time that you spoke, that you met with Doctor Espinal
19 during that time. I want to know how long were you at his
20 office.

21 A. Not long.

22 Q. How long?

23 A. I'm not gonna give a time but it wasn't long.

24 Q. Was it less than thirty minutes?

25 A. Some where around there. Maybe a little less.

1 Q. Right around thirty minutes?

2 A. Yeah. It wasn't - -

3 Q. And of the time that you were at his office, how much
4 time did Doctor Espinal spend with -

5 A. Well I had to fill all that paper work out front.
6 And then I had to go back there and be weighed. He did
7 put that thing, you know, on my heart. That's about it.

8 Q. How much time did he spend with you personally?

9 A. Three or four minutes.

10 Q. Did he examine you in any way?

11 A. He listened to my heart.

12 Q. Okay.

13 A. That's about it.

14 Q. All right.

15 A. Wasn't much to it.

16 Q. All right.

17 A. I wasn't - -

18 THE COURT: Wait, wait. He'll ask you a question.

19 A. Yes, sir.

20 Q. Did he discuss the surgery with you at that time?

21 A. Yeah.

22 Q. What did he tell you about the surgery?

23 A. He said I would go in on Wednesday, come out on
24 Friday go back to work on Monday.

25 Q. Did you tell him at that point that you wanted to

1 delay the surgery?

2 A. Yeah.

3 Q. And why did you want to delay the surgery?

4 A. Because I was already off that Monday, said I'd be
5 ready to come back to work Monday anyway.

6 Q. All right.

7 A. I felt better.

8 Q. Did he at anytime that you spent with him did he ever
9 ask you if you smoked?

10 A. I think he might have.

11 Q. Okay. What would you have told him?

12 A. I'd a told him yeah. I don't hide it. Why would I
13 want to hide it? I'm sixty-two years old. That ain't
14 something you would hide is it? It don't make sense to
15 me. They act like I been trying to hide it.

16 THE COURT: Just answer the question.

17 A. Yeah.

18 Q. Ricky, listen to my questions.

19 A. I apologize.

20 Q. Okay. Thank you. Did he advise you to quit smoking,
21 Doctor Espinal?

22 A. I tell you the truth I don't even remember talking
23 about it.

24 Q. Did --

25 A. I --

1 Q. Did -- You don't remember?

2 A. No. And I done forgot.

3 Q. Did he go over any risk of the surgery?

4 A. No. No risk, ain't nothing to it. You go in
5 Wednesday, come out Friday, go back to work Monday.
6 Nothing to it.

7 Q. So surgery was planned for March 7th and that was on
8 a Wednesday?

9 A. Yeah.

10 Q. Right?

11 A. Yeah.

12 Q. And you were supposed to show up at Six o'clock in
13 the morning. Right?

14 A. Yeah.

15 Q. Did you see Doctor Espinal, do you remember seeing
16 him again prior to the surgery?

17 A. Vaguely. But it was way off.

18 Q. You just don't remember?

19 A. Wouldn't swear to it no, sir.

20 Q. Let's go back one day March 6th, Tuesday. How were
21 you feeling that day?

22 A. Sick. Sick.

23 Q. What kind of sick were you?

24 A. It was the flu and it got worked up. I worked that
25 day and right up to quitting time.

- 1 Q. Did you have a fever?
- 2 A. I had a fever.
- 3 Q. Who took your temperature?
- 4 A. We didn't have no thermometer. I was just real hot.
- 5 Q. And - -
- 6 A. My nose was running.
- 7 Q. Were you coughing?
- 8 A. Coughing real bad.
- 9 Q. So you thought you had the flu?
- 10 A. What I thought yeah.
- 11 Q. Did you tell your wife that?
- 12 A. Yes, sir. She already knew it.
- 13 Q. Okay. Did your wife do anything after you told her?
- 14 A. She took my temperature. My sister told her to call
- 15 the hospital that they thought they probably won't want
- 16 you all to come tomorrow.
- 17 Q. Okay.
- 18 A. And she did and they said well bring him on in, we'll
- 19 look at him. We probably won't operate but we'll look at
- 20 you.
- 21 Q. So you got there the next morning March the 7th as
- 22 planned at Six o'clock in the morning.
- 23 A. Yeah.
- 24 Q. You woke up at what time that morning?
- 25 A. Three o'clock in the morning.

1 Q. How did you feel at Three o'clock the morning of
2 March 7th?

3 A. Terrible.

4 Q. How did you feel when you got to the hospital?

5 A. Terrible.

6 Q. Did you tell anybody that?

7 A. I told everybody. I told everybody. My wife told
8 the people I didn't tell.

9 Q. At some point while you were in the pre-op room, did
10 you pick up the phone and make a call?

11 A. Yeah. They told me they was gonna put my surgery
12 off. We gonna put it off. I said okay. I called my
13 sister. I knew she was gonna be up there.

14 Q. Is that Glynnis?

15 A. Yeah.

16 Q. You called Glynnis?

17 A. Yeah.

18 Q. This is prior to the surgery?

19 A. Yeah.

20 Q. And what did you want to let her know?

21 A. That they wasn't gonna do it.

22 Q. Did you tell her that?

23 A. Yeah.

24 Q. Okay. What happened if anything during the time that
25 you're talking to Glynnis?

1 A. A couple of guys come in and told me to hang the
2 phone up I was going to surgery.
3 Q. Okay. What did you say?
4 A. I didn't know what to say.
5 Q. Okay.
6 A. It was like a nightmare and it was get'n worser.
7 Q. Ricky, what's the -- So they took you into surgery;
8 is that correct?
9 A. Sir?
10 Q. They took you into surgery.
11 A. Yes, sir.
12 Q. What's the next thing you remember?
13 A. Waking up on life support.
14 Q. With a respirator mask?
15 A. No I was hooked up to life support when I woke up
16 when I was there but I don't remember nothing else.
17 Q. All right.
18 A. I remember looking in a little mirror and I didn't
19 even know who the hell I was looking at.
20 Q. How did you feel?
21 A. How would you feel? You go in a well man, you come
22 out just like you about dead. Yeah, I didn't know what to
23 think. And you know what?
24 Q. You had to get another surgery on the 10th. Right?
25 A. Don't remember that either.

1 Q. Okay. You don't remember anything?

2 A. No, sir.

3 Q. Do you remember about how much time you spent in the
4 hospital?

5 A. Well after a week or so I did about come to.

6 Q. Sir?

7 A. I said after about a week or so I think I come
8 around.

9 Q. Did you spend about five weeks in the hospital?

10 A. Yeah.

11 Q. And after that did you go to HealthSouth Rehab?

12 A. Yes, sir.

13 Q. And you spent about a week there?

14 A. Yes, sir. They wanted me to stay two more weeks
15 there and I told them no I about died and I wanted to die
16 at home.

17 Q. Okay. So you went home?

18 A. Yes, sir.

19 Q. And you have -- What were you doing when you got
20 home?

21 A. I had a walker I walked all over and I was hooked up
22 to oxygen twenty-four hours a day and they said I'd be on
23 that for the rest of my life. Put me on disability. I
24 mean it was a nightmare and it only got worse. The longer
25 it went on the worse it got.

1 Q. Now, how long were you out of work, Ricky?

2 A. I went back to work about the end of August. I
3 wasn't able to go to work and I had to go back.

4 Q. So you were out of work about six months?

5 A. Six months. March, April, May, June, July and
6 August.

7 Q. And you didn't get paid any monies?

8 A. I didn't get one penny.

9 Q. And you incurred a great amount of medical bills.
10 Right?

11 A. Thousands of dollars yes, sir.

12 Q. Was that about three hundred, somewhere around in
13 there?

14 A. Three hundred and sixty-five. I believe that's what
15 it had. And I ain't counting, at that time my wife wasn't
16 working either.

17 Q. Okay.

18 A. All right.

19 Q. Now, Ricky, as a pipe fitter, you had certain
20 mandatory test that you had to do every year.

21 A. Yes, sir.

22 Q. And what were those?

23 A. Well the respiratory test they did -- what's that
24 thing when they check your heart? And they put all these

25 --

1 Q. EKG?

2 A. Yeah. They did one of them every year and your blood
3 pressure. I was in good health.

4 Q. Well let's talk about the respirator.

5 A. I passed it every year.

6 Q. What was the purpose of the respirator test?

7 A. That's where you go wear a respirator at work.

8 Q. Prior to March of 2007 ---

9 A. Yes, sir.

10 Q. --- had you ever had any difficulty breathing?

11 A. No, sir.

12 Q. Have you ever had any difficulty performing your job
13 duties as a result of losing your breath?

14 A. No. And we climb up in the top in that tree out
15 there.

16 Q. Okay.

17 A. I --

18 Q. Had you prior to March of 2007 had you ever been
19 diagnosed with any lung disease?

20 A. No.

21 Q. Did anybody ever tell you that you had emphysema?

22 A. No.

23 Q. Did anybody ever tell you that you had COPD?

24 A. No. I never heard that until he told me that in the
25 hospital. First time I ever heard of that.

- 1 Q. Okay. Let's talk about now.
- 2 A. Okay.
- 3 Q. You went back to work six months later.
- 4 A. Yes, sir.
- 5 Q. How are you doing on your job as opposed to how you
- 6 were doing before this all happened?
- 7 A. There's a lot of stuff I can't do now you know. A
- 8 lot I can't pick up I used to pick up.
- 9 Q. Do you have a weight limit now?
- 10 A. I ain't got no weight limit. If it's real heavy I
- 11 let one of the young boys get it.
- 12 Q. Okay.
- 13 A. I'm a whole lot smarter than I used to be too. And
- 14 they don't mind.
- 15 Q. Ricky, when you went into the hospital how much did
- 16 you weigh?
- 17 A. I weighed a hundred and seventy-four pounds.
- 18 Q. And when you got out of the hospital.
- 19 A. A hundred and twenty-six pounds.
- 20 Q. So you lost about fifty pounds?
- 21 A. That's without my underwear and socks.
- 22 Q. And - -
- 23 A. It was awful wasn't it, Honey?
- 24 Q. How much do you weigh now?
- 25 A. About a hundred and fifty-five.

1 Q. Okay. Just bear with me one second.

2 A. Yeah.

3 (PAUSE.)

4 Q. Ricky, now as a result of the operations do you have
5 any scars on your body?

6 A. Yes, sir.

7 Q. Where are they?

8 A. On my stomach.

9 Q. Okay. And can you describe the scars?

10 A. You want to see 'em?

11 MR. ANDREWS: Judge, do you mind?

12 THE COURT: No.

13 (WITNESS DISPLAYED HIS STOMACH.)

14 A. They go all the way down to - I'm not gonna get down.

15 Q. Don't do that.

16 A. All right.

17 Q. Okay.

18 MR. ANDREWS: Those are all the questions I have for
19 you, Ricky. Thank you. Answer any questions Mr. King may
20 have for you.

21 THE COURT: Mr. Rogers.

22 CROSS EXAMINATION

23 RICKY SEXTON BY MR. ROGERS:

24 Q. Mr. Sexton, you were ask to do an intake form when
25 you first went to see Doctor Espinal weren't you?

1 A. Ask to what?

2 Q. You were ask to fill out a form when you first went
3 to see Doctor Espinal, talking about your history, your
4 condition.

5 A. That's right.

6 Q. A lot of general information about yourself.

7 A. Yes, sir.

8 Q. So he can treat you the best he could he needed to
9 know a lot about your history and what medical conditions
10 you had and stuff of that nature.

11 A. Okay.

12 Q. If you look with me at Exhibit Thirty-three, I'll
13 bring it up for you.

14 A. Thank you.

15 Q. This is the intake form, the first page that you
16 filled out when you went to see Doctor Espinal?

17 A. Yes, sir.

18 Q. Okay. And if you will turn with me -- and he ask you
19 a lot of background information - on Page 1 and it keeps
20 going on to Page 2.

21 A. Okay.

22 Q. And do you see at the top of the page where I have
23 circled in blue ink on this sheet, and this is Chart-15,
24 Page 2 of Exhibit 33, where he ask you about your prior
25 alcohol.

1 A. He didn't ask me nothing. There ain't nothing marked
2 now. I wasn't pregnant neither.

3 Q. Yes, sir. You didn't put anything about you smoking.

4 A. I didn't put nothing about being pregnant or not
5 neither. I didn't see that.

6 Q. You didn't put anything about your past alcohol -

7 A. No. Not that I was trying to hide it.

8 Q. Okay.

9 A. I'm a alcoholic for forty years, I ain't never hid
10 it.

11 Q. You told the jury you smoked very little; is that
12 correct?

13 A. Well not very little but maybe a half a pack a day.

14 Q. Turn to Tab 26 in your notebook.

15 A. Yes, sir. If I can. I got it.

16 Q. And at the first page of Exhibit 26, and this is a
17 record of Doctor Denenberg. Do you remember seeing a
18 pulmonologist in the hospital?

19 A. No. I heard them talk about him but I do not
20 remember seeing him.

21 Q. Do you remember telling Doctor Denenberg that you
22 smoked two packages of cigarettes per day ---

23 A. No, sir.

24 Q. --- for forty years?

25 A. I don't remember that.

1 Q. You don't remember that? Is that --

2 A. I don't remember him so how would I remember that?

3 Q. Is it a true statement that you smoked -

4 A. I don't know if it's true or not.

5 Q. You don't know if you smoked two packages of
6 cigarettes per day for forty years?

7 A. That's not the question you ask me. You ask me did I
8 tell him that. I said I don't remember talking to him.

9 Q. Well, sir, --

10 A. I don't even know the man.

11 Q. I'm asking you is it true what's in Doctor
12 Denenberg's record that you said - -

13 A. I don't really know where that came from. I don't
14 know. I don't even recall anything like that.

15 Q. Well I'm asking you now, have you smoked
16 approximately two packs of cigarette's --

17 A. No I have not. I mean I don't know where the two
18 packs come in at. I may have. It might been a day I
19 smoked two packs but I don't know when.

20 Q. Do you remember telling --

21 A. What does that have to do with anything anyhow?

22 THE COURT: Just answer the question, Mr. Sexton.

23 A. Okay.

24 Q. Do you remember when my law partner, Mr. King, took
25 your deposition, your testimony before today?

1 A. Yeah.

2 Q. Do you remember telling him you smoked a pack, a pack
3 and a half of cigarettes - -

4 A. I may have done that.

5 Q. Per day for forty years?

6 A. I may have done that.

7 Q. Okay. Is that a true statement?

8 A. It may be true that I said it. Like I said I open a
9 pack up but I usually have half of it left tomorrow. But
10 like I say I drank a lot of liquor over the years...
11 cigarettes.

12 Q. If you'd look at Page 20 of your deposition where my
13 partner, where you see the Q is a question, Mr. King said,
14 "and what's the most you've ever smoked on a regular
15 basis?" And you said, "probably a pack." And he says, "a
16 pack a day?" And then you said, "maybe a pack and a
17 half." And you told him that you smoked about a pack and
18 a half a day.

19 A. Probably.

20 Q. Okay. And you consider that a significant amount of
21 smoking?

22 A. Uh, are you a lawyer or are you a doctor?

23 THE COURT: Just answer the question, Mr. Sexton.

24 You got to do this.

25 A. I understand.

1 THE COURT: Well - -

2 A. Yeah that would be a lot yes it would.

3 Q. Do you remember seeing the digestive disease doctor
4 that did your colonoscopy that sent you to see Doctor
5 Espinal?

6 A. Doctor Richardson?

7 Q. Yes.

8 A. Yes I do.

9 Q. Do you remember him asking you about your smoking?

10 A. No I don't.

11 Q. Okay. Do you remember telling him that you smoked
12 very little?

13 A. I don't remember seeing him. How do I remember
14 telling him anything?

15 Q. If you would turn with me to Tab 28 in that notebook
16 in front of you.

17 A. Okay.

18 Q. And then at the bottom under Tab 28 which is Exhibit
19 28 if you'd turn to the page number in the bottom right it
20 says DDA-15.

21 A. All right.

22 Q. All right. Do you see in the middle of DDA-15 where
23 he says review of symptoms, Doctor - -

24 MR. MCGOWAN: Your Honor, I'm going to object to this
25 line of questioning. This is no expert witness that

1 directly links this smoking to any injury that's been
2 caused.

3 THE COURT: Well - -

4 MR. ANDREWS: None. No testimony.

5 THE COURT: This is cross examination so I'm gonna
6 let him go ahead and ask him.

7 MR. ROGERS: Thank you, Your Honor.

8 Q. Do you see where the doctor ask you do you smoke?
9 Right before you went to see Doctor Espinal this is a
10 doctor that referred you to him.

11 A. Yeah.

12 Q. And he said, "do you smoke?" And you said, "yes."
13 And it says if yes how much and you responded very little.

14 A. Right.

15 Q. Do you consider a pack and a half per day for forty
16 years very little smoking?

17 A. Yeah I do.

18 Q. Are you aware that polyps in the colon carry with
19 them a risk of developing into cancer, colon cancer?

20 A. No I'm not aware of that. Why I went and had a
21 colonoscopy.

22 Q. All right. And the doctor's told you that they
23 needed to remove that polyp in your colon ---

24 A. Yeah.

25 Q. --- to make sure that you didn't develop cancer?

1 A. That's what he said yeah.

2 Q. And you acknowledge that all surgeries carry risk
3 with them? That anytime you undergo a surgical procedure
4 --

5 A. I believe the word the doctor used I go in on
6 Wednesday, come out on Friday and go back to work Monday.
7 Nobody never said nothing about no risk.

8 Q. Nobody ever told you anything about any risk?

9 A. No, sir. Go in on Wednesday, come out Friday.

10 Q. The digestive disease - -

11 A. And I ask about that. I mean it was supposed to be
12 real minor is what I thought.

13 Q. You ask about the risk?

14 A. Yeah.

15 Q. And what did the doctor tell you?

16 A. I don't think he ever give me an answer that I can
17 recall.

18 Q. Well did you followup with him when you ask him?

19 A. No. It had to do with something else. Everybody at
20 work had the colonoscopy. Nothing bad ever happened to
21 them.

22 Q. But you ask the doctor about risk?

23 A. Yeah. I remember asking him and I don't remember
24 following up on it. He never give me an answer that I can
25 recall.

1 Q. And he didn't answer you and you didn't follow up?

2 A. I'm a little bit hard of hearing. He might have
3 answered and I didn't hear him but I don't remember it. I
4 don't know which.

5 Q. So you don't know if he answered the question or not?

6 A. No. No I don't. I don't think he did but I don't
7 know for sure.

8 Q. If you'd turn with me to Tab 29, Exhibit 29.

9 A. Yeah. Go ahead. Twenty-nine. Twenty-nine, okay.

10 Q. You see that top line where it says, "My physician
11 has informed me of the planned operation/procedures for
12 medical treatment. The nature and purpose of the
13 operative procedure or medical treatment, the most common
14 side effects, the treatment benefits and alternatives, the
15 risks involved, and the chance of complication in the
16 treatment of my condition have been explained to me by my
17 physician." It's got your name there as the patient.
18 It's got the procedure that Doctor Espinal was to perform
19 on you. It's got the physician who's going to perform the
20 procedure down below, Doctor Espinal. And on the next
21 page you signed that, I understand, have read this form,
22 it's been explained to me and I fully understand the
23 contents of this authorization and you signed the informed
24 consent. And this is for the second procedure, this is
25 3/10/07. Right?

1 Is that your signature there?

2 A. I don't know if it is or not. I don't remember
3 signing this.

4 Q. Can you recognize your signature, Mr. Sexton?

5 A. It looks like mine yeah.

6 Q. That looks like your signature?

7 A. Yeah.

8 Q. And if you'd look, that was the informed consent for
9 the second procedure. If you'd turn to the next - -

10 A. Well if this is the second procedure I wasn't even
11 awake so how did I sign it? I never woke up from the time
12 I went in on the first one I never woke up until I was on
13 life support so how did I sign that?

14 Q. Sir, you're claiming that's not your signature?

15 A. I'm claiming I don't remember. That's what I said.
16 I'm not saying it's not. I'm saying I don't remember
17 signing that and I wasn't even awake on that day.

18 Q. Well let me ask you, sir, you've signed the identical
19 informed consent explaining the first procedure to you
20 which is the next page, didn't you? The third page in
21 Exhibit 29, the same explanation.

22 A. It don't have no date on it. This one here's got
23 3/10 on it.

24 Q. Yes, sir, that's the second one. Turn to the next
25 page, the third page.

1 A. I did. Is that the one you're talking about?

2 Q. Yes, sir.

3 A. Uh-huh. There ain't no date on that.

4 Q. It's on the next page, sir, we'll get to the next
5 one.

6 A. Okay.

7 Q. This is the informed consent. You signed the same
8 informed consent that he explained all the risk and the
9 complications involved with your first procedure to you
10 before you underwent the first procedure and you said you
11 understood all these risk and he explained them to you.
12 And this here the next page, the forth page of that
13 exhibit.

14 MR. ANDREWS: Is there a question, Your Honor?

15 Q. Is that true? Did you sign this informed consent - -

16 A. I don't know if I did or not. I don't remember
17 signing none of this stuff.

18 Q. Does that look like your signature?

19 A. Yeah it sure looks like it. It really does.

20 Q. That's the day before you underwent the first
21 procedure, sir, is that correct? That's the March the
22 6th, 2007.

23 A. How did I on the day before.

24 I worked on the day before did I not, Honey?

25 I worked all day. How did I sign this that day?

1 Q. Sir, I'm asking you is that your signature on this
2 informed consent?

3 A. Like I'm telling you that's my signature but that
4 don't mean I signed it. Somebody commit forgery? I
5 don't know. I worked Five, 6:30 in the morning till Five
6 o'clock and drove home. I didn't been to no doctor on
7 that day.

8 Q. Sir, are you denying you signed the informed consent?

9 A. I'm telling you I don't remember. How about that?
10 I'm not denying anything. What has all this got to do - -

11 THE COURT: Mr. Sexton.

12 A. I'm sorry again, Your Honor.

13 Q. Mr. Sexton, you agree with me that Doctor Espinal
14 explained to you when he was getting you to sign that
15 first informed consent - -

16 A. I thought we done talked about that?

17 THE COURT: Answer his questions.

18 A. I did.

19 THE COURT: If anybody is gonna stop anything it's
20 gonna be me but you answer the questions.

21 A. I do not remember that conversation. I remember
22 asking him but he may have answered me.

23 Q. Mr. Sexton, Doctor Espinal explained to you that the
24 risk of the first procedure before he got you to sign that
25 informed consent ---

1 A. No he did not. No he did not.

2 Q. --- were bleeding, infection, damage to other organs.

3 A. That's a lie. I deny that.

4 Q. You deny that?

5 A. I'm denying that yes.

6 Q. And you agree with me that there is no such thing as
7 a simple surgery?

8 A. Uh I thought it was gonna be a whole lot simpler.

9 Q. And there is no surgery out there that doesn't have a
10 risk of complications even if the doctor does everything
11 he's supposed to do you can still have complications?

12 A. I woke up on life support. Went in there for minor
13 surgery, if that's what you want to call it, it's my
14 fault. But I'd like to know how you all get it's my
15 fault? I went up there with the flu.

16 THE COURT: He'll ask you another question.

17 A. All right.

18 Q. Mr. Sexton, on the day you went to have the first
19 procedure performed upon you by Doctor Espinal, you
20 claimed that you thought you had the flu.

21 A. I didn't claim anything.

22 Q. And they were going to put off the surgery. Who was
23 it that told you that they were going to put off the
24 surgery?

25 A. There was a couple of people that come out there and

1 told me.

2 Q. And who were the couple of people that told you they
3 were going to put off the first surgical procedure?

4 A. I don't know who the people was. They were hospital
5 people is all I knew. Like I said I about had the flu,
6 felt bad, sick. I didn't get any names.

7 Q. Do you recall what they looked like?

8 A. Vaguely. They had hospital gowns and stuff on but I
9 wasn't you know.

10 Q. So more than one person that worked at the hospital
11 told you that your first surgical procedure was going to
12 be delayed?

13 A. Yeah two to them. Two of them and I really didn't --
14 I didn't even pick my head up. You just lay here and rest
15 a while and we'll be back.

16 Q. Were they both female?

17 A. Yeah.

18 Q. And what did they look like? How tall were they?

19 A. Looked like nurses. I don't know maybe five, four.

20 Q. How old were they?

21 A. I don't know how old they were. Like I said, I was
22 about half out of it, you know, being sick.

23 Q. Were they thin?

24 A. No they wasn't real big.

25 Q. Okay.

1 A. Kind of stocky.

2 Q. And when were you told that, that they were going to
3 delay the surgery? How long after you got to the
4 hospital?

5 A. Well I was upstairs and they done put me in a room.

6 Q. How long had you been in there when you were first
7 told they were going to - -

8 A. I was about half asleep, I dozed off. I don't know
9 what time it was. I was waiting on them to make up their
10 mind. I really didn't think they would operate.

11 Q. Well how long after you arrived at the hospital did
12 they tell you - -

13 A. I told you I don't know what time it was. I didn't
14 even have a watch on.

15 Q. Well had it been a long time or had it been a hour,
16 ten minutes?

17 A. I don't know, probably about that long. Maybe forty-
18 five minutes or an hour. I don't know.

19 Q. Did they tell you why they were gonna put off the
20 procedure?

21 A. Uh probably with the flu and my oxygen level was low.

22 Q. They told you, you had the flu at the hospital?

23 A. They said it looked like I'm get'n the flu.

24 Q. Okay. And who told you that?

25 A. Now one of the nurses told me. I don't know her

- 1 name.
- 2 Q. Now who went to the hospital with you that morning?
- 3 A. My wife went.
- 4 Q. Anybody else?
- 5 A. My brother in law come over there.
- 6 Q. Okay. How about your sister?
- 7 A. She got there later on.
- 8 Q. How about your brother-in-law?
- 9 A. He was there for a while then -- you can talk to him
- 10 about that.
- 11 Q. Was he there when your -- when you first got there,
- 12 your brother-in-law Mr. Beard?
- 13 A. I don't remember. I don't think he was.
- 14 Q. Was he there when they told you they were gonna delay
- 15 your surgery?
- 16 A. Yes.
- 17 Q. Okay. Who else was in the room with you when they
- 18 told you they were gonna delay your surgery?
- 19 A. I don't think nobody was. I think they were out in
- 20 the waiting room.
- 21 Q. Okay. It was just you?
- 22 A. I think yes, sir.
- 23 Q. Okay.
- 24 A. In that time.
- 25 Q. Your wife nor your brother-in-law heard that?

1 A. They were in the waiting room.

2 Q. Were you running a fever on the morning when you
3 arrived at the hospital?

4 A. Felt like I was.

5 Q. If you'd turn with me to Tab 3 in the third page in
6 Tab 3.

7 A. Where we at?

8 Q. Page 3.

9 A. Oh, Page 3. I'm sorry.

10 Q. That's okay.

11 A. Okay.

12 Q. And then the third page in Tab 3.

13 A. Okay.

14 Q. Which has PMC-00843 at the bottom. Do you see your
15 temperature when you got to the hospital that day?

16 A. No I didn't have no temperature according to that did
17 I?

18 Q. 98.0 degrees.

19 A. It's supposed to be about 98.4 -

20 Q. Do you know if most people with the flu or pneumonia
21 run a temperature of 98 degrees?

22 A. I don't know. I don't. You trying to tell me I
23 wasn't sick too?

24 Q. Before the surgery you were very physically active.
25 You have a very hard, a very demanding job.

1 A. That's exactly right. Still do.

2 Q. Do a lot of heavy lifting?

3 A. Not a lot of heaving lifting not no more I don't. I
4 tell you if I have to.

5 Q. You do a lot of climbing?

6 A. A lot of climbing if I need to.

7 Q. A lot of bending over?

8 A. That's right.

9 Q. Picking up stuff?

10 A. That's right. I have a job.

11 Q. And you were doing this all the way up to the day of
12 the surgery?

13 A. Absolutely.

14 Q. When they told you, you said they told you they were
15 canceling your surgical procedure when you went there to
16 have it done because you were sick.

17 A. Uh-huh.

18 Q. Why did you not leave the hospital when they told you
19 that you weren't having your surgical procedure that it
20 was going to be delayed? When your family members left
21 the hospital, why didn't you leave with them?

22 A. They didn't tell me I could leave and I didn't ask
23 them. I said I was laying back there and my head was
24 hurting, hip was hurting, I was sick.

25 Q. But what I'm trying to figure out --

1 A. Well when you figure it out I'd like to know myself.
2 I don't know either.

3 Q. You don't know why you didn't leave --

4 A. I don't know why I didn't leave. I really don't.

5 Q. Nobody told you, you couldn't leave?

6 A. Nobody told me I could either. Evidently I didn't
7 get up and leave.

8 Q. So when they told you, you weren't having the
9 procedure and your family left, why didn't you just get up
10 and leave with them? You weren't hooked up to anything

11 --

12 A. My family wasn't even there. I think they was out in
13 the waiting room. I really didn't know.

14 Q. Well - -

15 A. You got to understand this is early in the morning.
16 I been sick all night, half the night.

17 Q. The story we're getting is that you were told that
18 your procedure was being delayed and all your family left
19 the hospital. But you stayed in there and then somebody
20 came and got you and took you to surgery. What I'm trying
21 to figure out --

22 A. If you don't believe that you want me to show you my
23 stomach?

24 Q. What I'm trying to figure out is when your family
25 left why didn't you leave with them. If they cancelled

1 the surgery and you can leave why wouldn't everybody -

2 A. Evidently nobody told me I could leave. I don't know
3 why I didn't leave.

4 Q. Do you know why your family left you there?

5 A. I don't know why that either. I really don't. I
6 ain't never thought about it.

7 Q. Do you know why there's nothing in the records from
8 the hospital or any physicians ---

9 A. I have no idea.

10 Q. --- that say that they ever contemplated cancelling
11 your first surgery?

12 A. I have no idea.

13 Q. You don't know why there's nothing in the records
14 about it?

15 A. I don't know why. And evidently you don't know why
16 either.

17 Q. Did you see Doctor Espinal between your first surgery
18 and your second surgery?

19 A. No, sir, I don't remember anybody from that first
20 surgery on up to I woke up on life support and I don't
21 know when that was.

22 Q. Do you remember anything about switching your
23 pulmonologist from Doctor Denenberg to Doctor Aylene?

24 A. I don't know. I don't remember Denenberg or whatever
25 his name. Is that his name? I do remember Aylene. Yes,

1 sir, I do remember that man.

2 Q. But you don't remember why you switched pulmonologist
3 from Denenberg --

4 A. I don't think that's got anything to do with that
5 anyway. Like I said I wasn't even conscious when all that
6 was going on. That's what you don't understand or you
7 don't want to believe one. I don't know which.

8 Q. And HealthSouth, you went there after you were
9 discharged from the hospital ---

10 A. Yes I was.

11 Q. --- and stayed a week in rehab?

12 A. That's right.

13 Q. And they helped you?

14 A. Yes, sir.

15 Q. All right. And you voluntarily left after one week
16 of rehab?

17 A. I sure did.

18 Q. And you could walk. Again you were improving pretty
19 well?

20 A. I could get around yes I could.

21 Q. And you missed about four and a half months of work
22 total?

23 A. I wasn't able to work. I done lost fifty pound.

24 Q. Right. The total amount of work you missed was about
25 four and a half months.

1 A. Right. More than that. Right at -- Let's see,
2 March, April, May, June, July and August. I missed six
3 months work.

4 Q. How has your life changed from before the first
5 surgical procedure to now?

6 A. In what way are you talking about? Health wise?

7 Q. Yes, sir. Has the surgical procedure had any
8 permanent impact?

9 A. Oh it done a lot of permanent impact. Every time I
10 pick something up it pulls on my stomach. My stomach is
11 like a piece of raw meat. It ain't never healed
12 completely inside and I don't think it ever will.

13 Q. When is the last time you've gone to see any doctor
14 or medical --

15 A. It's been a couple of years. I'm scared to death of
16 a doctor. Wouldn't you be?

17 Q. So you're still having significant pain?

18 A. I still have a lot of pain absolutely. But I'm
19 alive.

20 Q. But you haven't seen any doctor about it in two
21 years?

22 A. It's been maybe three years. I don't remember how
23 long.

24 Q. You don't take any pain medications for that pain?

25 A. I don't think I need any of it, I really don't.

1 Q. And you still work long hours and you've worked under
2 three years since the surgery forty hours a week?

3 A. I worked four and a half years. Well I went to work
4 in August, be August, four years yes, sir.

5 Q. And you work pretty much consistent forty hours a
6 week or more heavy manual labor?

7 A. That's right.

8 Q. Since your surgery?

9 A. Now I was laid off here and there. Sometimes we
10 don't have any work. Not because of health wise. If we
11 working I been a working that's correct. It ain't as easy
12 as it used to be. We can get by.

13 Q. Were you ever told that you had below oxygen level
14 when you reported the day of your first surgical
15 procedure?

16 A. No.

17 Q. Did you wonder why they hooked you up to an oxygen
18 mask before you went into surgery? Did they tell you when
19 they hooked you up to it why they were doing that?

20 A. Did they know it?

21 Q. Did they tell you why they hooked you up to oxygen?

22 A. I never ask anybody.

23 Q. And they never told you?

24 A. No.

25 Q. The anesthesiologist never told you?

1 A. Let me think a minute. No I don't think so. I don't
2 recall.

3 MR. ROGERS: That's all I have. Thank you.

4 MR. ANDREWS: Briefly, Your Honor.

5 REDIRECT EXAMINATION

6 RICKY SEXTON BY MR. ANDREWS:

7 Q. Ricky.

8 A. Yes, sir.

9 Q. Did Doctor Espinal ever tell you that you had
10 diminished lung capacity and explained the risk of
11 diminished lung capacity, the abnormal x-ray?

12 A. Nobody ever did. Nobody never said anything about my
13 oxygen or nothing until after I was on life support.

14 Q. Did Doctor Espinal tell you that due to your lung
15 impairments that were experienced on the 7th, and that
16 were known and were in the chart, did he ever tell you
17 that as a result of those lung impairments you had
18 increased risk

19 ---

20 A. No.

21 Q. --- of harm?

22 A. No. That ain't never happened. That ain't never
23 happened.

24 Q. Ricky, have you told the truth to these ladies and
25 gentlemen?

1 A. I have told the truth and nothing but the truth.

2 Q. You tried to lie to them ---

3 A. I'd drop dead if I did.

4 Q. --- and pull one over on them?

5 A. Why would I lie to anybody? Anybody knows me know I
6 don't need to lie.

7 MR. ANDREWS: Nothing further.

8 THE COURT: Mr. Rogers, anything further?

9 MR. ROGERS: No, sir.

10 THE COURT: All right. You can step down and have a
11 seat with your counsel.

12 MR. SEXTON: I'm sorry, Your Honor. I apologize.

13 THE COURT: Members of the jury panel, we're going to
14 stop for the day and stop back at 9:30. Please be in the
15 jury room and we'll try to start as promptly at that time
16 as possible. I have another matter scheduled at Nine
17 dealing with another matter but I should be through by
18 9:30. We'll see you in the morning at 9:30. Keep in mind
19 what I told you not to do as far as research or any
20 discussing or making up your own mind. Have a pleasant
21 evening. Just leave those in the chairs.

22 (JURY DISMISSED AT 05:30 PM.)

23 THE COURT: I don't know what else we have to do but
24 we need to deal with a motion in limine before we stop for
25 the day. I believe we're getting into the next witness

1 who possibly will be looking at that. I have read the
2 Field's case and also the case it cites *Webb versus Elrod*.
3 Be glad to hear anything else before I rule from both
4 sides.

5 MR. ANDREWS: Your Honor, just on the stand right
6 there I think we took care of it. He cross examined and
7 opened the door about this. He's saying why did he leave?
8 Why did he leave? Well Chuck Beard left because he was
9 told it was cancelled, that's why he left. Why did
10 Glynnis leave?

11 THE COURT: Well I disagree. That's the sole basis
12 for your argument, I'm not buying what you're saying.
13 It's a good argument but - -

14 MR. ANDREWS: Okay. I'm sorry, Your Honor, I've got
15 this infection and I'm not hearing too - -

16 THE COURT: I don't think that's enough. I don't
17 think they've opened the door.

18 MR. ANDREWS: Okay. Then I'll sit down.

19 THE COURT: Okay. All right anything else?

20 MR. KING: Nothing.

21 THE COURT: I'm going to grant the motion in limine.
22 This is hearsay on hearsay. Unlike the Fields case and
23 the *Webb versus Elrod* case, those cases deal with
24 statements that did not go to the truth of the matter
25 asserted. This goes to the heart whether the truth of the

1 matter asserted that the surgery was not going forward.
2 Not only was it not going forward but it was due to oxygen
3 saturation level of 60. It's hearsay on hearsay and I
4 grant the motion in limine.

5 MR. ANDREWS: I want to make sure I understand
6 exactly. So if I ask Mr. Beard why he left and he says it
7 was cancelled am I okay?

8 THE COURT: I think if he left --

9 Do you object to that part?

10 MR. KING: Yes, sir. Yes, sir, I do because the next
11 question is why did you leave then.

12 MR. ANDREWS: Because he said it was cancelled. I'm
13 not going to get into why it was cancelled. Did you stay
14 for the procedure? No. Why not? It was cancelled.

15 MR. KING: And Ricky just testified he was the only
16 one in the room when they told him it was cancelled.

17 MR. ANDREWS: Different, completely different
18 conversation.

19 THE COURT: No. It's not important as to why he
20 left. I believe that's the thing, the truth of the matter
21 is whether or not they cancelled surgery and whether or
22 not he had a saturation level of 60, its just not. I just
23 don't find why they left is important to the issues that
24 the jury is going to determine.

25 MR. ANDREWS: It's vitally important to why they

1 left, Your Honor. It's vitally important because it goes
2 to the whole theme of our case that his respiratory -- he
3 had respiratory issues, he had the flu, they weren't going
4 to do the surgery.

5 THE COURT: I can't help that it goes to the heart of
6 the case. You got to prove your case. This is hearsay on
7 hearsay. If he relied, if he says that happened he relied
8 on it and that doesn't have anything to do with whether it
9 really happened or not. That's the issue. Not what some
10 third party told him but tat the party -- you mentioned
11 earlier Rule 803, there is really no evidence that whoever
12 made this statement had any authority to make it, that
13 they received any event that they had any first hand
14 knowledge of, we've got a vital statement is what it
15 amounts to. I can't let that -

16 MR. ANDREWS: Well he's walking back to the operating
17 room where he is. And a person in a hospital gown in a
18 mask is what he testified to.

19 THE COURT: Well I'll let you make a proffer on that
20 and maybe reconsider it but not right now.

21 MR. ANDREWS: He's going back to the pre-op room
22 where he is to tell him good luck and they say no need to
23 go back there it's cancelled.

24 THE COURT: Who said that though?

25 MR. MCGOWAN: If I can just preserve an issue for an

1 appeal if needed?

2 THE COURT: Yes, sir.

3 MR. MCGOWAN: This goes directly to the Fields case.
4 Mr. Beard, why did you leave? Well because they told me
5 it was cancelled. That's not offered for the truth of the
6 matter, that's to the effect on the listener which is
7 directly on all fours in the Fields case.

8 THE COURT: No I don't believe it is. I read that
9 case. In that case it was kind of a double whammy. He
10 testified, the statement did not allowed was based on
11 legal counsel he did not become board certified because he
12 wrote the test so to speak. And then the opposing counsel
13 made great use of the fact that he wasn't board certified
14 and they said that did not go to the truth of the matter
15 asserted, was the truth of the matter asserted was whether
16 or not it breached the standard of care. It had to do
17 with his qualifications and why he did not take it. So I
18 don't find this to be on all fours with that case. And
19 then the Webb case, they wanted the testimony in to show
20 not what the third party actually said but to show -- not
21 to show the truth of what she told him but just to show
22 she talked to them. The purpose was to show the operative
23 fact I talked with a third party, not to show the truth of
24 what she told them and here you're going right to - -

25 MR. MCGOWAN: No, sir. Then the proper thing to do

1 with respect is a limiting instruction if that's really
2 the issue. And secondly, and so we're preserved on this
3 issue also, is that this lawyer got up and said well why
4 did your whole family leave? And now we're not allowed to
5 say why they left. They opened the door why they left and
6 so now in the interest of just basic fairness they opened
7 the door to it and they didn't have to ask those questions
8 but they did.

9 THE COURT: Let me think. They may have opened the
10 door as to why they left is because they told them the
11 operation was cancelled, not as to the saturation.

12 MR. MCGOWAN: Exactly.

13 MR. ANDREWS: I'm sorry, I don't mean to deduct.
14 That's what I meant earlier, Your Honor.

15 MR. MCGOWAN: Right.

16 THE COURT: What do you have to say about that, Mr.
17 King? Why did he leave?

18 MR. KING: I don't know. I'll let Mr. Rogers deal
19 with that. But I take an issue of being team tackled.

20 MR. ANDREWS: I'm sorry.

21 MR. MCGOWAN: I'll do all the talking from now on
22 then.

23 THE COURT: No. I think that he has opened the door
24 as to why they left because they all gathered but I don't
25 believe that opened the door to why anybody was telling

1 him it was sixty percent oxygen saturation.

2 MR. ROGERS: Your Honor, we're fine with that.

3 THE COURT: All right. Well everybody's happy.

4 MR. MCGOWAN: We're equally unhappy yes, sir.

5 THE COURT: Anything else we can do for today?

6 MR. MCGOWAN: Nothing from the plaintiff, Your Honor.

7 THE COURT: Defense?

8 MR. ROGERS: No, sir, Your Honor.

9 THE COURT: All right. Well we'll start back at -- I
10 have a conference at Nine o'clock, should be through by
11 9:30.

12 MR. ANDREWS: Start back by 9"30?

13 THE COURT: 9:30 and everything should be safe here
14 in this room over night.

15 (COURT IN RECESS AT 05:45 PM.)

16 (COURT BACK IN SESSION TUESDAY, AUGUST 2, 2011 AT
17 09:35 AM.)

18 THE COURT: Anything before we get the jury in from
19 the Plaintiff?

20 MR. ANDREWS: Nothing from the Plaintiff.

21 THE COURT: Defense?

22 MR. ROGERS: Nothing.

23 THE COURT: All right. Bring in the jury.

24 (JURY ENTERS COURTROOM AT 09:37 AM..)

25 THE COURT: Good morning.

1 Q. Where do you live, Trish?

2 A. 1836 Malibay Drive, York, South Carolina.

3 Q. And how long have you lived there?

4 A. About four years.

5 Q. And who lives there with you?

6 A. My husband John R. Sexton, which we call him Ricky.

7 Q. Okay. Tell the jury where you were born?

8 A. York County in Rock Hill.

9 Q. And where --

10 A. And I lived in Fort Mill.

11 Q. And where did you grow up?

12 A. Fort Mill.

13 Q. Did you go to school?

14 A. Yes, sir.

15 Q. How far did you get in school?

16 A. The 9th.

17 Q. Ninth grade?

18 A. Yes, sir.

19 Q. And after you finished 9th grade, what did you do?

20 A. I went to work.

21 Q. And are you working now?

22 A. Not this week, but I am working.

23 Q. Okay. And what kind of jobs have you done since you
24 started working after you finished school, dropped out of
25 school in the 9th grade?

1 A. I worked in a cotton mill for about 20 years, and then
2 I worked at a yarn mill for another ten. And I worked in
3 distribution centers. And I took care of my sister because
4 she's an invalid.

5 Q. So you've worked your entire life?

6 A. Yes, sir, I have.

7 Q. Trish, I want to go back, and I want to talk to you
8 about Ricky's medical conditions prior to March of 2007.

9 A. Okay.

10 Q. Okay? Were you aware of any major hospitalizations
11 Ricky had prior to March of 2007?

12 A. No, sir.

13 Q. Were you aware of any breathing problems that Ricky
14 was experiencing prior to March of 2007?

15 A. No, sir.

16 Q. Now let's focus on the reason why we're here. Did you
17 accompany Ricky to his visit with Dr. Richardson, the colon
18 doctor?

19 A. Yes, sir, I did.

20 Q. And you understand that Ricky had a colonoscopy
21 performed by Dr. Richardson on February the 16th, 2007?

22 A. Yes, sir, I did.

23 Q. And he had to get some polyps removed; is that right?

24 A. Yes, sir.

25 Q. And the gastroenterologist, Dr. Richardson, was able

1 to remove some of the polyps with a snare?

2 A. Yes, sir.

3 Q. But there was one polyp, about two or three
4 centimeters that was flat that he couldn't get.

5 A. Yes, sir.

6 Q. Did you come back a week later in a meeting with Dr.
7 Richardson where Dr. Richardson informed you of all of
8 that?

9 A. Yes, sir, I did.

10 Q. And then he referred y'all to Dr. Espinal for the
11 surgery?

12 A. Yes, sir.

13 Q. Were you at the appointment on March 2nd with Ricky
14 that he had with Dr. Espinal?

15 A. Yes, sir, I did.

16 Q. How much time did Dr. Es -- Were you in the room with
17 Ricky when Dr. Espinal came back?

18 A. Yes, sir, I did.

19 Q. How much time did Dr. Espinal spend with y'all when he
20 came back into that room?

21 A. I'd say probably about five minutes or so.

22 Q. Okay.

23 A. It wasn't long.

24 Q. What type -- Did he ask Ricky any questions?

25 A. I don't recall.

1 Q. Did he examine Ricky in any way?

2 A. Not that much, no.

3 Q. Did you see him put a stethoscope on and listen to his
4 heart?

5 A. That I did, yes.

6 Q. Check his breathing? Did you notice anything about
7 that?

8 A. No, sir.

9 Q. Okay. What did Dr. Espinal tell you that he wanted to
10 do?

11 A. He said he was going to go in and try to get the forth
12 one that was in there. It was too big. And they was gonna
13 go in through the belly or something like that. I don't
14 know a whole lot about that kind of surgery, but it was
15 going to be a simple thing to go in and get it out.

16 Q. Say that one more time.

17 THE COURT: Can y'all hear? I think you need to get a
18 little closer to the microphone.

19 A. Okay.

20 They said it's going to be something they would go in
21 through the belly button, and somehow or another pull it
22 out.

23 Q. Did he tell you how long Ricky would be out of work?

24 A. He said he would be in the hospital about two or three
25 days, rest the two days, and then he could go back home

1 Monday.

2 Q. Was Ricky concerned about getting the surgery at that
3 time?

4 A. He -- Actually he wanted to wait.

5 Q. Say that --

6 A. He actually wanted to wait. He wasn't -- really
7 didn't want to have the surgery that soon.

8 Q. And what was the reason for that?

9 A. The outages at Duke Power. That's where you make your
10 money when you work so you get a lot of hours over time so
11 he wanted to be there.

12 Q. Did he tell Dr. Espinal that?

13 A. Yes, sir, he did.

14 Q. And in response to that, what did Dr. Espinal tell you
15 and Ricky?

16 A. He assured us that it was going to be a simple
17 procedure, and that he would be up -- He would be able to
18 go back to work on that Monday.

19 Q. Did Dr. Espinal ever ask Ricky a series of questions
20 about his health while you were in the room?

21 A. No, sir.

22 Q. Did Dr. Espinal ever tell you about any risk
23 associated with the procedure?

24 A. No, sir.

25 Q. Were you in the room the entire time?

1 A. Yes, sir, I was.

2 Q. Well, let's go ahead a few days. So the surgery's
3 planned for March 7th, 2007. Right?

4 A. Yes, sir.

5 Q. And y'all -- It's going to be done about Seven o'clock
6 or so in the morning?

7 A. Yes, sir.

8 Q. And you're supposed to get there early in the morning
9 on the 7th. Right?

10 A. Yes, sir.

11 Q. About Six?

12 A. Yes, sir.

13 Q. Let's go back a day. Had Ricky worked on March 6th
14 which was a Tuesday?

15 A. Yes, sir, he did.

16 Q. When Ricky got home that night -- or that afternoon,
17 how was Ricky feeling?

18 A. He said he was really sick. Actually, he came home a
19 little earlier, a couple of hours earlier from work because
20 he was sick.

21 Q. And when you say he was sick, describe what you saw.

22 A. He had the signs of the flu because he was very hot.
23 And I checked his temperature and he had a 101, and I -- I
24 knew then they weren't gonna do the surgery, most likely
25 they wouldn't.

1 Q. Was he coughing at all?

2 A. He was coughing and hacking, and he had chills. He
3 was freezing.

4 Q. And as a result of that, did you make a phone call to
5 someone?

6 A. Yes, sir, I did. I called my sister-in-law Glynnis to
7 ask her what should I do. And she advised me I needed to
8 call and reschedule the appointment, and cancel that
9 appointment.

10 Q. Did you call -- This was after doctors' hours.
11 Correct?

12 A. Yes, sir, it was.

13 Q. So who did you call?

14 A. I called Piedmont Medical, and they transferred me to
15 the area where they said his name was on the list. And
16 they wouldn't take his name off the list, and we scheduled
17 it. That they would not do the surgery with him having a
18 fever. If he was -- If he had the flu, they wouldn't do
19 it.

20 Q. What did they tell you about coming in the next
21 morning?

22 A. They did advise me that I -- he did need to come up
23 there, but they would not do the surgery. And I was kind
24 of wondering why but I guess they maybe wanted to talk to
25 him or something and they said be up there about forty-vie

1 minutes to an hour. So that's what I did.

2 Q. All right. So you got up the next morning, and you
3 took Ricky up to the hospital; is that right?

4 A. Yes, sir, I did.

5 Q. How was Ricky feeling on the morning of March 7th?

6 A. He didn't really feel like going but I said we got to
7 go. They said be there.

8 Q. And where were you when they took Ricky back? Where
9 were you waiting?

10 A. I was in the waiting room.

11 Q. When you got there -- Let's go back. Did you tell the
12 -- Did you speak to any of the nurses or anybody at the
13 hospital at that time?

14 A. I did. I did. I talked to someone at the desk, and
15 they sent two medical people out there, and I was wanting
16 to find out what was --

17 Q. Did you tell them ---

18 A. Oh, I told them he was --

19 Q. --- about Ricky's condition?

20 A. Yes, sir, I did. I told them again at the desk.

21 Q. And you were in the waiting room; is that correct?

22 A. Yes, sir.

23 Q. And in the waiting room with you was who?

24 A. My brother-in-law Chuck.

25 Q. Did Chuck tell you anything while you were in the

1 waiting room prior to the surgery?

2 A. He said that they told him that they weren't going to
3 do the surgery also.

4 MR. KING: Objection, Your Honor, hearsay.

5 THE COURT: I sustain the objection as to Chuck.

6 BY MR. ANDREWS:

7 Q. Did Chuck leave the hospital prior to you?

8 A. Yes, sir, he did. He went to work.

9 Q. And after he left the hospital, did you have -- Did
10 you talk to anybody at the hospital about your husband?

11 A. I did. I said, "How long is he going to be up here,
12 and what are they going to do?" And they said, "He needed
13 to be up there about 45 minutes to an hour." And I said,
14 "Well I been up here since Six. Can I leave to go get
15 something to eat?" And they said, "He was not gonna go to
16 surgery." And I said, "Okay, I'll be back in an hour."

17 Q. Did anyone tell you that the surgery was canceled?

18 A. Yes, sir, they did.

19 Q. Who told you that?

20 A. There were two. I'm not sure who they were, but there
21 was one anesthesiologist [SIC], and another nurse in the
22 medical.

23 Q. And they told you that the surgery was being canceled?

24 A. They assured me that it was canceled.

25 Q. And what did they tell you with respect to coming back

1 up and getting Ricky?

2 A. They told me that he would be there another forty-five
3 minutes to an hour, that I could leave and I could come
4 back.

5 Q. And why did you leave?

6 A. Well I hadn't had anything to eat all morning, so I
7 was going to grab a bite to eat. And I went home and come
8 back.

9 Q. All right. And when you went home, did you receive a
10 phone call?

11 A. Yes, sir, I did.

12 Q. And as a result of that phone call, what did you do?

13 A. I hurried back to the hospital.

14 Q. All right. And when you got back to the hospital,
15 what did you find out?

16 A. That they already -- they were already doing the
17 procedure.

18 Q. And who was there when you got back?

19 A. My sister-in-law.

20 Q. Is that Glynnis?

21 A. Yes, sir, it is.

22 Q. Okay. When is the first time you recall seeing Ricky
23 on the 7th?

24 A. On the 7th?

25 Q. After the surgery, what was --

1 A. After the surgery. It was late in the evening because
2 we kept asking them at the desk what -- what was going on,
3 why he hasn't come out of recovery yet. And I was very
4 concerned because hours had done went by, and so it was
5 late in the evening. I'd say about Five o'clock.

6 Q. And when you saw him, what did he look like?

7 A. Oh, he looked horrible. I was devastated.

8 Q. Tell us what you saw.

9 A. He wasn't -- He wasn't even really responding. And he
10 was -- He just looked really sick, he looked really pale.

11 Q. Did he have a mask on?

12 A. He had a big one on.

13 Q. Did you have any conversations with Dr. Espinal on
14 Wednesday, March the 7th?

15 A. My sister -- we called him to come in.

16 Q. Did you talk to Dr. Espinal yourself?

17 A. Yes, sir.

18 Q. What did Dr. Espinal tell you with regard to Ricky's
19 condition?

20 A. He just said that he was going to be okay and stuff
21 but it didn't look t me like he was.

22 Q. And we've already gone through all of this, but Ricky
23 spent another few days in the hospital.

24 A. Yes, sir, he did.

25 Q. Now, were you there?

1 A. Yes, sir.

2 Q. Did you -- Tell the jury how much time you spent at
3 the hospital from the 7th through the time that he left.

4 A. I pretty much lived up there.

5 Q. Was somebody from the family with Ricky at all times?

6 A. Yes, sir, they were.

7 Q. Did y'all kind of take shifts?

8 A. Yes, sir.

9 Q. Now we know he had a second surgery on March the 10th
10 to fix the leak; is that right?

11 A. Yes, sir.

12 Q. How much more time did Ricky spend in the hospital
13 after that?

14 A. After the second surgery?

15 Q. Yes, ma'am.

16 A. About five weeks.

17 Q. And then he went to Health South Rehab?

18 A. Yes, sir, he did.

19 Q. And he spent about a week there?

20 A. Yes, sir.

21 Q. And then he came home?

22 A. Yes, sir.

23 Q. And how long was it before he went back to work?

24 A. A little over six months.

25 Q. Okay.

1 MR. ANDREWS: I don't have any further questions.
2 Please answer any questions the defense counsel may have.

3 CROSS EXAMINATION

4 PATRICIA SEXTON BY MR. ROGERS:

5 Q. Ms. Sexton, you married Ricky in 2006?

6 A. Yes, sir.

7 Q. This is your third marriage?

8 A. Yes, sir, it is.

9 Q. You're currently on layoff from D2 Atlantic?

10 A. Not at this time, no, sir.

11 Q. You've gone back to work?

12 A. Yes, sir.

13 Q. How many hours a week are you working right now?

14 A. Sometime forty-eight, sometimes sixty a week.

15 Q. Ricky has been for over forty years and still is a
16 heavy smoker.

17 A. I wouldn't say he's heavy. He does smoke about a pack
18 a day.

19 Q. He smokes about a pack a day?

20 A. A half a pack to a pack a day.

21 Q. And he's been smoking around a pack a day for over
22 forty years?

23 A. I wouldn't know that. I wasn't married to him at that
24 time.

25 Q. He was smoking at the time of the surgery?

1 A. Yes, sir.

2 Q. And he's been smoking since y'all have been together?

3 A. Well he stopped there for a while, and then he started
4 back.

5 Q. How long did he stop?

6 A. Well he was on oxygen, he had to stop.

7 Q. That was after the surgery. Right?

8 A. Yes, sir.

9 Q. If y'all would turn with me to Tab 33. The second
10 page in Tab 33 should be Chart 15.

11 You went with your husband when he first went to see
12 Dr. Espinal a few days before the surgery?

13 A. Yes, sir, I did.

14 Q. Did you help him fill out these forms, these intake
15 forms?

16 A. No, sir, because I don't have good handwriting. I
17 didn't fill out no paperwork.

18 Q. You didn't help him fill out any of this?

19 A. No, sir, I did not.

20 Q. This is all his handwriting?

21 A. Yes, sir. It's not mine.

22 Q. Okay. Do you see at the top of that page, Chart 15
23 where it says, "Tobacco and alcohol use"? It's about the
24 fourth line down from the top.

25 A. Oh, yes, sir, I do. I'm sorry, I do.

1 Q. Did Ricky put anything to inform Dr. Espinal of his
2 40-year smoking history?

3 A. I don't see that.

4 Q. Did he put anything to inform Dr. Espinal that he used
5 to be an alcoholic?

6 A. He don't have it on paper but he did tell him that
7 when we was in the office.

8 Q. He didn't disclose anything about his tobacco or
9 smoking did he?

10 A. He told him that in the office.

11 Q. What day did he tell him that?

12 A. When we went up there when -- before he done the
13 surgery.

14 Q. And what did he tell him?

15 A. He told him he smoked.

16 Q. And how much did he tell him he smoked?

17 A. A half a pack to a pack a day.

18 Q. Did he tell him for how long?

19 A. I'm not aware.

20 Q. Did you go with him to see the digestive disease
21 doctor who performed the colonoscopy?

22 A. Yes, sir.

23 Q. And that's the doctor that referred your husband to
24 see Dr. Espinal?

25 A. Yes, sir.

1 Q. Did you hear Ricky tell the digestive disease doctor
2 that he had smoked very little in his lifetime?

3 A. No, sir. He told him that he smoked.

4 Q. He told him he smoked very little. Or you recall
5 that?

6 A. A half a pack to a pack a day. I've never smoked, so
7 I don't know if you call that a lot or not.

8 Q. The records indicate that he told him he smoked very
9 little. You don't recall that?

10 A. Okay. Well, I guess you'd have to say how much is
11 very little..

12 Q. But you consider a pack a day for 40 years very
13 little?

14 A. I've never smoked.

15 Q. Do you agree with me that a long history of smoking
16 can cause breathing problems?

17 A. Yes, sir.

18 Q. And your husband's been advised to quit smoking for
19 his health, but he continues to smoke?

20 A. I'm not aware of that.

21 Q. You're aware that colon polyps carry with them a risk
22 of developing into colon cancer?

23 A. I do now. I didn't know what all that meant but,
24 yeah, I do now.

25 Q. You understand that it was necessary to remove the

1 polyp on your husband's colon?

2 A. No, sir.

3 Q. You don't think that Dr. Espinal should have done
4 that?

5 A. Definitely not, no.

6 Q. Did Dr. Espinal inform your husband of the possible
7 complications that could flow from his surgery?

8 A. No, sir.

9 Q. Do you recall going with your husband to Piedmont
10 Medical Center the day before his surgery for surgical
11 prep?

12 A. Yes, sir.

13 Q. If you'd tab -- turn with me to Tab 29? And the third
14 page in Tab 29, which is PMC-1381. We're going to look at
15 1381 and 1382 the next page. Now I'm going to read with
16 you the first paragraph of PMC-1381, and you tell me if I'm
17 incorrect. "My physician has informed me of the planned
18 operation/procedure for medical treatment. The nature and
19 purpose of the operative procedure of medical treatment,
20 the most common side effects, the treatment benefits and
21 alternatives, the risks involved, the chance of
22 complication in the treatment of my condition have been
23 explained to me by my physician." Is that correct?

24 A. I see it on here, but I don't recall it.

25 Q. And the patient is John Sexton and a laparoscopic

1 colectomy, the first procedure is outlined there that the
2 physician who performed the procedure Alex Espinal. And if
3 you turn with me to the next page, at the very top reads,
4 "I understand, have read this form" -- and this is in
5 capital letters -- "I understand, have read this form
6 explained to me and fully understand the contents of this
7 authorization." And then your husband signed it below.

8 A. I see that, yes, sir.

9 Q. You see the date which is the day before the surgery
10 was performed, which is the 6th?

11 A. Yes, sir.

12 Q. You recall your husband signing that the day before
13 the surgery?

14 A. No, sir.

15 Q. Do you know why he would have signed that if he had
16 not been informed of the potential complications and the
17 risk involved with the surgery?

18 A. No, sir.

19 Q. You agree that all surgeries carry risk?

20 A. I'm sure they do, but I'm not a professional.

21 Q. And Ricky actually wanted to put off the surgery
22 because of some heavy work coming up on his job, but Dr.
23 Espinal recommended that they go forward with the surgery
24 as scheduled?

25 A. Yes, sir.

1 Q. And the day before the surgical procedure, you say the
2 evening before, you called the hospital and told them that
3 Ricky was sick?

4 A. Yes, sir, I did.

5 Q. And you testified that they told you if he had a
6 temperature the next morning that they would likely delay
7 the surgery?

8 A. They didn't say likely. They said they would not
9 perform the surgery.

10 Q. Do you deny that you testified upon direct examination
11 that they told you if he had a temperature the next
12 morning, they would delay the surgery?

13 A. I said they would not. They would delay it. They
14 wouldn't do it that day.

15 Q. They told you that if he had a temperature, they would
16 delay?

17 A. Yes, sir.

18 Q. Do you know if he was running a temperature on the
19 morning of surgery?

20 A. Not -- I didn't check it that morning, but I checked
21 it the night before.

22 Q. If you'd turn with me to Tab 3 in your notebook.

23 A. In this --

24 Q. Yes, ma'am.

25 And in Tab 3, this will be the third page in Tab 3,

1 which is PMC -- at the bottom, PMC-00843. And you can see
2 in the middle section, his admission temperature on the
3 morning of surgery, temperature 98.0.

4 A. Yes, sir.

5 Q. So he did not have a fever on the morning of surgery?

6 A. That's what they're saying.

7 Q. Do you know if most people that have the flu or
8 pneumonia run a temperature of 98.0?

9 A. No, sir, I don't know.

10 Q. And you claim that surgery was canceled on the first
11 morning, the 7th?

12 A. That's right.

13 Q. And you claim that you were told that Ricky would need
14 to stay there another forty-five minutes or an hour after
15 they canceled the surgery?

16 A. Yes, sir.

17 Q. What reason did they give you? Why would he need to
18 stay another forty-five minutes to an hour if they canceled
19 the surgery?

20 A. They had gave him something that kind of made him
21 drowsy but I'm not sure what. So they he didn't want to
22 leave. So, I don't know.

23 Q. So they had already given him some type of anesthesia
24 before they decided to cancel the surgery?

25 A. I don't know what they did back there. They just told

1 me he needed to stay back there forty-five minutes to an
2 hour. They are the professionals, I'm not.

3 Q. They didn't give you any reason why he would need to
4 stay?

5 A. No.

6 Q. And you heard him testify he had not been hooked up to
7 anything when they canceled the surgery?

8 A. Correct.

9 Q. So you don't really know why he would have needed to
10 stay?

11 A. They told him he had to stay forty-five minutes to an
12 hour and that's all I know.

13 Q. Do you know why there is nothing in any of the medical
14 records, nothing in the anesthesiologist records, nothing
15 in the hospital records, nothing in Dr. Espinal's records
16 to indicate there was ever any contemplation that surgery
17 would be canceled or postponed on the day of surgery?

18 A. I'm sorry. I don't understand that. Can you repeat
19 that?

20 Q. Do you know why there's nothing in the records that
21 indicates that anyone even considered canceling the surgery
22 on the morning of the surgery?

23 A. Well they told him they canceled.

24 Q. Do you know why there's nothing in the records to
25 indicate --

1 A. I have no idea.

2 Q. And you testified that the anesthesiologist told you
3 that the surgery was going to be canceled?

4 A. It was two medical people at the hospital that told me
5 that. I asked them, "Can he leave when I leave?" And they
6 said they canceled the surgery, but he needed to be there
7 another forty-five minutes to an hour. And I didn't
8 question that because they are professional, and I am not.

9 Q. And you're aware that the anesthesiologist has
10 testified that the surgery was never canceled or never
11 contemplated to be canceled?

12 A. No, sir.

13 Q. Did Ricky ever complain about being short of breath
14 before the surgery?

15 A. No, sir.

16 Q. Prior to the surgery, Ricky was very physically
17 active?

18 A. Yes, sir.

19 Q. He had a very hard, demanding job?

20 A. Yes, sir.

21 Q. And he worked that job all the way up to the day of
22 surgery?

23 A. Yes, sir.

24 Q. How was Ricky after the first surgery?

25 A. He -- He didn't do that well. He wasn't responding,

1 and he -- When they finally did put him in a room he still
2 wasn't doing that good.

3 Q. When did he start declining after the first surgery?

4 A. We -- Well, we kept telling the nurse to call Dr.
5 Espinal. In three days, he was like going down fast.

6 Q. Do you remember seeing Dr. Dennenberg, the first
7 pulmonologist?

8 A. Yes, sir.

9 Q. Do you recall switching pulmonologists from Dr.
10 Dennenberg to Dr. Ayllen?

11 A. Yes, sir.

12 Q. Do you know why that was done?

13 A. We did that for a sake of my husband's life. At that
14 point, we thought he wasn't going to make it.

15 Q. Did you not think that Dr. Dennenberg was doing a good
16 job treating your husband?

17 A. No, sir.

18 Q. And then you discharged him and hired another
19 pulmonologist?

20 A. Yes, sir.

21 Q. Have you sued Dr. Denenberg?

22 A. No, sir.

23 Q. After the second surgery, after Mr. Sexton was
24 discharged, he went to Health South for rehabilitation.

25 A. Yes, sir.

1 Q. And he got better in rehabilitation. They helped him
2 some?

3 A. Yes, sir, they did.

4 Q. And he stayed there about a week?

5 A. Yes, sir.

6 Q. And then went home?

7 A. Yes, sir.

8 Q. And went back to work within four and a half to five
9 months of the surgery?

10 A. About six months.

11 Q. And he still today works long hours and has a very
12 hard, demanding job?

13 A. Yes, sir.

14 Q. And you agree with me that just because there are
15 complications from a surgery, that doesn't mean that the
16 doctor committed malpractice?

17 A. That's where I don't agree.

18 Q. So you think any time that there's complications from
19 surgery, the doctor committed malpractice?

20 A. Not every time, no, but in some cases, yes.

21 Q. And sometimes you've got complications, even though
22 there's complications, that does not mean that the doctor
23 messed up?

24 A. I don't agree.

25 Q. So any time there's complications, the doctor messed

1 up?

2 A. In some cases yes.

3 Q. Ms. Sexton, you testified earlier that Dr. Espinal
4 didn't ask any questions of your husband upon the consult
5 before the first surgery, but then you testified that Ricky
6 told Dr. Espinal that he smoked. Why would he just start
7 talking to Dr. Espinal if Dr. Espinal didn't ask him any
8 questions?

9 A. I don't know.

10 MR. ROGERS: Nothing further, Your Honor. Thank you.

11 THE COURT: You can step down and have a seat.

12 (WITNESS LEAVING WITNESS STAND.)

13 THE COURT: Call your next witness.

14 MR. ANDREWS: The Plaintiffs call Chuck Beard.

15 MADAME CLERK: Mr. Beard, can I have you place your
16 left hand on the Bible, and raise your right?

17 (WHEREUPON: CHARLES BEARD, BEING
18 FIRST CALLED AND DULY SWORN, TESTIFIED AS FOLLOWS:)

19 DIRECT EXAMINATION

20 CHARLES BEARD BY MR. ANDREWS:

21 Q. Make sure you pull that microphone up, and you talk
22 loudly enough so we all can hear.

23 What's your name, sir?

24 A. Charles A. Beard.

25 Q. And you go by Chuck?

1 A. Yes, I do.

2 Q. Okay, I'm going to call you Chuck, if that's okay,
3 sir.

4 A. That's fine.

5 Q. Where do you live, Chuck?

6 A. Rock Hill in South Carolina.

7 Q. How long have you lived in Rock Hill, South Carolina?

8 A. Since 1962.

9 Q. And who are you married to?

10 A. Glynnis Beard. Well, Glynnis Sexton was her maiden
11 name.

12 Q. And is Glynnis Ricky's older sister?

13 A. Yes.

14 Q. How long have you known Ricky?

15 A. Since he was about nine or ten years old.

16 Q. And so you've known him your whole life; is that
17 right? His whole life, basically.

18 A. Most of it.

19 Q. Are you retired, sir?

20 A. Yes, sir.

21 Q. Where did you work prior to --

22 A. Bowater, Carolina Corporation.

23 Q. How long did you work at Bowater?

24 A. Forty years.

25 Q. And you retired when?

1 A. January 14th, 2004.

2 Q. I know you testified in your deposition earlier that
3 you didn't keep up with Ricky's medical conditions.

4 A. That's right.

5 Q. Is that right? So, you really didn't have any
6 knowledge of what his history was prior to 2007?

7 A. No, sir.

8 Q. Is that fair?

9 A. I'd say that's fair. He -- Then -- He had no major
10 things that I would be aware of.

11 Q. You learned that Ricky had to have this surgery with
12 Dr. Espinal; is that correct?

13 A. Yes, sir.

14 Q. On March the 7th, did you go up there that morning?

15 A. Yes, sir.

16 Q. What time did you get to the hospital on March the
17 7th, the day of the surgery?

18 A. It was probably around Six, 6:15 in the morning, 6:30,
19 somewhere around that area.

20 Q. And where did you go?

21 A. I went to the waiting room, the surgical waiting room,
22 at Piedmont Medical.

23 Q. And when you got there, was Trish already there?

24 A. Yes, she was.

25 Q. And prior to the scheduled surgery, did you make an

1 attempt to talk to Ricky?

2 A. Yes, sir. I went back to see him.

3 Q. And when you went back to see him, what happened?

4 A. Well, when I got to the room where they were prepping
5 him -- or where the prep room was -- the lady came out of the
6 room, and she met me, and I told her I wanted to see him.
7 She said, "We're not going to do the surgery." So, I said,
8 "Well, is he okay?" She said, "Sure." So, I went back to
9 tell Trish that they weren't going to do the surgery and
10 call my wife because my wife was coming up. And she was
11 trying to get ready and everything so I just called her and
12 told her not to be in a hurry they weren't going to do the
13 surgery.

14 Q. And after doing that, what did you do?

15 A. I left to go to work.

16 Q. And when is the next time that you found out anything
17 about Ricky?

18 A. Later on that day I found out that they did do the
19 surgery, and I came back up there after I got off from
20 work.

21 Q. And did you spend a good amount of time at the
22 hospital staying with Ricky?

23 A. During the time of his illness I went every morning
24 before I went to work, to relieve Trish so that she could go
25 get something to eat or something and before my wife would

1 come up and stay the day.

2 Q. You never had any conversations with Dr. Espinal?

3 A. No, sir.

4 Q. Was somebody in the family always with Ricky during
5 this stay at the hospital?

6 A. Pretty much so all the time.

7 Q. Do you see Ricky quite as much as you used to?

8 A. No, sir.

9 Q. Did you used to see him quite a bit before the
10 surgery?

11 A. We saw some. You know, we -- we -- probably once a
12 month or something like that, we would get together, family
13 type things and everything.

14 Q. Would you have left that hospital if someone had told
15 you that it -- Would you have left that hospital just to
16 leave?

17 A. No.

18 Q. Okay, thank you very much.

19 CROSS EXAMINATION

20 CHUCK BEARD BY MR. ROGERS:

21 Q. Mr. Beard, did you -- What time did you arrive at the
22 hospital the morning of the first surgery?

23 A. Like I said before, between 6:15, 6:30, somewhere in
24 that range.

25 Q. Did you talk to Ricky when you arrived?

1 A. No, sir.

2 Q. Did you ever see Ricky?

3 A. No, sir.

4 Q. You were in the waiting room the entire time?

5 A. No, sir. I went back to his room. I went back to see
6 him and was told that the surgery is canceled, the lady
7 told me. She said, "He's not going to have the surgery."
8 I said, "Is he okay?" She said, "Sure." So, I went back
9 to tell Trish that they wasn't going to do the surgery. I
10 called my wife to tell her that, and I left to go to work
11 because I was working at the golf course at that time.

12 Q. Had you planned on going to work that day?

13 A. Yes, sir. After the surgery, I was going on in to
14 work.

15 Q. So, who was it that told you the surgery was going to
16 be canceled? Can you describe the person?

17 A. It was a female employee of the hospital. I thought
18 it was a nurse anesthetist, but I don't know. I really
19 don't.

20 Q. You thought it was a nurse anesthetist?

21 A. Yes, sir.

22 Q. Or somebody that worked with the anesthesiologist?

23 A. Yes, sir.

24 Q. So if the anesthesiologist canceled the surgery, the
25 anesthesiologist should know about that and be able to

1 testify to that. Would you agree with that?

2 A. I would think so.

3 Q. Did you ask the nurse anesthetist that worked with the
4 anesthesiologist why the surgery was canceled?

5 A. Yes, sir, I did.

6 Q. And what did she tell you?

7 A. Well I was told I couldn't say this, but they told me
8 that his blood-oxygen level was too low.

9 Q. And did you have any further questions or discussions
10 with her about that?

11 A. No, sir.

12 Q. Did they say anything about him having the flu, or
13 pneumonia, or anything like that?

14 A. No, the nurse didn't tell me anything like that.

15 Q. And when you left, you were planning on going into
16 work. You weren't going to go home with Ricky or anything
17 like that?

18 A. Say again?

19 Q. You weren't going to go with Ricky from the hospital
20 anywhere? You didn't have any plans like that? You were
21 headed to work?

22 A. No.

23 Q. You're aware that your testimony here today could help
24 Ricky get a monetary award in this lawsuit?

25 A. Well, that would be up to the jury, sir.

1 Q. But you're aware that your testimony could help him
2 get money from Dr. Espinal in this lawsuit?

3 MR. MCGOWAN: Objection. Judge, we need to approach
4 on that issue.

5 THE COURT: Well, I --

6 MR. MCGOWAN: That was --

7 (SIDE BAR AT 10:15 AM OFF THE RECORD, OUT OF THE
8 HEARING OF THE JURY)

9 THE COURT: I'm going to let the jury go to the jury
10 room just for a few minutes while we take up a matter of
11 law.

12 (JURY EXITS COURTROOM AT 10:16 AM..)

13 THE COURT: Mr. McGowan.

14 MR. MCGOWAN: Your Honor, that question, number one is
15 objectionable, and number two, opens the door to Dr.
16 Espinal's liability coverage.

17 This counsel's question to this witness was "You
18 understand that your testimony can be used to make Dr.
19 Espinal pay money?" That is, as a factual matter, not
20 true.

21 Second of all, it creates a misapprehension to the
22 jury that Dr. Espinal will have to pay this money out of
23 pocket. He doesn't. He won't. He will never have to.
24 It's his insurance carrier. That opens the door under Rule
25 411 because it is not admitted for the purpose of showing

1 that the person was acting negligently or otherwise
2 wrongfully. That's not the purpose. This is for another
3 purpose, which is to cure the problem, the prejudice, the
4 error that this Counsel's question created. It says, "It
5 does not require the exclusion of evidence of insurance
6 against liability when offered for another purpose. And
7 then there's some examples. This is another purpose
8 because the lawyer has created the impression to the jury
9 that Dr. Espinal will have to pay this money out of pocket
10 because make Dr. Espinal pay money. It is not true, and
11 the way to cure that is for us to ask Dr. Espinal if he has
12 liability coverage and, in fact, none of this comes out of
13 his pocket.

14 MR. ROGERS: Your Honor, I believe my question was
15 "You're aware that your testimony could aid your brother-
16 in-law in getting a monetary award against Dr. Espinal?"
17 The monetary award would be against Dr. Espinal.

18 MR. MCGOWAN: That's not what he said.

19 THE COURT: All right, let's stop --

20 MR. ROGERS: It's just like --

21 THE COURT: Let's stop and let me hear what the exact
22 question was, if the court reporter will tell us.

23 MADAME COURT REPORTER: It will take me just a moment,
24 Judge.

25 THE COURT: I know.

1 MADAME COURT REPORTER: Yes, sir. Judge, I'm not
2 hooked up to my speakers. You'll probably have to come
3 down and listen because I don't think you can hear it from
4 the roar. And I have it right on where the question was
5 ask.

6 (COURT LEFT BENCH.)

7 MADAME COURT REPORTER: Ready, Judge?

8 THE COURT: Uh-huh.

9 THE COURT: All right. He said, "Help Ricky get any
10 monetary award in this law suit." That's what the question
11 was.

12 MR. MCGOWAN: That's not the right question, Judge,
13 because he specifically said in reference to Doctor
14 Espinal.

15 THE COURT: All right. Let's try another one.

16 MADAME COURT REPORTER: All right. That's the first
17 question, Judge.

18 THE COURT: All right. The next one.

19 MR. MCGOWAN: It was the next one. The one right
20 before it, Judge.

21 THE COURT: Why don't you back it up a little bit
22 before that and then let Mr. McGowan listen to it and see
23 if he can pick out something different.

24 MADAME COURT REPORTER: All right. There's the
25 question. Let me back it up just a tad.

1 THE COURT: Go back a couple of questions.

2 (TESTIMONY REPLAYED.)

3 THE COURT: All right.

4 MADAME COURT REPORTER: I'm gonna get my speakers
5 while you're listening.

6 MR. MCGOWAN: There it is right there, Judge. Says,
7 "You're aware that your testimony could help your brother
8 in law get money from Doctor Espinal. That was the
9 question.

10 MADAME COURT REPORTER: I'm gonna back it up just a
11 tad, Judge.

12 (TESTIMONY REPLAYED.)

13 THE COURT: That was the bench conference. Why don't
14 you hook your speakers up.

15 MADAME COURT REPORTER: I am.

16 THE COURT: Then we'll hear it. Why don't we take a
17 short break and take our break because the jury is taking
18 their break and she'll have the speakers hooked up and we
19 can do it a little more.

20 He can come down and use the restroom and get some
21 water or whatever. Just don't talk --

22 MR. ROGERS: Don't you talk to anybody.

23 (WITNESS LEAVING WITNESS STAND.)

24 (COURT IN RECESS AT 10:25 AM.)

25 (ATTORNEYS RE-LISTENED TO TESTIMONY.)

1 (WHEREUPON: CROSS EXAMINATION OF CHUCK BEARD BY MR.
2 ROGERS REPLAYED FOR THE COURT.)

3 (COURT BACK IN SESSION AT 10:30 AM..)

4 THE COURT: Let me hear Mr. McGowan again first since
5 he is the objector.

6 MR. MCGOWAN: That question was improper and opened
7 the door to liability insurance coverage, under Rule 411,
8 admitted for another purpose as allowed under Rule 411. At
9 minimum, we request, Your Honor, to strike the question and
10 instruct the jury that whether or not Dr. Espinal will pay
11 a judgment is of no concern to the jury whatsoever.

12 THE COURT: Do you have any problem with that, Mr.
13 Rogers?

14 MR. ROGERS: Your Honor, I think we would be fine for
15 an instruction along those lines just to say the jury is
16 not to be concerned about who pays any award in this case.

17 THE COURT: Well, why don't y'all structure up --

18 Mr. McGowan, not the dilemma but here's where we are.
19 He didn't answer the question, so all we have is a question
20 with no answer. The question was objected to, and I'm
21 going to sustain the objection. So the question can be
22 stricken with no answer. So I feel comfortable striking
23 the question, we'll tell them to disregard it. But there
24 wasn't any answer, so there is no answer to strike.

25 Now the other thing, I know this is going up to the

1 precipice of where you are with your request, but -- and it
2 may be splitting hairs, but the complaint says, "Plaintiff
3 respectfully pay for judgment against the Defendants for
4 actual damages." And the jury's award is going to be
5 against Dr. Espinal. So, we --

6 MR. MCGOWAN: But that's different.

7 THE COURT: Well, it is, but that's why I say he's got
8 the precipice. I don't think he went over the precipice,
9 and then there wasn't any answer. But that's why I'll be
10 glad to give a curative instruction.

11 MR. MCGOWAN: Yes, sir.

12 THE COURT: Disregard that question.

13 MR. ROGERS: Yes, sir. And to me it's a lot like the
14 argument making an automobile negligence case is --

15 THE COURT: Well, you've already won.

16 MR. ROGERS: I can't -- I won't keep going there.

17 Thank you, Your Honor.

18 THE COURT: Not one, but I mean I've already --

19 MR. ROGERS: Ruled in my favor. Yes, sir.

20 THE COURT: Well I haven't ruled in your favor.

21 MR. ROGERS: Thank you.

22 (PAUSE.)

23 THE COURT: Mr. Rogers, do you want to look and see
24 what they've got?

25 MR. ROGERS: Yes, sir.

1 (ATTORNEYS REVIEWING DOCUMENTS.)

2 MR. ROGERS: I agree with that. Yes, sir.

3 THE COURT: Okay.

4 MR. MCGOWAN: Now that we've got you, Judge, I assume
5 the door's been opened to why the surgery was canceled?

6 THE COURT: Well, I'm afraid so. He ask what he was
7 told but he's already answered. So I don't know how far
8 that goes because his answer is, I think, kind of a
9 cautious answer, quite frankly. But I think the doors been
10 opened.

11 All right. You ready for the jury?

12 MR. MCGOWAN: Yes, sir.

13 THE COURT: All right, bring in the jury.

14 (JURY REENTERS COURTROOM AT 10:37 AM.)

15 THE COURT: Members of the jury panel, right before
16 you went out, there was a question asked, and there was an
17 objection to it. You should disregard the last question,
18 the question that was objected to because I have ruled, and
19 sustained the objection, and ordered it stricken from the
20 record. Who would pay judgment you may render is of no
21 concern of yours whatsoever. You are to determine whether
22 or not the Plaintiff was entitled to a judgment.

23 All right.

24 MR. ROGERS: Thank you, Your Honor. I have no further
25 questions for this witness.

1 MR. ANDREWS: Briefly.

2 REDIRECT EXAMINATION

3 CHARLES BEARD BY MR. ANDREWS:

4 Q. Chuck, have you told the truth today?

5 A. Yes, sir.

6 Q. Did you and your family cook up this whole story to
7 try to get some money out of the Defendant?

8 A. No, sir.

9 Q. You understand that's the -- that's what he implied to
10 you. Right?

11 A. Yes, sir.

12 Q. How does that make you feel?

13 MR. ROGERS: Objection, Your Honor.

14 THE COURT: I sustain your objection.

15 MR. ANDREWS: No further questions.

16 THE COURT: All right. Any?

17 MR. ROGERS: No, sir, Your Honor.

18 THE COURT: All right. You can step down and have a
19 seat.

20 (WITNESS LEAVES WITNESS STAND.)

21 THE COURT: Call your next witness.

22 MR. ANDREWS: Yes, sir. I call Glynnis Beard to the
23 stand.

24 MADAME CLERK: Ms. Beard, can I have you place your
25 left hand on the Bible and raise your right, please?

1 (WHEREUPON: GLYNNIS BEARD, BEING
2 FIRST CALLED AND DULY SWORN, TESTIFIED AS FOLLOWS:)

3 DIRECT EXAMINATION

4 GLYNNIS BEARD BY MR. ANDREWS:

5 Q. Tell us who you are.

6 A. Glynnis Beard.

7 Q. And can you pull that microphone a little closer to
8 you and speak into it a little bit louder, please?

9 A. Glynnis Beard.

10 Q. And Glynnis, how are you related to Ricky?

11 A. I'm Ricky's sister.

12 Q. Are you his older sister?

13 A. Yes, sir.

14 Q. I don't want to ask you how old you are, but how much
15 older are you than Ricky?

16 A. Five years.

17 Q. What type of relationship did you have with Ricky
18 growing up?

19 A. Wonderful.

20 Q. Have you stayed -- Were you and Ricky close?

21 A. Yes. When I was in 5th grade, he was in 1st, and I've
22 kind of always been his protector, always were.

23 Q. And you've always been there for him?

24 A. Always.

25 Q. And you're still there for him today?

1 A. Yes, sir.

2 Q. Let's talk a little bit about -- Now you're married to
3 Chuck, right?

4 A. Yes, sir.

5 Q. And you and Chuck have been married how long?

6 A. Forty-nine years.

7 Q. And do you work, ma'am?

8 A. Retired.

9 Q. Where did you retire?

10 A. I worked at an orthodontic office, Dr. Robert Pulley
11 as a medical receptionist.

12 Q. How long did you do that, ma'am?

13 A. Thirty-five years.

14 Q. Have you ever filed a lawsuit against anybody?

15 A. No, sir.

16 Q. Did you know much about Ricky's prior medical history
17 before March of 2007?

18 A. Yes, sir.

19 Q. What did you know?

20 A. Some years back he saw Doctor Burch. He was having
21 acid reflux. I went with him to those visits. He went
22 into the hospital and had an endoscopy; he had an endoscopy
23 and he had, I think, a small aneurism that he removed
24 during the endoscopy. That's the only medical history. I
25 think he had appendicitis when he was small.

1 Q. Appendicitis?

2 A. Yes, sir.

3 Q. And Ricky smoked?

4 A. Yes, sir, he did.

5 Q. And at one point, he drank a lot.

6 A. Yes, sir, he did.

7 Q. What do you know about his drinking -- as far as, has
8 he quit drinking?

9 A. Yes, sir. He's been sober twelve years.

10 Q. Twelve years.

11 A. Yes, sir.

12 Q. Now let's talk about what led up to the surgery with
13 Dr. Espinal, okay?

14 A. Yes, sir.

15 Q. Did you understand that Ricky had -- He went and got a
16 colonoscopy from Dr. Richardson?

17 A. Yes, sir.

18 Q. Did you have any involvement in that?

19 A. I actually went with he and Trisha to Dr.
20 Richardson's, and I sat in the waiting room.

21 Q. And he did the colonoscopy, found some polyps, removed
22 them. And there was one that was two to three centimeters
23 that was flat, they couldn't be removed, and he referred it
24 to Dr. Espinal.

25 A. Yes, sir.

1 Q. Is that right?

2 A. Yes, sir.

3 Q. And he met with Dr. Espinal on March the 2nd. Were
4 you aware of that?

5 A. Yes, sir.

6 Q. Did you go with Ricky to that appointment?

7 A. No, sir.

8 Q. Okay. Did you talk to Ricky after that appointment?

9 A. Yes, sir, I did.

10 Q. And did you learn that there was a surgery that was
11 scheduled for March the 7th?

12 A. Yes, sir, I did.

13 Q. Okay. What were your plans with respect to going to
14 that surgery?

15 A. I was to go that morning to meet them at Six, but I
16 was running late getting ready. So my husband went ahead
17 of me.

18 Q. Let's go back to the day before March 6th.

19 A. Okay.

20 Q. Did you learn anything about Ricky's condition the
21 night of the evening of the 6th?

22 A. Yes, sir.

23 Q. How did you learn that?

24 A. I either called Ricky or Ricky called me. I think
25 Ricky called me.

1 Q. Okay. And how did he sound?

2 A. He -- He was coughing really bad, and he said he had
3 been sick all day that day.

4 Q. Did anybody ask you any questions?

5 A. Yes, sir, he did. He said, "I don't think" -- He
6 said, "I think I'm getting the flu" and he was coughing
7 horribly. And he said, "What should I do about the surgery
8 tomorrow?" And I told him that maybe get Trish to call the
9 hospital.

10 Q. And you were planning to go up to the hospital the
11 next day; is that right?

12 A. Yes, sir.

13 Q. And you received a telephone call ---

14 A. Yes, sir.

15 Q. --- that morning?

16 A. Yes, sir.

17 Q. And you received a telephone call from your husband?

18 A. Yes, sir.

19 Q. And what did he tell you?

20 A. He said for me not to rush getting there. That he
21 went back to the room, and as he got to the door, a nurse
22 or an anesthetist came out and said that the surgery was
23 not going to be held that day due to low oxygen.

24 Q. Okay. And as a result of the -- Subsequent to that
25 phone call, did you receive another phone call?

1 A. Yes, sir.

2 Q. Who called you?

3 A. Ricky his self called me from his room and was telling
4 me -- He was coughing really bad. He said that they had
5 done a chest X-ray, and he thinks a breathing treatment,
6 and that he would be going back home that he -- They said
7 that after the chest X-ray, he would not be going to
8 surgery that day.

9 Q. So he told you that they had canceled the surgery?

10 A. He -- Yes, sir -- called -- Yes, sir. He had told me.

11 Q. All right. And during that phone conversation, did
12 anything else happen that you heard?

13 A. Yes, sir. There was people talking, and he -- he was
14 saying to them, "What's going on?" They said, "We're here
15 to take you to surgery." He said, "No, my surgery has been
16 canceled." They said, "No, Dr. Espinal read the chest X-
17 ray and decided you're going to surgery."

18 Q. Okay. And did you get to talk to Ricky anymore?

19 A. No, sir. He just -- He just told me bye and that was
20 it.

21 Q. And what did you do next?

22 A. Went straight to the hospital.

23 Q. You finished getting ready and went on up to the
24 hospital?

25 A. Yes, sir.

1 Q. You got there about thirty minutes later. Is that
2 fair?

3 A. Yes, sir. Within thirty minutes.

4 Q. All right. And when you got there, who was there?

5 A. Trish. I called Trish and told her what was going on.

6 Q. Okay. And when you got to the hospital, where did you
7 go?

8 A. We went to the surgical waiting room, and he had
9 already gone to surgery.

10 Q. Who -- You were informed that he was in surgery?

11 A. Yes, sir.

12 Q. How long was Ricky in surgery?

13 A. I'm not sure exactly how long, probably an hour and a
14 half in surgery. I'm just guessing that time because we
15 would go to the nurses' desk and ask. And actually, I
16 think they actually finally called and said the surgery was
17 over.

18 Q. Okay.

19 A. He had gone to recovery.

20 Q. And he was in the recovery room?

21 A. Yes, sir.

22 Q. And he was in the recovery room for about a couple of
23 hours; is that right?

24 A. He was in there a long time. And Trish and myself
25 walked to the desk and got them to call back to check on

1 him. And they said they were having problems getting him
2 to breath good in the recovery room; he would be there a
3 while longer.

4 Q. How did that make you feel?

5 A. Really bad because I knew he was sick when he went to
6 surgery.

7 Q. All right. Now, at some point, he got out of
8 recovery?

9 A. We called back the second time. We got them to call
10 back two times, and they said he would be in his room an
11 hour, an hour and a half.

12 Q. Okay.

13 A. And they did call us after that and tell us he would
14 be going to his room. It was early afternoon.

15 Q. And did -- It was sometime in the early afternoon that
16 he made it to his room?

17 A. Yes, sir.

18 Q. And did you -- Were you there when he was going into
19 the room?

20 A. Yes, sir.

21 Q. Tell us -- Tell the ladies and gentlemen of the jury
22 what you saw.

23 A. He had a large oxygen mask on his face, and he was
24 trying to push the mask, and all this. And when they
25 finally got him in the bed we were trying to understand

1 what he was trying to tell us. He was really drowsy. He
2 was not even getting enough oxygen with the large mask on
3 his face. He -- He felt like he was smothering.

4 Q. And y'all would always -- As far as with the mask, if
5 he tried to wiggle it off, what would y'all do?

6 A. Well we decided that, you know, he looked like he was
7 struggling, having a hard time. Trish and myself would
8 stand by the bed, if he would try -- He would take his
9 hands and try to hit at it, and one of us would just calm
10 him back down. He was very drowsy from the anesthesia, so
11 we just took turns keeping him -- all that day -- on the
12 oxygen, keeping the mask on his face.

13 Q. Okay. Was somebody in the family always with Ricky?

14 A. Yes, sir.

15 Q. How did Ricky -- The next few days, how was Ricky's
16 appearance, how was he doing?

17 A. Well the next day, he started just -- He was so hot,
18 the hospital furnished a fan and put on him. He was so
19 hot. He just -- He felt like he was burning up. During
20 that day, they changed the oxygen mask to a small oxygen
21 mask. He did not fight that anymore. He kept that on all
22 the time. He didn't struggle with it, but he still felt
23 like all the time, he would say "I feel like I'm
24 smothering, my chest. I just feel like I'm smothering."

25 Q. What else about him did he --

1 A. That -- That day they came and said he would have a
2 liquid diet. And I think they brought him soup and
3 something. And he just -- It made him sick to even look at
4 it.

5 Q. Okay.

6 A. So as the day wore on, I asked if I could go home and
7 prepare like a scrambled egg sandwich and bring for him.

8 Q. And he -- Did he eat that?

9 A. He took two bites and got very nauseated and sick.

10 Q. But as far as -- Did you notice anything about was he
11 having difficult breathing?

12 A. Yes, all day long, he had difficulty breathing.

13 Q. Did he seem to have a temperature?

14 A. Yes, sir. He was very hot. We kept putting cold wash
15 cloths on his forehead, his arms. When he wanted a cloth
16 around his neck, we would keep wetting that, changing it.
17 And he could have ice chips, but he did not ask for ice
18 chips very much.

19 Q. Did you notice anything about his belly?

20 A. Yes, sir. It started swelling.

21 Q. Did those things that we talked about, did they get
22 any better over the next day or two?

23 A. No, sir, they got worse.

24 Q. They got worse.

25 A. Yes, sir.

1 Q. And then -- I want to go back before we get into the
2 surgery of the 10th. And I want to ask you, did you have
3 any conversations with Dr. Espinal the day of the surgery,
4 after the surgery?

5 A. He never came to the room after the surgery. We never
6 saw him that day.

7 Q. You never saw him?

8 A. No, sir.

9 Q. When is the first time that you saw Dr. Espinal?

10 A. On Wednesday night, Ricky had had a really bad day on
11 Wednesday. And I think Trish had spent the night. She
12 even went home, slept a few hours, and came back and stayed
13 with me.

14 I kept getting the nurses to call him and tell him how
15 Ricky was doing. His stomach was swelling more. He was
16 very nauseated. He was coughing profusely. I got them to
17 call, and I think we made an appointment. He came there at
18 Seven o'clock that night.

19 Q. Was that -- Wednesday was the day of the surgery?

20 A. This was Thursday night. You asked me the next day.
21 I thought we had gone to the next day. Wednesday, we did
22 not see him at all.

23 Q. Okay. You didn't see him Wednesday?

24 A. No, sir.

25 Q. So the first time that you saw Dr. Espinal ---

1 A. Was Thursday night.

2 Q. --- and talked to Dr. Espinal was Thursday evening
3 about Seven o'clock?

4 A. Yes, sir.

5 Q. Tell me what transpired during that conversation.

6 A. Okay. I was very upset with him that he had not been
7 to the room. He had not -- He had not -- Ricky was not
8 getting good care. Trish, and myself -- and my other
9 sister came on board and started helping us. He would --
10 The nurses were not hardly coming in there. And I was very
11 upset that Ricky had, had the surgery knowing he was so
12 sick ---

13 Q. Did you tell Dr. --

14 A. --- so I -- My first conversation with him was "Dr.
15 Espinal, he is not doing good at all. Why did you take him
16 to surgery at all?" He said, "What do you mean?" And I
17 said, "Well they had called and said his oxygen level was
18 low, and he" -- I said, "I spoke with him on the phone. He
19 could not quite coughing. He was coughing so." He said,
20 "Let's go beyond that, and let's get him well."

21 Q. Okay.

22 A. "Let's go beyond that." And he was very nice.

23 Q. And he had to end up -- They did the CAT scan, and had
24 to do a second CAT scan. They found out that he had a leak
25 where they had tied the colon together. Right?

1 A. Yes, sir.

2 Q. And they had to do another surgery?

3 A. Yes, sir.

4 Q. And you were there for all of that?

5 A. Yes, sir, all week.

6 Q. Okay. And Ricky had to spend, we've heard -- hear
7 about -- about five more weeks in the hospital?

8 A. Yes, sir.

9 Q. During the time that he was in the hospital, what did
10 the doctors tell you about his condition?

11 A. Several times he almost died. He got sepsis in his
12 blood stream. I'd never heard the word. I went into
13 intensive care that day, and he was on the ventilator. His
14 whole body was so swollen, his fingers were just -- Is this
15 okay if I tell it? His whole body, even his face and his
16 head was so swollen. And I asked and they said that they
17 suspected sepsis. So they got a doctor and he came out in
18 the hallway and talked to us, and said that he did -- I
19 think that was Doctor Charles -- that he did have sepsis.
20 And I asked how serious this was. And he said, "Very
21 critical. That could take his life."

22 Q. Okay. You had several conversations with Dr. Espinal
23 after the first conversation; is that right?

24 A. Yes, sir, just -- just briefly. I would get the
25 nurses to call him. Yes, sir.

1 Q. And you were upset with Dr. Espinal?

2 A. Yes, sir, very. The sicker Ricky got, Dr. Espinal
3 hardly ever came in that room. I would have to call and
4 ask to get to see him. And he would say, "I could come at
5 certain time." One night he came at Ten o'clock at night,
6 and we met at Ten o'clock at night.

7 Q. Did there ever come a time when you discussed with him
8 why the surgery was done -- the first surgery was done, and
9 did he ever make a response to you with regard to that?

10 A. Yes, he did.

11 Q. Tell us about that.

12 A. That was on about Friday night when he -- a Friday
13 night when Ricky was so bad off. His stomach was really
14 pertruse, and I knew that there was a blockage there. I
15 just knew there was because every day he was getting larger
16 in his stomach area. And I met with him, Trish and myself,
17 I think at Ten o'clock at night. That was on Saturday
18 night after -- That was on the day of his surgery, that
19 night, at Ten o'clock at night. I was really upset with
20 him. He had hardly been in that room all that week. He
21 didn't keep us prgressed on what was going on. I would
22 have to call when Ricky got Doctor Denenberg. We need to
23 speak of that too." I said to Dr. Espinal, "Dr. Espinal,
24 he would not be dying, he would not be in this shape if you
25 had not done the first surgery." And his exact words were

1 "No, I shouldn't have done it." I can't even find it.

2 Q. What are you looking at?

3 A. My deposition and my notes that I took in the
4 hospital.

5 Q. Did you take some notes in the hospital?

6 A. Yes, sir, I did.

7 Q. Did you take them contemporaneous with what things
8 were going on?

9 A. Yes, sir, I did.

10 Q. And then -- And what did -- When you -- This
11 conversation you had with Dr. Espinal, what was his
12 response to you?

13 A. He said, "No, I shouldn't have done the first surgery,
14 but let's try to get him well, and let's quit dwelling on
15 the first surgery. Let's go on from here."

16 Q. Now you knew Ricky before the surgery. Right?

17 A. Yes, sir.

18 Q. Pretty well?

19 A. Yes, sir.

20 Q. And you knew -- And you'd been around Ricky after the
21 surgery?

22 A. Yes, sir.

23 Q. Has there been a change in Ricky since the surgery?

24 A. Oh, yes, sir.

25 Q. How has the surgery impacted him, physically,

1 mentally, whatever way?

2 A. I think it always -- I think even mentally --
3 Yesterday, the man on here was not the Ricky from the past.

4 He -- During all this for four years, we always -- I,
5 myself have tried to talk with him about the surgery. He
6 would never let me talk about it, always tell him what a
7 miracle he is. I've never spoke with him that I don't tell
8 him, "God saved you for a reason, Ricky." And he always
9 just says, "Yes." We don't discuss it.

10 Yesterday it was like he was so angry when he was here
11 on -- I guess, looking at what's going on here, and maybe
12 hearing all this stuff. He's just angry. He's never been
13 like that in his life.

14 Q. That wasn't the Ricky you knew?

15 A. No, sir. I was so shocked. I was just so stunned and
16 hurt.

17 Q. Has -- Have you -- Were there any other changes about
18 Ricky that you noticed?

19 A. Yes, sir. He's almost turned into a recluse. All he
20 does is work. He works and goes home. I might see him
21 once a month, and I might not get to see him once a month.
22 He will plan to come over, and he doesn't come. And he's
23 never been like this. He's withdrawn.

24 Q. Just one second.

25 (PAUSE.)

1 Q. You've told the jury the truth today; is that right?

2 A. Yes, sir, I have. Yes, sir.

3 Q. You've never filed a lawsuit in your life. Right?

4 A. Never, never.

5 Q. Did you and your family cook up this whole story?

6 A. No, sir. You couldn't cook up this story. We lived
7 it. No, sir.

8 Q. Thank you very much.

9 CROSS EXAMINATION

10 GLYNNIS BEARD BY MR. ROGERS:

11 Q. Ms. Beard, you believe that your mother died as a
12 result of medical malpractice; is that correct?

13 A. Yes, sir, she did.

14 Q. And you know Dr. Espinal? He lives in your
15 neighborhood?

16 A. Yes, sir, he does. I did not know that at the time
17 though.

18 Q. You see your brother Ricky Sexton about once a month
19 at family events. And you know he was a terrible alcoholic
20 for a number of years?

21 A. Sir, what's that got to do with this case?

22 THE COURT: Well, just answer the question, please.

23 A. Yes, sir, I do.

24 Q. And you know that he smoked since he was about
25 fourteen years old, a pack to a pack and a half a day?

1 A. I've never said him smoked a pack and a half a day.

2 Q. How much did you testify in your deposition that he
3 smoked? Do you recall that? You don't have to look back.

4 A. No, sir.

5 Q. Tell me what you think he smoked?

6 A. Probably a pack a day is what I would think.

7 Q. So one pack a day since fourteen years old?

8 A. I said fourteen because I was just guessing. I have
9 no idea how old he was.

10 Q. Long history of heavy smoking.

11 MR. ANDREWS: Your Honor, if he could let her finish
12 her response.

13 MR. ROGERS: Yes, sir, Your Honor.

14 Q. He's had a long history of heavy smoking?

15 A. If that's what you call heavy smoking. I've never
16 smoked.

17 Q. And you claim on the morning that he went in to have
18 the surgical procedure done by Dr. Espinal originally, that
19 he was coughing terribly?

20 A. Yes.

21 Q. I believe you testified in your deposition that you
22 talked to him on the phone before they wheeled him back to
23 surgery, and he coughed for two to three minutes before he
24 could even say anything?

25 A. Yes, yes. He was lying flat down.

1 Q. If you would turn with me to Tab Three of your
2 notebook? And on the fourth page, which is PMC-00844, do
3 you see where the nurse is diagnosing him upon intake, upon
4 his physical examination, and she -- See the box where it
5 says -- the third box from the right on the top, it says,
6 "Cough." What box did she mark for Ricky on the morning of
7 the surgery?

8 A. She marked "None."

9 Q. "None," correct?

10 A. Yes, sir.

11 Q. No cough? The nurse found she hadn't coughed at all
12 -- He wasn't coughing at all that morning of the surgery?

13 A. He might not have been coughing when she was in there
14 but he was coughing when I was speaking with him.

15 Q. Well you can see the nurse's history and physical goes
16 on for a number of pages. You'd imagine she was in there a
17 significant amount of time with Ricky to do this history
18 and physical.

19 MR. ANDREWS: Your Honor, I object.

20 THE COURT: Yeah, I --

21 MR. ROGERS: I'll move on, Your Honor.

22 THE COURT: That's getting into speculating.

23 BY MR. ROGERS:

24 Q. And you say that you think he had the flu on the
25 morning of surgery?

- 1 A. I was just told the night before by him, he thought he
- 2 was taking the flu.
- 3 Q. Are you aware of what his temperature was upon
- 4 admission to the hospital that morning?
- 5 A. Yes, sir. I heard y'all say yesterday.
- 6 Q. 98.0?
- 7 A. Yes, sir.
- 8 Q. Is that indicative of the flu in your opinion?
- 9 A. Well he could have taken medication before he went
- 10 there, I don't know.
- 11 Q. What time did you arrive at the hospital the morning
- 12 of Ricky's surgery?
- 13 A. It was after Seven o'clock.
- 14 Q. And he was already back in surgery?
- 15 A. I didn't get to see him. They said I couldn't see
- 16 him. He had -- I don't know whether he was already in
- 17 surgery. I went to the surgical waiting room, and they
- 18 called and said we could not see him. I could not see him.
- 19 Q. And were you present when Dr. Espinal came out and
- 20 talked to the family in the waiting area after the first
- 21 surgery?
- 22 A. I was there but Dr. Espinal did not come out.
- 23 Q. You don't think he ever came out ---
- 24 A. No, sir, he did not come out.
- 25 Q. --- and talked to the family?

1 A. No, sir. He did not come out. I was there.

2 Q. You don't think it was possible he came out, and you
3 had gone to the restroom?

4 MR. ANDREWS: Your Honor, just -- again could she --

5 THE COURT: You need to let her finish her answer, Mr.
6 Rogers.

7 MR. ROGERS: Yes, sir.

8 A. I was there, but he never came out. They called on
9 the phone.

10 Q. After the procedure, Ricky was having some trouble
11 with his oxygen mask, and he was pulling on it?

12 A. Yes, sir.

13 Q. And you contend in your deposition testimony you gave
14 earlier that the anesthesiologist told your husband that
15 the surgery was going to be put off because of decreased
16 oxygen saturations?

17 A. Yes, sir.

18 Q. Do you know why there's nothing in the
19 anesthesiologist notes that reflect that she ever
20 contemplated canceling the surgery?

21 A. No, sir, I don't know that. But I do know that, that
22 was my husband and Ricky that was told he was not going to
23 have the surgery. Both told me that they were told he was
24 not having the surgery.

25 Q. And Dr. Espinal called you on your cell phone several

1 times during Ricky's recovery period to talk to you about
2 Ricky and his progress?

3 A. No, he actually called and asked if I was okay with
4 what was going on that day with the doctors had been taking
5 care of him, things like that. That was it.

6 Q. He called you multiple times after the surgery while
7 Ricky was in the hospital and talked to you?

8 A. Two times, yes, sir. And he called me at my home one
9 night on a Sunday night when Ricky was extremely critical.
10 Around 10:30 that night, I came in from the hospital, and
11 he called that night.

12 Q. And Dr. Espinal continually said, "Let's get Ricky
13 well" too.

14 A. Yes, sir, yes, sir. He said, "Let's don't dwell on
15 the first surgery. Let's get Ricky well." He even told me
16 one time, "Let's try to keep him alive."

17 Q. And on the second day after the surgery, Dr. Espinal
18 ordered a CT scan to check out Ricky's abdomen? Do you
19 recall that?

20 A. I think that was the third day.

21 Q. That was the second CT scan. It had to be redone, do
22 you remember, because the contrast didn't work.

23 A. Yes, sir. I think that was the -- I don't think he
24 did a CT scan until about the third day.

25 Q. It was on March 9th, the first one.

1 MR. ANDREWS: Is that a question?

2 A. That would be the third day.

3 Q. Do you recall?

4 MR. ANDREWS: Your Honor, he's making statements and
5 --

6 THE COURT: All right. Just put a question mark at
7 the end.

8 MR. ROGERS: Yes, sir.

9 Q. I'm asking if you recall a CT scan being done ---

10 A. Yes, sir.

11 Q. --- the second day after the surgery March 9th?

12 A. The surgery was the 7th, so that would be the third
13 day wouldn't it? 7th, 8th, 9th.

14 Q. That would be the second. I count 7, 8, 9.

15 A. Okay.

16 Q. Okay. And then the CT scan had to be redone because
17 the contrast didn't show up in the appropriate area on the
18 first CT scan. Do you recall that?

19 A. Yes, sir.

20 Q. And do you recall Dr. Espinal shortly after getting
21 the results of the second CT scan taking him back for a
22 second surgical procedure?

23 A. Yes, sir, that was on a Saturday. Yes, sir.

24 Q. And you understand the polyps and the colon need to be
25 removed because they can grow into cancer?

1 A. That polyp didn't need to be removed that day. I know
2 that.

3 Q. You agree it needed to be removed?

4 A. At some time, yes, sir, when he was better.

5 Q. You understand that colon cancer is the second highest
6 killer of cancer patients in this country?

7 A. No, sir, I've never heard that.

8 Q. You agree that all of Ricky's complications stem from
9 the first surgery?

10 A. Yes, sir, I do.

11 Q. You agree that Ricky should have been honest with his
12 medical care providers about his health habits, smoking
13 history, alcohol history, things of that nature?

14 A. Probably they needed to know about his alcohol history
15 --

16 THE COURT: All right. Just answer what he asked.

17 BY MR. ROGERS:

18 Q. Do you agree that Ricky should have been honest with
19 his medical care providers about his smoking history, and
20 alcohol history, and things of that nature?

21 A. If he was asked those questions, yes, sir.

22 Q. And Ricky's return to work at his heavy labor job and
23 has continued to do so starting about five months after the
24 surgery?

25 A. Yes, sir.

1 MR. ROGERS: That's all I have of this witness, Your
2 Honor.

3 MR. ANDREWS: Briefly, Your Honor?

4 THE COURT: Yes, sir.

5 REDIRECT EXAMINATION

6 GLYNNIS BEARD BY MR. ANDREWS:

7 Q. Glynnis, you remember Defense Counsel saying that your
8 brother was a terrible alcoholic?

9 A. Yes, sir.

10 Q. He's been sober for twelve years?

11 A. Yes, sir.

12 Q. You think he's terrible?

13 A. No, sir.

14 Q. Not your words, were they?

15 A. No, sir.

16 Q. Thank you, ma'am.

17 MR. ROGERS: Nothing further, Your Honor.

18 THE COURT: Thank you. You can step down. Thank you.

19 (WITNESS LEAVING WITNESS STAND.)

20 MR. ANDREWS: The Plaintiff rests.

21 THE COURT: Members of the jury panel, the Plaintiff
22 is telling us they have presented their evidence. We now
23 have to take up some matters of law before we move into the
24 case for the Defense. So, we'll take a break at this time
25 while we take up some matters of law.

1 (JURY EXITS COURTROOM AT 11:07 AM.)

2 THE COURT: Anything from the Plaintiff at this time?

3 MR. MCGOWAN: I don't think we have a motion that
4 would have any chance of being granted.

5 THE COURT: Defense?

6 MR. KING: For the record, Your Honor, we move pursuant
7 to Rule 50 for -

8 THE COURT: You need to speak up.

9 MR. KING: I'm sorry.

10 THE COURT: We need -- it's the fan that blows up here
11 all the time.

12 MADAME COURT REPORTER: Please go to the mic.

13 MR. KING: That's the forth time.

14 MR. MCGOWAN: Speak into the machine.

15 MR. KING: That's the forth time I've been counceled
16 on speaking.

17 Your Honor, we move for a directed verdict ---

18 (SIRENS GOING BY COURTHOUSE - HEARING DIFFICULT.)

19 MR. KING: --- both as to actual damages and punitive
20 damages under Rule 50. Taking the evidence most favorable
21 to the plaintiff the only allegations of negligence that
22 had been made by an expert as Doctor Espinal, his failure
23 to do a proper pre-op and evaluation. I do not think even
24 assuming that to be true that it caused the injuries and
25 the complications that came from these surgeries. So our

1 motion is as to Rule 50, both as to cause in chief and as
2 to the claim for punitive damages.

3 THE COURT: You need to speak up a little.

4 MR. ROGERS: I'm sorry.

5 THE COURT: It's the fan that blows up here behind me
6 all the time.

7 MR. MCGOWAN: We think Dr. Solymvari's testimony was
8 directly on point to establish duty, breach, causation, and
9 damages.

10 (PAUSE - SIRENS GOING BY COURTHOUSE - MAKING HEARING
11 DIFFICULT.)

12 MR. MCGOWAN: Therefore it establishes a prima facie
13 case of negligence and also a prima facie case of
14 recklessness.

15 THE COURT: In looking at the case in the light most
16 favorable to the Plaintiff, for the non-moving party, I
17 deny the motion for directed verdict. I find that there is
18 evidence of which a jury could make an award.

19 MR. KING: Thank you, sir.

20 THE COURT: I'm king of thinking out loud. We'll take
21 a little break.

22 Does the Plaintiff intend to pursue punitives?

23 MR. MCGOWAN: Yes, sir.

24 THE COURT: Should we do this bifucating?

25 MR. MCGOWAN: Yes, sir.

1 MR. KING: Well I'm already renewed my motions.

2 THE COURT: Oh, I know. I know when we get to that
3 point, but I'm trying to work on the verdict form and my
4 charge.

5 And can you run each of them a copy?

6 MADAME CLERK: Yes, sir.

7 THE COURT: Here is what I can sort of come up with.
8 She's going to run you a copy. This case is modeled after
9 a case which we just tried about a month ago. And you'll
10 notice that there are, at least as to John Richards Sexton,
11 some sub-findings, and I can talk to you about those. You
12 probably know why they're there. And as to Patricia
13 Sexton's loss of consortium, it's much simpler. And I'll
14 explain my thinking on that too after you all have had a
15 chance to look at it.

16 We'll take a break. We don't need to finish this up
17 today, but I'm -- The legislature now with it's economic
18 and non-economic damages and caps, when the caps would be
19 exceeded and all of that, made it a little more complicated
20 than the old, "We find for X," or "We find for Y"

21 MR. MCGOWAN: Yes, sir.

22 MR. KING: Just a comment. I don't know whether this
23 is going to change your calendar or not, your schedule
24 today. The only witness that we are planning to call today
25 is Dr. Espinal. And I would anticipate Dr. Espinal will be

1 a fairly lengthy witness both as to the direct and cross
2 examination. So --

3 THE COURT: Well the direct will probably take us to
4 about lunchtime. Maybe we'll do direct, and then take
5 lunch. And then do cross, and then that will get us
6 through the day. And then tomorrow, Mr. King, tomorrow
7 leaves us with Bour and Lupo.

8 MR. KING: Tomorrow morning.

9 THE COURT: Right. Just those two.

10 MR. KING: Yes, sir.

11 MR. MCGOWAN: So we anticipate then doing arguments
12 and charge.

13 THE COURT: Right before lunch tomorrow or shortly
14 thereafter.

15 MR. MCGOWAN: Yes, sir.

16 THE COURT: When you have a request to charge ready,
17 I've got the Defense, and we'll of course do that, maybe
18 something we'll do this afternoon.

19 MR. MCGOWAN: The only unusual request to charge we're
20 going to have, Judge, is we're going to go try to find some
21 law that a consent form does not consent to negligence as a
22 matter of law.

23 MR. ANDREWS: And we're also going to ask for that
24 same charge, Your Honor, we did in the last case, it's on
25 the purpose of tort law is to protect --

1 MR. MCGOWAN: It's Ford versus Sapp case, which I think
2 we always ask you, and you always say no or something.

3 MR. ANDREWS: 2009.

4 MR. MCGOWAN: You let us argue it, but ---

5 THE COURT: All right.

6 MR. ANDREWS: You let us argue it, but you never let
7 us -- you never charge it.

8 MR. MCGOWAN: At least we're persistent.

9 MR. KING: I got lost. What is that you all are asking
10 for?

11 THE COURT: All right. We'll do that and --

12 MR. ANDREWS: It's Ford versus Sapp.

13 MR. MCGOWAN: The purpose of tort law is public
14 safety.

15 MR. KING: This is not a car wreck.

16 MR. ANDREWS: You could have fooled me by the way
17 y'all are defending this.

18 MR. MCGOWAN: Yes, sir.

19 THE COURT: We'll take about a 10 minute break, and
20 then call direct.

21 (COURT IN RECESS AT 11:12 AM.)

22 (COURT BACK IN SESSION AT 11:20 AM.)

23 THE COURT: Plaintiff ready?

24 MR. MCGOWAN: Yes, sir, Your Honor.

25 THE COURT: Defense ready?

1 MR. KING: Yes, sir.

2 THE COURT: All right. Bring in the jury.

3 (JURY REENTERS COURTROOM AT 11:23 AM.)

4 THE COURT: Call your first witness.

5 MR. KING: Yes, sir.

6 The Defense calls Dr. Alex Espinal.

7 THE COURT: Come up and be sworn.

8 MADAME CLERK: Doctor Espinal, place your left hand on
9 the Bible, and raise your right.

10 (WHEREUPON: DOCTOR ALEX ESPINAL,
11 BEING FIRST CALLED AND DULY SWORN, TESTIFIED AS FOLLOWS:)

12 DIRECT EXAMINATION

13 DOCTOR ALEX ESPINAL BY MR. KING:

14 Q. Dr. Espinal, you are the Defendant in this case, are
15 you not, sir?

16 A. Yes, sir.

17 Q. And what is the name of your medical group?

18 A. Palmetto Surgery, LLC.

19 Q. And where is it located?

20 A. We're located in Rock Hill.

21 Q. And what address?

22 A. 1578-01 Constitution Boulevard.

23 MR. KING: Madame Court Reporter, do you have any
24 trouble hearing him?

25 MADAME COURT REPORTER: No, sir.

1 MR. KING: Okay.

2 Q. What other physicians are in that group?

3 A. I have one other partner Dr. Kamran Borhanian.

4 Q. And you practice general surgery?

5 A. Yes, that's correct.

6 Q. And do you live in Rock Hill?

7 A. Yes, I do.

8 Q. You have a family?

9 A. Yes, I do.

10 Q. Is this your wife in the courtroom?

11 A. Yes, it is.

12 Q. And would you point out which one of the ladies she
13 is.

14 A. The orange sweater.

15 Q. And her name?

16 A. Lisa.

17 Q. And how long have you and Lisa been married?

18 A. Fourteen years.

19 Q. How long have you been practicing medicine?

20 A. Ten, eleven years now.

21 Q. How long of that practice has been in Rock Hill?

22 A. Approximately eight or nine of those.

23 Q. And tell the jury about your education and medical
24 training.

25 A. I grew up in Ohio, so I went to undergraduate college

1 at University of Akron. And then I did my medical degree
2 at Northeast Ohio University College of Medicine, it's a
3 six-year -- it's called a BS MD program as opposed to a
4 traditional four years of college and four years of medical
5 school. It's an accelerated program that you do it all in
6 six years and it goes to eight. So, I did that so I could
7 be -- wouldn't be in my mid-thirties when I got out of
8 schooling. So after that, I went to my residency for five
9 years at Akron City Hospital. Now it's called Summa Health
10 Care System. After those five years, I went into practice.

11 Q. And is the five years all in general surgery?

12 A. Yes.

13 Q. And so you finished that, when?

14 A. The residency?

15 Q. Yes.

16 A. In '99.

17 Q. And when did you come to Rock Hill?

18 A. I moved to Chester first and practiced there for two
19 or three years, and then I moved to Rock Hill after that.

20 Q. So when did you start your practice in Rock Hill.

21 A. I guess that would be about 2003, 2002.

22 Q. And are you licensed by the state of South Carolina?

23 A. Yes.

24 Q. Any other states that you're currently licensed in?

25 A. I have a North Carolina license as well.

1 Q. You cross the state line to see some patients?

2 A. People are aware of the whole hospital situation, the
3 fight for the hospital in Fort Mill. Most doctors carry,
4 we call it mini privileges, where it's the primary place
5 that we work, but not knowing who's going to get this
6 hospital built, you want to make sure that you have
7 somewhere to work if all of the sudden tomorrow Piedmont
8 doesn't exist. So I also have privileges that can be
9 quickly moved over to be able to operate in CMC and
10 Presbyterian so I carry a North Carolina license for that
11 reason. But I don't do any surgeries there now electively.

12 Q. And so the privileges you have, admitting privileges,
13 and primarily the hospital you work out of, is Piedmont
14 Hospital?

15 A. Correct.

16 Q. How do you divide your day between patients in the
17 office and patients in the hospital?

18 A. A typical day for most general surgeons involves
19 operations. I like to do them in the morning because most
20 of my patients are -- can't eat after midnight prior to the
21 day of surgery, and starting a case at noon, of course,
22 leaves the person starving to death by the time you do the
23 operation. So we like to do the cases in the morning, and
24 then usually I see patients in the afternoon. That's the
25 usual flow.

1 A couple of days of the week, I see patients in the
2 office all day, and then one other day I see -- I operate
3 all day.

4 Q. When do you round? When do you see patients in the
5 hospital other than in surgery?

6 A. I usually see them in the morning. That's when most
7 doctors make their rounds. I usually see them in between
8 surgeries. It depends on how many patients I have in the
9 hospital. I'll see them after surgeries, before I go to
10 the office usually. And if there are any other pressing
11 issues, then I have to go see post-operative patients after
12 an operation as you come back in the evening and you do
13 that at that time.

14 Q. Doctor, there's been terminology used in this trial
15 and in medical negligence cases called "board
16 certification."

17 A. Yes, sir.

18 Q. What is board certification?

19 A. Board certification is a designation given by American
20 Board of Surgery that states that you have passed certain
21 requirements. You've done "x" amount of cases in your
22 training to be fully qualified to do general surgery. I
23 mean you take an oral and a written test, and then you
24 become board certified.

25 Q. And you're mentioning only the surgical board.

- 1 A. Yes.
- 2 Q. Is there -- Are there boards for other medical
3 specialists ---
- 4 A. Yes.
- 5 Q. --- that apply that same way.
- 6 A. Yes.
- 7 Q. In other words, board --
- 8 A. Internal medicine. There can be infectious disease,
9 orthopedics. There's other boards.
- 10 Q. And your board certification has been in general
11 surgery?
- 12 A. Yes.
- 13 Q. And when were you board certified in general surgery?
- 14 A. Straight out from residency. So that was about 2001.
- 15 Q. And does that, in the case of general surgeons, does
16 that board need to be retaken ---
- 17 A. Yes.
- 18 Q. --- periodically? How often?
- 19 A. You take it every ten years.
- 20 Q. And as of today, August 1st, 2011, are you board
21 certified?
- 22 A. No.
- 23 Q. When do you cease being board certified?
- 24 A. Yesterday.
- 25 Q. And tell us how that applies.

1 A. That applies by the fact that, as I mentioned, the
2 board certification, re-certification, you have to do every
3 ten years. So January of this year, which was my tenth
4 year, I called -- After my tenth year, I called the Board
5 of Surgery and they admitted that they'd been sending my
6 information to the wrong address. So I said, "Well, no
7 problem," it's January, I -- my board certification runs
8 out July 31st. So I'll just take the test. They only give
9 the test in December or November. So by default, I have to
10 wait until November. I have no other option.

11 Q. Okay.

12 A. And so I have everything ready to go, I just have to
13 sit down and do the -- well I can't do that until November
14 because that's when the test is only given.

15 Q. And in March 2007, when this incident occurred, were
16 you board certified in general surgery?

17 A. Yes, because this was in the first ten years.

18 Q. And you have discussed this with Piedmont Hospital?

19 A. Yes.

20 Q. Now, Mr. Sexton was referred to you by a
21 gastrointestinal group?

22 A. Yes.

23 Q. Any particular physician?

24 A. Dr. Richardson.

25 Q. Doctor, this is -- You have what we've marked as the

1 exhibit notebook which are some of the records that have
2 been generated. You have that notebook up there in front
3 of you?

4 A. Yes.

5 Q. If you wish to refer to anything in there, you can do
6 so. We would ask -- the jury also has copies of that
7 notebook -- if you are going to a record, would you tell
8 the jury where you are, so they can find it in the
9 notebook?

10 A. Sure.

11 Q. And for what reason was Mr. Sexton sent to you?

12 A. Because he had a un-colonoscopically unresectable
13 polyp or a polyp that couldn't be removed non-invasively
14 with a colonoscope or colonoscopy.

15 Q. And what is a polyp?

16 A. A polyp is a growth of abnormal tissue that doesn't
17 belong in the body that is very common especially in the
18 colon. You can get it in other places of the intestinal
19 tract, but the colon is the most common place. And there
20 are various types of polyps. And we remove them so that
21 they don't become cancer.

22 Q. Doctor, we have a medical illustration of a colon.
23 Would you come down -- Doctor is this okay? Is this going
24 to bother you?

25 A. Yes.

1 THE COURT: Just try to make sure he's not in a
2 position where he won't block the jury's view in what he's
3 trying to show them.

4 MR. KING: Okay. All right.

5 Q. Doctor, does this appear to be to you an illustration
6 of a colon?

7 A. Yes, it is.

8 Q. And size-wise, is it larger than life?

9 A. A bit. Yeah, as I'm standing here now, this has to be
10 -- like if you approach -- If you're looking at my body
11 here. I guess the best way to describe this is if we could
12 make an incision here, open up. The colon begins on the
13 right side, of course, there's substantive material from
14 the small intestine which is liquid, foods that we've eaten
15 it empties into the colon. And this is the appendix down
16 here, I think, on the right side. And then the colon
17 processes the material as it comes up the right colon. So
18 again, this is on my right side --

19 MADAME COURT REPORTER: Just a minute, Doc.

20 Mr. King, that mic will come off. Pull the mic off
21 the stand, Mr. King.

22 MR. KING: Pull the mic?

23 MADAME COURT REPORTER: The whole mic. There you go,
24 Doc, pull it. There you go. Thank you. He was trying to
25 get that from you, Doc.

1 A. And then as I was mentioning, the liquid still comes
2 into the right colon, also called the ascending colon. It
3 comes across the transfers colon, and then the descending
4 or left colon. Sigmoid colon is the very end. That's the
5 place where a lot of people here about problems like
6 diverticulosis and diverticulitis, they are conditions that
7 can cause abdominal pain. And then of course, down to the
8 rectum and at the bottom.

9 Q. And the yellow color in the middle of that
10 illustration, I see the word "mesentery"?

11 A. Correct.

12 Q. What is mesentery?

13 A. Mesentery again is this yellow material here. This is
14 a two-dimensional picture, so I'm going to try to explain
15 to you how it looks really in three-dimensional. But the
16 mesentery is, I think of it that like a curtain -- like a
17 curtain off a window, and it contains blood vessels. What
18 I mean by that is the top of the curtain rod or the
19 curtain's hanging from is the actual colon here.

20 And then the curtain hangs off here with all the blood
21 supply into it, which eventually goes into the aorta.
22 Remember the aorta, which is the main artery in the body.
23 Again, if we go back to this opening, moving everything
24 aside, the aorta would be on the spine. And so the blood
25 vessels come out of that, and into this part of the colon.

1 So when you -- If you have a patient -- a patient
2 laying here, and you can pick up the colon, its still
3 connected to this curtain. You can move the colon around
4 like this. You can take the transverse colon. And this is
5 what they're trying to show in this picture. This --
6 They've flapped up this way so you can see it, but in
7 reality, this is usually down here. You can see they were
8 trying to draw a little shadow there to show that it's
9 flipped up. So the mesentery supplies the blood flow to
10 the colon.

11 It also contains the lymph nodes. The same thing as
12 you get a sore on your neck when you get a throat or a
13 virus, those little things that swell up we have them all
14 over our body. And they are interspersed throughout the
15 mesentery.

16 And they lay close to these blood vessels, and they're
17 little filters. Filters that accept any fluid that's
18 absorbed from usually the colon. There's also mesentery
19 that goes in the small intestine, which isn't shown in this
20 picture, but it filters that fluid. So if you have cancer
21 and the cancer cells start to spread, the first place they
22 will go to before they get to the blood stream is passing
23 through those filters first. And when we take out a
24 cancer, for example, we take out a lot of the mesentery
25 because we want a sampling of those lymph nodes because the

1 lymph nodes are what dictate whether the patient has more
2 advanced cancer. So, the mesentery is very important on a
3 resection if you believe there is cancer there.

4 Q. I see red, and it appears to me to be blood vessels?

5 A. Yes.

6 Q. Correct?

7 A. Yes.

8 Q. And they are feeding throughout the mesentery, and
9 they are different sizes. Is that -- Is that --

10 A. That -- That's right. These are arteries, which are
11 carrying blood away from the heart and the aorta to the
12 intestine or to the colon.

13 Q. And the aorta is in the middle there, and that is the
14 major --

15 A. Comes right off the heart, yes.

16 Q. And then there are smaller arteries that are actually
17 -- appear to go to the mesentery?

18 A. Yes.

19 Q. And does the mesentery and the arteries in the
20 mesentery feed blood to the colon?

21 A. Yes, that's correct.

22 Q. And polyps develop in the colon?

23 A. Yes.

24 Q. And for what reason?

25 A. Well, the cellular characteristics of the colon are

1 such that the -- just like your skin regenerates and we
2 sluff skin, and dandruff, and things of that nature, the
3 colon does the same sort of process riding itself of old,
4 used cells and puts new ones in place. And in that process
5 when there is a -- any organ that makes lots of -- it
6 divides very quickly, if something goes wrong in the
7 division of the cells, something goes haywire -- I don't
8 understand why we get polyps, but if that happens then it
9 starts to grow a little blob, called a blob but its
10 different kinds of abnormal tissue cells all grouped into
11 one.

12 Q. And do polyps need to be removed?

13 A. Yes, because the same process that caused the normal
14 cell division that go haywire and make this blob could
15 proceed into becoming a cancer.

16 Q. Other than becoming cancerous, can a polyp cause
17 problems to the patient?

18 A. Absolutely. If you think of it, what it would look
19 like in here, depending on the size of the polyp, if a
20 patient had a polyp the size of a golf ball, the polyp
21 could get in the way of the bowel movements coming through.
22 And specifically, if you think about what I said earlier
23 that the liquid stool in here, it's liquid at this point,
24 absorbs fluid, and then we get the hard bowel movemens down
25 here. So a polyp on the right colon is very different from

1 the polyp on the left because this one on the right will
2 become symptomatic much later than the one on the left.
3 Because here is a hard bowel movement, so if you try to
4 push a bowel movement, you know, in a fixed-sized tube. If
5 this is like a clog in a pipe, I'm calling -- the polyp
6 would be the clog, and the colon is the pipe because the
7 pipe is round, the colon is round. And the stool is trying
8 to get through it, it would have a hard time getting past
9 that polyp. So if you let a polyp grow large enough,
10 eventually it can cause a blockage. Or as the bowel
11 movement rubs it when it goes by, it could cause bleeding.
12 And the reason it is different on this side where it's
13 liquid, you have to wait for a polyp to get really big and
14 nasty, and really enclosed, and really squeezing its way
15 into the rest of the colon before it becomes symptomatic
16 because liquid can go through a little pinhole.

17 So that's why when we detect right-side polyps,
18 they're actually a little bit more dangerous leaving those
19 because patients don't have symptoms. And then when you
20 hear people say, "Yeah, I went to the doctor and also had
21 colon cancer, and I didn't have any symptoms." Every day I
22 see patients that have that, and they don't believe that
23 they have colon cancer because they hadn't had any
24 symptoms. That's very typical of a right-sided polyp,
25 which becomes a cancer.

1 Q. So the fact that I'm walking around and am not
2 bleeding.

3 A. Means nothing.

4 Q. And have no abdominal pain?

5 A. That's right. That means nothing, and you can still
6 harbor a cancer or a polyp. And that's why at age fifty,
7 depending on risks and stuff like that, we usually start to
8 recommend colonoscopies.

9 Q. And how big is the colon? Most, most of us.

10 A. About, what a meter long?

11 Q. Right. And how wide is the colon?

12 A. It's a distensible, like a balloon I guess you could
13 say. If there's stuff in it it can get larger. I've seen
14 colons get about this large before. And then most of the
15 colons that are normal, most of us without doing anything,
16 or having a procedure or anything like that, are about this
17 big around.

18 (THE WITNESS INDICATED.)

19 Q. And the procedure that was done on Mr. Sexton by
20 Digestive Disease Associates, before your involvement, was
21 a colonoscopy?

22 A. Yes.

23 Q. And that procedure has advanced over the last years
24 where the physician can actually go from the rectum all the
25 way around to the ascending side?

1 A. That's correct. It used to be invogued to do what we
2 call flexible sigmoidoscopy, which was a lessor procedure
3 when you go about this far with the camera. And then, you
4 would miss a good third of the colon. So some people would
5 do that. It would have to be done more frequently. Then
6 there was barium enemas that used to be done, which was
7 very uncomfortable. So they would with the technology
8 being what it is today a colonoscopy is really the way to
9 go.

10 Q. And also the digestive disease physicians have
11 advanced their skills to where they can remove, at the same
12 time they do this procedure, without having to put it off
13 and bring a patient back again. They can remove certain of
14 those polyps?

15 A. That's correct, right.

16 Q. And what polyps are they able to remove?

17 A. The polyps that they feel can be removed adequately.
18 What I mean by that is -- It would probably be better if I
19 described -- I think earlier I think someone used -- or
20 yesterday it was -- mushroom as a good descriptor. It has
21 a little stem on the bottom. It comes off the wall of the
22 colon, so within this colon, if we picture a tube, a polyp
23 -- a mushroom growing out of the colon wall would look just
24 like a mushroom. So when they go in there they have a
25 little lasso, but it's a little metal instrument. It looks

1 like a lasso. And they lasso the mushroom, put it down to
2 the base, they cinch the lasso closed, and they get a
3 little burst of cautery which is electricity, and it sort
4 of burns the base of it because if you just ripped the base
5 of it off it would just bleed and bleed and bleed. So they
6 use a little bit of cautery, but there's an art to it,
7 because if you just burn the living day light out of it you
8 can burn a hole in the colon. And that's particularly
9 concerning for right-sided lesions because the thickness of
10 this colon on this side -- Remember over here, it's got the
11 hard stool, so that the muscles are real hearty. Over here
12 the muscles are paper, paper thin. You can almost see the
13 stool through the colon in some patients. So it's really
14 thin.

15 So if you can imagine, if I have a tree growing out of
16 the ground here with the tree being the polyp, I'm going to
17 chop down the tree right about here. If I try to go to the
18 floor, it's very dangerous because I could chop into the
19 floor.

20 So two important things about polyps are the location,
21 and then the other thing is the type of polyp, which in
22 this case we're talking about what was called a sessile
23 polyp, which it was like a carpet on the ground as opposed
24 to a mushroom or a tree. If we try to take this carpet off
25 by chopping away at it, and we can't hit the hard wood or

1 whatever we have underneath the ground here, it's very
2 dangerous if you -- if you don't want to get into the --
3 and -- and -- and damage the ground.

4 So what they'll typically do is try to biopsy it, and
5 if it's a bigger polyp, you can't just take 5000 biopsies.
6 Because you take this biopsy grasper it takes literally
7 about a millimeter of tissue so that's a tip of a pen. And
8 this -- A polyp can be whatever -- depending on the size,
9 the polyp size can be anything. So you would literally
10 probably have to take about fifty or sixty bites, each one
11 being dangerously close to ripping a hole in the colon.
12 And that's why they don't just proceed with that -- the
13 surgeon.

14 Q. So the biopsy doesn't tell the physician or patient
15 whether or not you have cancer.

16 A. It tells the patient that, that piece that they
17 removed, whether it has or does not have cancer. But it
18 does not rule out whether there's cancer in the rest of
19 that polyp. All you know at that time is that there is a
20 growth in the colon, and the growth could have cancer, but
21 if it doesn't have cancer, it may have the capability of
22 forming into cancer.

23 Q. And what other portions of the anatomy are continuous
24 to the colon?

25 A. What do you mean? Can you rephrase that?

1 Q. Where is the abdomen in relation to --

2 A. Oh. The abdomen -- And this is in the abdominal
3 cavity. So again going back to the three dimensions, the
4 patient's skin, and muscles, and all of that would come up
5 like this and into the paper. So this would be contained
6 within the abdominal cavity.

7 Q. And so if you have a leak for whatever reason, a
8 perforation. If you were talking about the biopsy and
9 perforation or a surgical leak, where does the colon
10 content leak go if it leaks out of the colon?

11 A. It would be contained in the abdominal cavity.

12 Q. And is that dangerous to the patient?

13 A. Deadly.

14 Q. All right, because why?

15 A. Bacteria; stool, which is the highest concentration of
16 bacteria of any -- anything in the body could leak out into
17 an area where it's not supposed to be, where it's not
18 confined and the body has trouble fighting off that
19 infection.

20 Q. Go back and take a seat if you would. Can I have the
21 mic back, Doctor.

22 (THE WITNESS RETURNED THE MIC AND RETURNED TO WITNESS
23 STAND.)

24 MR. KING: Thank you.

25 Q. Doctor, looking at the exhibit notebook that's in

1 front of you, can you find your records?

2 A. Tab 1.

3 Q. So, if I'm looking on Tab 1, the first page numbered,
4 I see is Palmetto Surgery-002.

5 A. Yes, sir.

6 Q. Let me ask you to look back at Tab 33. That also has
7 a Palmetto Surgery printed name on the top and that appears
8 to be a three-page document?

9 A. Yes.

10 Q. Now who fills that out, the three-page document?

11 A. The patient or their family member.

12 Q. And what is the purpose of asking the patient to fill
13 this out?

14 A. Demographics, where they live, their phone number in
15 case we've got to get a hold of them. There's questions
16 about insurance on there. There's issues that pertain to
17 medications, the patient's medical history, the purpose of
18 their visit, and any other family medical history there is,
19 allergies to medications, prior surgeries that they had in
20 their life.

21 Q. And health hazards? I see tobacco and alcohol use on
22 page 2?

23 A. Yes.

24 Q. And how is that significant to you, the physician?

25 A. This paper is important because it can key us in on

1 certain factors that we may want to ask more questions
2 about.

3 For example, a person that's going to be taken to
4 general surgery is on anti-reflux medicine, Nexium for
5 example here, an anesthesiologist wants to know that
6 because it's important. Those patients have a higher
7 propensity of -- of -- of aspirating when they're put to
8 sleep. So they'll usually give them something to get to
9 take care of the acid in the morning so that the surgery
10 and or the anesthesia will go well. So that's just one
11 example of why we take this information. If a patient says
12 there's something specific, they have a bleeding
13 abnormality, well, I'd like to know that before I take them
14 to surgery because -- or ask them more about that. So
15 that's why we have this form.

16 Q. So on the third page has to do with past medical
17 history, family medical history, and asks about allergies.
18 Correct?

19 A. Correct.

20 Q. And the second page asks about purpose of the visit,
21 other physicians that treat you, medications you're taking.
22 And then it has the question about tobacco and alcohol use.

23 A. Yes.

24 Q. And what did Mr. Sexton put down about tobacco and
25 alcohol use?

1 A. Nothing.

2 Q. Now let's go back to the Tab 1 and your History &
3 Physical. Is that sometimes short, Doctor, in your
4 vernacular to HMP?

5 A. Yes.

6 Q. How long does it take you to do -- to take a history
7 and do an examination -- specifically -- Let me withdraw
8 that question and ask you again. How long did it take you
9 to do -- take the history and do the examination in this
10 case with Mr. Sexton?

11 A. I would say unusually long.

12 Q. Can you put parameters on that, in minutes, hours,
13 what?

14 A. It would be hard to say. I can't recall the exact
15 timing of it, but I will venture to guess to say somewhere
16 around thirty minutes.

17 Q. And tell me how the history and physical proceeds.

18 A. Do you want it in this particular situation?

19 Q. Yes, yes, sir.

20 A. Well the patient comes in initially with these intake
21 forms. And I proceed to discuss with them and find out the
22 reason why they understand they've come to see me to make
23 sure it coincides with what I'm understanding they're
24 coming for. And then I proceed to take a history to find
25 out what's been going on with the particular problem

1 they're coming to see me. And then I go through their --
2 the -- the rest of the -- the rest of the information, like
3 that's on the intake form, the medical histories, and
4 things of that nature to find out if there are any other
5 issues pertinent to the patient. Then a physical
6 examination is performed, and then I make my assessment,
7 and then discuss the plan with the patient.

8 Q. You do not rely just on the intake form?

9 A. No.

10 Q. You ask questions of the patient?

11 A. Yes.

12 Q. Do you -- Are you dependent upon the accuracy of the
13 patient both honesty and how good a historian he is as to
14 what he tells you?

15 A. Yes.

16 Q. If he doesn't tell you about a procedure, how do you
17 know about it?

18 A. I may not.

19 Q. Did you question Mr. Sexton about smoking?

20 A. Yes.

21 Q. And what did he tell you there?

22 A. None.

23 Q. The procedure in this case is a laparoscopic
24 colectomy. Correct?

25 A. Laparoscopic colectomy. Right colectomy, yes.

1 Q. And "laparoscopic" means small incision as opposed to
2 an open procedure?

3 A. Yeah, as technology has gone forward, a majority of
4 colectomies are still done open in the United States. And
5 what that means is just like I showed you earlier, it's a
6 big incision that goes down the middle. And we use
7 retractors and what not to get room to get the hands in
8 there and do the work. And then after the operation the
9 patients are without a doubt, much more uncomfortable
10 because of a large incision. It takes more time to heal.
11 It's more of a stress on the body, and it's more dangerous.

12 And now there's more and more studies coming out of
13 the benefits of laparoscopy. And laparoscopy takes the
14 same operation, but it's the access which is different. I
15 tell my patients, it's sort of like fooling the body as to
16 what we've done because we go in through band-aid sized
17 incisions, put a camera through the belly button, and then
18 two or three other little holes about a centimeter or two,
19 less than an inch in size. And instead of putting hands
20 inside, what happens is the patient lays on a table and
21 with the camera, we're actually able to watch on a
22 television screen. So if I could sort of mimic how it
23 works. We -- I stand like this. The patient would be
24 here. And I work with my hands like this and watch on a TV
25 screen what I'm doing from the camera that's inside the

1 patient.

2 Q. And --

3 A. And the benefits of that are of course three little
4 incisions which are much more tolerable and less painful.
5 And with that, you have less wound infections, less chances
6 of abdominal hernias. There is less chances of blood clot
7 formation, and quicker back to work, and all those
8 benefits.

9 Q. And is the laparoscopic procedure less invasive?

10 A. Yes.

11 Q. Now, did Mr. Sexton understand this procedure and why
12 this procedure was being done?

13 A. And that -- that's the primary reason why it took an
14 inordinate amount of time is my trying to explain to him so
15 that he could fully understand and fully consent to what
16 was going on the nature of the surgery.

17 When a person is told they have something -- a growth
18 in their colon, or a spot on the lung, we all just jump to
19 cancer. So when a person comes to see me, they think if
20 there's any possibility of cancer in their mind, they're
21 thinking, "I may have cancer" so they're very anxious about
22 the whole visit.

23 So, could you re-ask the question?

24 Q. The question I was asking you is did Mr. Sexton
25 understand ---

1 A. Okay.

2 Q. --- why he was having the procedure and what procedure
3 was the purpose of it?

4 A. Well to go on, then. He understood at the end by the
5 time I got done. He couldn't quite understand the
6 reasoning behind why -- a couple of things. "Why do I have
7 to have surgery?" Because I wanted him to feel
8 comfortable, so I assured him, there's no sign you have
9 cancer as we're sitting here. The biopsy was done. It
10 doesn't show cancer. But there's a possibility because the
11 biopsy is one piece, one tiny little piece of this growth,
12 that there could be cancer in the rest of that polyp. If
13 there's not cancer in that polyp, it still has to be
14 removed because it could become a cancer.

15 So for two reasons it has to be removed because there
16 may be a cancer hiding in it, or it could develop into a
17 cancer. And he had trouble understanding that.

18 So I used the analogy because I knew he was a pipe
19 fitter, plumbing. And I use that with my patients because
20 most people understand plumbing. I said, "We need to go
21 in, remove a piece of the piping, sauter it back together,
22 or however the pipe -- plumbers do it, but we use sutures,
23 and then you turn the water back on and look for a leak."
24 Well when we talk about turning the water on in piping,
25 it's a little bit different in the colon. Basically we

1 start feeding the patient and produce bowel movement. And
2 that's how we turn on the water to check and see if there's
3 anything -- any problem with -- with -- with the integrity
4 of the connection. Because if anywhere you're going to
5 have a problem in a colon, just like a piece of piping,
6 it's going to be where you just did the work. It's not
7 going to break in the middle of the pipe, it's probably
8 going to leak somewhere where you've done some kind of work
9 or there's a joint.

10 Q. So the analogy to what he did work-wise helped Mr.
11 Sexton understand what it is that you were going to do
12 surgically?

13 A. It helped.

14 Q. And did you discuss with Mr. Sexton -- I believe his
15 wife was there present?

16 A. Yes.

17 Q. Did you discuss with them the risk and complications
18 that comes with this procedure?

19 A. Yes.

20 Q. And are those mentioned on your forms, on this initial
21 visit?

22 A. Some of them are, yes.

23 Q. Can you point us to where they are?

24 A. This would be Palmetto Surgery-003 at the bottom.

25 Q. Okay. And could you go through those, those that are

1 listed -- what -- Could you elaborate to the jury and
2 explain to them what those type -- what are those
3 complications in laymen's language?

4 A. These were among the complications discussed, so it
5 included these. But there were other ones that come out in
6 my operative note that aren't in here. But I try to kind
7 of get a general highlight of the things that I've talked
8 about in the office in my history and physical, and talk to
9 him about just reading this aloud. An anastomotic leak,
10 which is what occurred in this particular case. Colostomy,
11 which means a bag, could end up needing a bag. Conversions
12 with an open procedure since I was planning on doing little
13 incisions. If you get in there, and you cannot do the
14 operation safely, you cannot do the operation comfortably,
15 you get into bleeding, or for whatever reason, you can't do
16 it with your hands this far away from the actual specimen,
17 then you have to open the patient. Sort of like tying your
18 shoes, we all do it real easy, but if you took the tongs
19 off your grill that you kind of would move food around and
20 try to tie your shoes with it, that's laparoscopy. It's
21 real clumsy if you don't know what you're doing. It's very
22 much more difficult than the natural way of doing it. So
23 sometimes you have to convert to an older procedure and get
24 your hands in there, and do it the old-fashion way. So
25 that's what that entails.

1 Infection, we really with any surgery, but
2 particularly with colon surgery since it's an organ full of
3 stool, there's a higher rate of infection. Bleeding, we
4 just saw the blood vessels that can cause problems with
5 colon surgery. That's always an issue. DVT is blood clots
6 that can form even though it has nothing to do directly
7 with what we do in the abdomen. Patients afterwards
8 because of the trauma that's exerted to the body have a
9 higher predisposition, I guess you could call it, or chance
10 of forming blood clots. And that's just simply from post-
11 operative patient laying completely still because they're
12 in pain, which most patients are, and if they don't get up
13 and move around, they can form blood clots. And that's
14 another reason I do laparoscopy, because the patients are
15 out much quicker, they're not having as much pain, plus
16 they don't get as much narcotics so they're not as drugged
17 up. And then bowel obstruction, there's always a
18 possibility from where we put the plumbing back together,
19 they could narrow down with time. And lieus is a condition
20 whenever we operate on a patient, that's always a
21 possibility. Lieus is a temporary, functional paralysis to
22 the colon. The colon repels stuff around the perimeter of
23 the picture that you see there. An lieus means that all
24 the intestine, all of a sudden for whatever reason
25 irritated, shuts down and doesn't flow or pass its contents

1 forward. So when you go into surgery as a surgeon, if you
2 take a piece of intestine and do this to it and poke it,
3 it's squirms. It doesn't like it. I always say that
4 intestines are very finicky. And the reason that, that
5 occurs is because they don't like being messed with. If
6 you go in there and start cutting things and handling
7 things, the chance of getting an lieus goes up. And that
8 just means that everything is stagnant. So that means
9 there's a possibility that the normal stuff that we pass
10 through our intestine, stomach acid, bile, or things that
11 we eat goes forward. And these patients that are getting
12 lieus; it stays in the intestine, in the stomach really
13 because it doesn't go any further because nothing's
14 propelling and then the belly gets extended. And once the
15 belly gets extended, it causes pain and prolonged
16 hospitalization.

17 Q. And did Mr. and Ms. Sexton have any questions about
18 complications?

19 A. No.

20 Q. Now looking at Tab 28. Excuse me, Tab 29, I'm sorry.
21 There are two Informed Consent forms. Are these forms
22 generated by Piedmont Hospital?

23 A. Yes.

24 Q. And actually the second one is the one that was done
25 for this procedure; is that correct?

1 A. The second one in the book, yes.

2 Q. I'm looking at PMC --

3 A. 1-3-8-1.

4 Q. And 1-3-8-2.

5 A. Yes.

6 Q. And that is -- Was that done in a pre-op the day
7 before the procedure?

8 A. Yes.

9 Q. That's not done by your nursing staff?

10 A. This may have been done by my nursing staff.

11 Q. And it had been done at Piedmont or at your office?

12 A. Probably -- I -- I don't know. I signed it, which is
13 my signature at the end, on the 7th.

14 Q. That's the day of surgery.

15 A. Mr. Sexton signed it on the 6th, the day before
16 surgery.

17 Q. Right.

18 A. Which probably was when he picked up his orders at my
19 office which is in the usual way that it works.

20 Q. Now, then on the morning of -- You would not have seen
21 him on the 6th?

22 A. I may not have. Correct.

23 Q. And on the morning of the 7th, you met with Mr. Sexton
24 at Piedmont Hospital?

25 A. Yes.

1 Q. Correct? And tell us about that meeting. Where was
2 he? Tell us what transpired.

3 A. Well his preoperative assessment prior to going to
4 surgery by the anesthesia, by nursing, was done that
5 morning. And so that's before I arrived. At the time when
6 I come in, my typical routine is to come in to see the
7 patient, talk to the nurse that's caring for the patient,
8 the anesthesiologist before taking them back to surgery.
9 The purpose of seeing the patient is to make sure that if I
10 have any questions. Often times family members come at
11 that point that weren't in the office, and oftentimes they
12 have questions. So we like to answer any questions they
13 may have and address any other issues that may have changed
14 in the condition of the patient between the time that I
15 originally saw the patient and the day of surgery.

16 Q. Now there was some questions about updating the H&P.
17 Do you do a complete examination -- re-examination at this
18 point?

19 A. No.

20 Q. All right. Do you update?

21 A. Yes, sir.

22 Q. And define what is "update"?

23 A. The update states -- it says it on the form, it tells
24 that the history and physical that you did in your office
25 is reflective of what you are observing on the patient the

1 day that you come in. Basically what it boils down to is
2 you come in and talk to the patient. "Have you had any
3 problems? Has anything changed in your health since I last
4 saw you in the office?" Because some people will have
5 issues that -- Sometimes we don't do the surgery for twenty
6 days. If it's greater than thirty days you have to redo
7 the whole physical examination. We have them come up to
8 the office. But it's well within the, what we call, JACO
9 or Hospital Accreditation Group that you can do this update
10 just before the operation, and that clears the patient for
11 surgery.

12 Q. Was that done in this case?

13 A. An update was done.

14 Q. Now there is an issue about the flu. You heard
15 testimony that --

16 A. In his testimony I have, yes.

17 Q. Did you know anything about the flu the morning of the
18 7th?

19 A. I did not.

20 Q. And there has been testimony about low oxygen
21 saturations that morning. Tell the jury what you knew
22 about oxygen saturations that morning.

23 A. Correct. I believe earlier that the conversation was
24 regarding eighty-five percent oxygen saturation, that I
25 didn't have knowledge of. What I had knowledge of on the

1 day of the procedure as I come in to see the patient, I see
2 he has two liters of oxygen, which is a nasal cannula. If
3 you've seen people that drive around, someone that has home
4 oxygen, that is when they have a little tubing that goes
5 right under the nose. And he had two liter nasal cannula
6 oxygen flowing. And his oxygen saturation as I walked in
7 the room, there's a monitor right there, it was ninety-two
8 percent.

9 Q. Let me ask you. Put Mr. Sexton for the jury, where is
10 he? Is he in pre-op? Or is he in --

11 A. Yes. No, he's not in the operating room. I
12 apologize. And let me give you a little scenario on how it
13 works. The preoperative area is a series of two hallways
14 with a bunch of rooms for patients, and there's a central
15 area where the nurses' station is located. So what we
16 typically do, we come in, we have the chart. A lot of this
17 information that you've seen put up on the overheads, I
18 can't read it either. I can't tell what -- who's written
19 what. I prefer to speak to people than to delve through a
20 thing like this. So what I typically do is I talk to the
21 anesthesiologist and the nurse that's admitting the patient
22 or bringing the patient in for the preoperative care. "Are
23 there any issues going on that I need to know about?" And
24 they say, "Yes, there are issues," "No there's not issues."
25 In this case, he's doing fine. We had put him on oxygen.

1 I turned to Dr. -- my anesthesiologist at that point and
2 know that from her standpoint, she's fine. She did an X-
3 ray. She cleared the X-ray. And so I'm satisfied at that
4 point, and the anesthesiologist has listened to the
5 patient's lungs that morning. So the fact that the nurse,
6 diminished breath sounds, although she said they were clear
7 they were diminished, I trust my anesthesiologist who
8 listens to lungs all day long to trump, if you will, the
9 nurse's findings. So I don't -- So to get back to what I
10 was saying was I come in the room, he's laying there, he
11 has a ninety-two percent saturation. That's perfect for me
12 to take him to surgery.

13 Q. You didn't see eighty-five percent?

14 A. I did not see eighty-five percent because he was
15 already on oxygen. It was ninety-two percent.

16 Q. And what is -- What is the significance of ninety-two
17 percent to you the surgeon if you've got a patient with the
18 two liters, he's got ninety-two percent oxygen?

19 A. Not a problem because we actually have a standing
20 order at the hospital that, that respiratory therapist will
21 automatically take off oxygen if someone's oxygen level is
22 greater than ninety-two percent, which his was ninety-two
23 percent. So you could make an argument two liters we
24 knocked it down to one. Two is really where people start
25 when you put them on. We don't put people on one liter.

1 So we just left him on two liters because anesthesia,
2 before they put you to sleep, like to build up as much
3 oxygen as they can for the procedure. So they only -- They
4 often have us put them on oxygen regardless.

5 Q. Now there's been testimony that this procedure -- that
6 the Sextons were told that this procedure had been
7 canceled. First off, do you know anything about this
8 surgery being canceled?

9 A. No, I do not.

10 Q. Have you gone through the medical records that have
11 been produced in connection with this case?

12 A. I have gone through the medical records.

13 Q. Is there anything in those records that you have seen
14 about the procedure being canceled by anybody?

15 A. No.

16 Q. Who has the authority to cancel a surgery?

17 A. The surgeon or the anesthesiologist.

18 Q. You said "or."

19 A. Yes.

20 Q. Is that -- Is "or" correct?

21 A. Both of us have that ability I guess I should say
22 "and." Either/or.

23 Q. So it doesn't have to be a joint decision?

24 A. No. Either one can cancel the operation.

25 Q. And the anesthesiologist -- What is the

1 anesthesiologist function or concern versus the function
2 and the concern of the surgeon?

3 A. The anesthesiologist, of course the concern is to make
4 sure that the patient is fit to undergo general anesthesia
5 or being put to sleep. That entails being put all the way
6 asleep on a breathing tube where a machine's breathing for
7 you. And they assess the patient in that regard to make
8 sure they can make it through the surgery, and that
9 afterwards they will be okay. They will be reasonably able
10 to breathe on their own and that sort of thing. Or if they
11 deem that the patient's going to need oxygenation
12 afterwards or be left on a ventilator, they make that
13 assessment.

14 Q. What are you the surgeons -- What are your
15 conclusions? What do you make?

16 A. I conclude or I decide whether the operation needs to
17 be performed or not.

18 Q. Now there has been discussions about surgeries that
19 are elective and surgeries that are emergent.

20 A. Yes.

21 Q. How does this surgery fall?

22 A. The terminology I guess is what gets people confused
23 because this is not an emergency surgery. It is considered
24 elective. But elective in the sense that we can do it
25 today, we can do it tomorrow, we can do it next week. But

1 a patient who has a polyp and potentially is harboring a
2 cancer, I would not feel comfortable going more than three
3 or four weeks on a patient like this because in the event
4 that he has cancer, "Oh, I wish I would have done this the
5 next day." And that's happened before. Patients will say,
6 "Well, you know I got -- I want to go to summer vacation,"
7 "I want to wait until my classes are done." And against my
8 recommendation they wait and by the time they do, we have
9 cancer, we have lymph nodes involved, and you kick yourself
10 thinking, "Gosh, if we would have done this four months ago
11 or three months ago, perhaps we would have got this at an
12 early stage." So it's ultimately the patient's option what
13 to do. We just basically tell them, here are the risks,
14 and here are the benefits.

15 Q. Is there any reason, Doctor, to have put off this
16 surgery?

17 A. No.

18 Q. Doctor, this procedure, you have told us, was to
19 remove a polyp of the ascending colon?

20 A. Correct.

21 Q. Could you again come down, and let's look at our
22 medical illustration?

23 MADAME COURT REPORTER: Get your mic, Doc.

24 Q. Let me give you a pen. Will you show the jury what
25 you did.

1 A. Okay. I knew going into the surgery having reviewed
2 the notes from the gastroenterologist, what they do when
3 they do this, this is the actual view that I get in
4 surgery. This is what I actually see. If there were
5 polyps in here, you may not see them because they're,
6 again, flat. I mean, if you had a big cancer in here, it
7 will -- you will see like a baseball or something huge like
8 that it's very obvious where it is. But the
9 gastroenterologist marks it for me so I know where it is.

10 Q. Is that called "tattoo"?

11 A. It's called tattooing. They actually tattoo the
12 patient with -- the colonoscope comes around, they'll see
13 the spot, and then they have an instrument where they can
14 put blue dye because everything is pink. Essentially pink
15 on the inside. They put blue dye just around this area so
16 what -- In this particular case, we have a polyp in the
17 ascending colon. And then I have the blue dye. It's
18 probably -- It's right -- right next to it. So they put
19 the blue dye here and here. So when I go in, I don't see
20 that polyp. I see the blue dye, and that's "X" that marks
21 the spot. I know exactly where the polyp is located. As
22 long as what I remove contains the blue dye, then I know I
23 have a polyp. Then at the end of the procedure I cut open
24 the piece that I took out. The patient's still asleep. I
25 open it up, and go, "Yep, there's the polyp. We got it."

1 Because you never know if for whatever reason -- Sometimes
2 they won't mark it and will say, "Yeah, it's a hepatic
3 flexure or in the right colon." And you've got to
4 remember, this thing, it's -- it's -- I have to take
5 someone else's word for where it's located and I always
6 have a problem with that because I was in residency once,
7 and they said, "Yeah, it's located in the left colon." It
8 was up here which is about this part of the colon - the
9 doctor did. And I was a doctor attending at that time, and
10 we had to go back and take more colon because they missed a
11 spot. So nowadays, we ask our gastroenterologist to mark
12 it so there's no mistakes made. So this is what I did.
13 This is the area of the polyp here. So what I did was I
14 came across the normal colon here -- That would be a -- We
15 use staplers. And what staplers are is sort of like a --
16 It's a long instrument that again goes like this. So it
17 clamps. And then within those clamps, it sends rows of
18 staples down, and then a knife through the middle. Not
19 staples like a piece of paper. I didn't mean to be gross,
20 but -- It basically seals off -- It cuts -- It seals off
21 that piece of tubing. So when I did it here, and I do it
22 here, what we're left with is two pieces of sealed colon,
23 and this part completely removed.

24 Q. So for an interval then you have taken out --

25 A. There's a space here.

1 Q. There's a space.

2 A. Yes.

3 Q. Just like if you had cut out a section of hose pipe?

4 A. Correct.

5 Now that I have two pieces of hose that are sealed off
6 at the end, I put them next to each other like this, and I
7 staple, and suture those back together.

8 Q. And what is that type of suture called?

9 A. It's called a side to side junction or what we call,
10 in technical terms, anastomosis.

11 Q. So when we're talking about anastomotic leak.

12 A. A leak at that point.

13 Q. And that is a complication of this surgery. Is it
14 not?

15 A. Of any colonic resection, yes.

16 Q. What causes an anastomotic leak?

17 A. Different things can cause them. It can range
18 anywhere from oxygenation of the tissues, which means if
19 for some reason you didn't get enough nutrients, I think
20 Doctor Salymvari was talking about that, not enough
21 nutrients at this part where the -- where the junctions
22 been put back together, that can cause the healing to fail,
23 and with that process you don't get a seal and the stool
24 can come out. It can come from technical issues. For
25 example, I talked earlier about the lieus where the bowel

1 become functionally impaired where it can't push stuff
2 along and everything blows up. If you put sutures in here
3 -- I'm going to -- or give you an analogy, if I were to tie
4 my shoes, if I had laces and tied them down. If my foot
5 were to get bigger, the laces stay the same amount of
6 tightness that I originally tied them with. And as that
7 foot gets bigger, eventually those laces are going to cut
8 to the shoe or whatever. It's going to cut into the foot.
9 Same thing you have in here. You can get the bowel
10 descending, which can cause the suture to either pop,
11 break, or tear out. Or you know, because it's the same --
12 the same thing as this thing gets larger, the sutures stay
13 the same size. So you can have technical reasons for it.
14 There can be blood flow reasons. People have bad vascular
15 disease or blood vessel disease, like bad hearts. They
16 also have bad blood vessels anywhere through the body. And
17 if they had bad blood flow through these vessels, there may
18 not be enough blood flow getting to that particular area.
19 So oxygenation is important.

20 Q. So you have -- You told the jury you removed a portion
21 of colon tissue?

22 A. Correct.

23 Q. How much colon tissue?

24 A. I believe in the path report, do you have that?

25 Q. I have Exhibit Ten, PMC 50. You want to look over

1 that please, Doctor? That's the pathology report of the
2 tissue you removed at this procedure?

3 A. Yes.

4 Q. On the 7th?

5 A. Yes.

6 Q. What did the pathologist look at?

7 A. It's a segment of approximately ten centimeters or a
8 little bit less than five inches long. So it's about like
9 this.

10 (WITNESS DEMONSTRATED.)

11 A. It has the polyp within it. Says it's flat. Calls it
12 a tubular adenoma which is a type of polyp which can
13 develop into cancer.

14 Q. Let me stop you. But it is not at this point
15 cancerous?

16 A. It's on its way there because it has a moderate
17 atypia. That's halfway through that report. A moderate
18 atypia; if we look on the spectrum of no cancer here and
19 cancer here, the atypia is in the middle. And there's mild
20 atypia, moderate atypia, and severe atypia, and this is
21 right in the middle. So with time, this has a higher
22 propensity to form into a cancer because atypia cells
23 beyond just the polyp white cells.

24 Q. The fact that the mushroom-like polyps had been
25 earlier removed, several of those had been removed by Dr.

1 Richardson, does that give you any comfort that the
2 remaining polyps are not going to be cancerous?

3 A. No.

4 Q. So can you leave that polyp?

5 A. No. I mean, you can if the patient decides not to do
6 anything about it, but your likelihood is that over time
7 it's going to become a cancer if you are willing to accept
8 that risk.

9 Q. So you took out colon tissue. And did you also take
10 out some mesentery tissue?

11 A. Yes.

12 Q. Okay.

13 A. The mesentery tissue I tried to draw it on here kind
14 of accurately. The path report says within the body of the
15 gross description, there's a two to three centimeter rim of
16 mesentery tissue, which means after I had done this, I have
17 to disconnect it from -- the curtain rod from the curtain.
18 Here's the curtain here. So I have to come across the
19 curtain. So I took about two centimeters worth which,
20 probably like that much.

21 (WITNESS DEMONSTRATED.)

22 Q. Now does that endanger blood supply to the colon and
23 to your suture sight?

24 A. No.

25 Q. And why not?

1 A. The reason why is as you can see in this picture,
2 picture each of these blood vessels flowing blood towards
3 the colon. If I cut these little ones here and tie them
4 off, the blood flow from this vessel can cross and go over
5 here. The blood flow from this vessel can cross. This is
6 all a networking. So blood flow sort of interconnects, and
7 that's how the body preserves it. If one of these blood
8 vessels gets knocked off, the colon can survive completely
9 well because the rest of the blood vessels pick up the
10 slack.

11 Q. It's like -- So lots of roads will get you there?

12 A. Yeah. Exactly.

13 Q. So it's not just one blood vessel ---

14 A. Correct.

15 Q. --- feeding the site of your surgical site?

16 A. Correct.

17 Q. So is the pathology report what you would have
18 expected?

19 A. Yes.

20 Q. How long did the surgery take, Doctor?

21 A. I think it was an hour and a half hour, hour and
22 forty-five minutes.

23 Q. Did Mr. Sexton have some issues with breathing after
24 surgery?

25 A. Yes.

1 Q. With longer in recovery?

2 A. Yes.

3 Q. And what would cause that?

4 A. He had low oxygen saturations after the surgery. When
5 we put people to sleep, it naturally causes the lungs to
6 collapse because we're not -- the patient's not breathing
7 for themselves. We're doing it by putting pressure, and we
8 don't completely inflate the lungs so when they wake up,
9 the primary things the patient's have to do is cough, deep
10 breathe, reopen up those closed airways so that oxygen can
11 get through. And we have to supplement them. Usually it's
12 very common we supplement patients after the oxygen because
13 they're real sleepy, and they're not taking deep breaths
14 until they wake up and they're more clear and lucid. Then
15 they start breathing better, and then we take off the
16 oxygen.

17 Q. Did you actually go follow Mr. Sexton to his room when
18 he came out of recovery?

19 A. When he comes out of the operating room he goes to
20 recovery room and I see him there several times. If -- And
21 then after he goes to the room, I don't follow him up to
22 the room.

23 Q. Okay.

24 A. The anesthesiologist assesses him in the recovery room
25 and says he's fit to go to the floor, he's stable. And

1 then they discharge him from the recovery room to the
2 normal medical floor.

3 Q. And did you see Mr. Sexton any more that day on the
4 7th of March?

5 A. Yes.

6 Q. Okay. You recall that?

7 A. Later in the day.

8 Q. Have you looked at the nurse's notes?

9 A. Yeah, I have.

10 Q. Do you have them in front of you? I think the nurse's
11 notes on the 7th are Tab 18.

12 A. Okay.

13 Q. If you would like to look at those. What happened --
14 What involved you on the 7th, after surgery, after he got
15 to the floor?

16 A. On the 7th -- On the 7th at -- at -- We use notes
17 every time, so I -- On the left column there, you'll see
18 1400. At 1400, it says, "Dr. Espinal to see patient." It
19 says it there. Is that what you're asking me?

20 A. Yes, sir.

21 Q. So the surgery was done at about 10:00, 11:00 o'clock.
22 Usually I see him frequently in the recovery room to see how
23 things are going. And then again I went up to check on him
24 again later on to see how -- how things were going. And
25 usually when I try to talk to patients after the surgery,

1 in his specific scenario, he was low-oxygen afterwards, you
2 know, sleepy still from the medicine. So I always like to
3 come back later on because if you go to sleep thinking,
4 "Gosh, the doctor said I could have cancer," and then I'll
5 see you tomorrow, patients usually appreciate, "Hey, how
6 did it go?" And they want to know how things went. And
7 that's the purpose of the visit around Two o'clock to say,
8 you know, "Things went well. You're going to be fine. We
9 got that polyp out, and we'll have it analyzed."

10 Q. Did you see him any more that day?

11 A. According to this chart, no.

12 Q. Now, you said that he was having issues with O
13 saturations?

14 A. Yes.

15 Q. Now on the following day which I'm going to call Day

16 2. This is the second --

17 A. On the 8th?

18 Q. The 8th. This is the second day he's in the hospital.

19 A. Yes.

20 Q. Did you order a pulmonary consult with Dr. Denenberg?

21 A. Yes.

22 Q. And why is that?

23 A. Low oxygenation after an operation is not a cause for
24 concern. It's very common after a procedure. But in his
25 particular case, because of the rapid desaturation or

1 dropping off of his oxygen levels that persisted after he
2 was awake and alert, that's what got me worried because
3 that's abnormal. A patient should once they're awake, be
4 able to maintain their oxygen levels. And because he was
5 still on a large concentration of oxygen, I felt it would
6 be prudent at this time to have someone specific to
7 pulmonary medicine seeing him. And that's why I got them
8 involved.

9 Q. Did Mr. Sexton have difficulty with utilizing the
10 mask, the oxygen mask?

11 A. Yes.

12 Q. Do you know why?

13 A. Well at first, it's not uncommon when patients are
14 waking up, they don't know where they're at, and they're
15 grabbing at what's on their face. They're trying to pull
16 things off, pull IV's out, which is normal. We expect that
17 when you're given narcotics and drugs that make you sleepy.
18 Patients aren't of the right mind. After approximately
19 those two hours in the recovery room, he's able to follow
20 commands. And that's part of the anesthesia discharge,
21 that they're alert, that they're oriented. They can't
22 discharge him to the floor if a person is completely out of
23 it. So that is done by the anesthesiologist who sees it
24 fit that the patient be discharged to the floor.

25 Q. And so Dr. Denenberg sees him on the second day, which

1 is the 8th. Correct?

2 A. Correct.

3 Q. And his consult note is at Tab 261; is that correct?

4 A. Yes.

5 Q. And did you do anything differently as far as after-
6 care treatment for Mr. Sexton after Denenberg made his
7 report, his consult made to you?

8 A. Can you repeat that? Did I do anything --

9 Q. Did Dr. Denenberg's consult note cause you to change
10 the treatment that was being rendered?

11 A. Not necessarily, no.

12 Q. And how did Mr. Sexton do on Day 2, the 8th?

13 A. Well, if you look at the nurse's notes, I guess from
14 the 7th, 8th, and 9th, again, and the family's testimony
15 that they were at bedside throughout because even after he
16 was alert, he was potentially pulling at the mask. And if
17 we can go to --

18 Q. There's an index in front, Doctor.

19 A. Yes.

20 Q. Tell me where you're at, I'll try to help you find it.

21 A. We'll start on the 8th, if you like. So this would be
22 Piedmont Medical Center, Page 8-0-8. And if we go down to
23 where it says 2000, the time 2000, it says that
24 "reinforcement patient need to be compliant with use of
25 oxygen and to use incentive spirometer every hour while

1 awake." A spirometer is a plastic -- You may have -- If
2 you've ever been in the hospital and seen it, it's a
3 plastic box that has a little ball in it, and it's intent
4 is for the patient to suck on a connection to inhale. And
5 it moves the ball up in the air, and it encourages a
6 patient as they can see a visual, how much air they're
7 taking in, so that we can make sure that they can get rid
8 of any closure of the remaining lung and get it to open
9 completely. So in this particular case, the patient
10 verbalizes understanding, but removes oxygen and states, "I
11 can't bring with that thing on." And then so his oxygen
12 sats dropped in the low 70's at this point. If we keep
13 going down --

14 Q. Doctor, while you're looking, under that same tab,
15 PMC-00812, do you see vitals on the 9th?

16 A. Yes.

17 Q. All right. Any of those vitals abnormal?

18 A. Yes, the oxygen level is abnormal.

19 Q. Is that what you just told us about?

20 A. Yes.

21 Q. Any other vitals there that are of a concern?

22 A. On that page, there is not. But there's continuous
23 references through the nurses notes over those three days
24 in the hospital that he made comments that we were -- that
25 we were trying kill him like forcing the oxygen on him, the

1 family was forcing the oxygen on him. And I remember him
2 telling me that he's passed his pulmonary tests at work
3 every year. "The doctors told me I don't have any problems
4 with my lungs, and I don't want to wear the oxygen." And I
5 explained to him that the oxygen is necessary to allow the
6 colon -- the surgery area to heal.

7 Q. Now, as of the 8th of March, do you have any suspicion
8 that you might have an anastomotic leak?

9 A. At that point, I did not.

10 Q. Now anastomotic leaks are delayed?

11 A. That's correct.

12 Q. So, now on the 9th, what happens on the 9th?

13 A. The -- On the 9th, he develops a high fever. His
14 abdomen becomes distended at that point. And --

15 Q. Distended is protrudes?

16 A. Protrudes, yeah, gets wider. And his oxygen levels
17 are still continuing to be a problem. It's that fever,
18 that temperature that really sparks the surgeon's interest
19 because a postoperative fever, if a person's having
20 breathing problems, is acceptable to even go up to about a
21 101.5. Even up to a 102 can be blamed on a lung issue such
22 as pneumonia or something of that nature. You get up to a
23 104, you have to start looking for intra-abdominal
24 catastrophes like a leak.

25 Q. So on the 9th, you have identified a sick patient?

1 A. Yes.

2 Q. And what do you do for him to ascertain what is going
3 on? Why is he getting sicker?

4 A. Well I proceeded to get some X-rays including a CAT
5 scan of the abdomen, which is if anybody's seen, getting a
6 doughnut, it looks like a big doughnut. And it takes
7 pictures of -- almost as if you took an apple and cut it in
8 half and could see the insides of the apple.

9 Q. Now you ordered the CT. You started on the afternoon
10 of the 9th?

11 A. Correct.

12 Q. And it's used a contrast?

13 A. Yes.

14 Q. Which is?

15 A. Contrast is very important in a case like this because
16 contrast is the material that the patient drinks, and it
17 allows us to see almost like a cast of the colon -- of the
18 intestinal tract including the colon. So as it percolates
19 through the intestinal tract, you will be able to see
20 definition. We'll be able to see, specifically in his
21 case, I want to see if there's any leakage of that contrast
22 from within the tube or a pipe outside the pipe.

23 Q. And insofar as the first CT with contrast, what did
24 that tell you?

25 A. It said that there were changes in the abdomen which

1 could be attributed to the abdominal surgery that I just
2 did on the 7th, but because the temperature of a 104, I
3 didn't feel comfortable relying on that reading. I wanted
4 to make sure that, that contrast got down to the spot
5 because it hadn't got down in the first CT scan. So, it's
6 like if the plug in the drain is further on down and you
7 don't wait for the stuff to get there, it's not going to
8 work. So in order for me to see the fact if he has a leak
9 or not, I have to wait more time, give him more contrast so
10 it will percolate through. And that's eventually what it
11 showed.

12 Q. And when was that though?

13 A. The morning of the 10th.

14 Q. Now did you feel comfortable with what you saw on the
15 9th going back into another surgical procedure?

16 A. No.

17 Q. The morning of the 10th, what did you see with the CT
18 contrast?

19 A. I saw the same findings I saw on the one the night
20 before. Those were -- Or I saw the same findings as the
21 night before, but in addition to that, I saw the contrast
22 leaking out of the pipes or the colon into the back part of
23 the abdomen.

24 Q. So was that the medical evidence that you needed to
25 see that you now knew that you had a patient that had an

1 anastomotic --

2 A. That's diagnostic of a leak, yes.

3 Q. And what did you do?

4 A. I took him immediately to surgery.

5 Q. And the doctor is Dr. Lupo, the anesthesiologist in
6 that case also?

7 A. She was.

8 Q. And how did that procedure go?

9 A. The procedure itself, operatively speaking, I removed
10 the part that had leaked and put the -- again the same
11 thing back together. Again, he's at risk. Every time you
12 take him to surgery and redo a junction, you're at risk
13 for an anastomotic leak. So, I guess theoretically it
14 could happen ten times in a row, and you'd have to go to
15 ten surgeries, but that's really unusual. It's unusual to
16 have a leak in the first place. Leaks occur in
17 approximately three to five percent of patients, but that's
18 the going, acceptable number. So surgeons keep track of
19 that. I like to know that my -- that I'm within the
20 national average on my leaks because if I --

21 MR. MCGOWAN: Your Honor, I object. What the national
22 average is, his averages make no difference to whether
23 there was negligence in this case.

24 MR. KING Go ahead. Go ahead and proceed. Don't talk
25 about the national averages.

1 A. Okay. What were we talking about?

2 Q. You were talking about the leak in this case, as to
3 what you were doing to repair the leak in this case.

4 A. Okay. So what I did in this case is I removed that
5 portion of the colon and put the two parts of the intestine
6 back together. And during the surgery -- That's what
7 you're asking, what kind of complications. That went fine.
8 It took, I think, about an hour to do that particular
9 procedure. But during the surgery, he had some EKG changes
10 on the monitor that the anesthesiologist has. And the EKG
11 changes were believed to be possibly him having a heart
12 attack. They were the same findings that we have in
13 patients who have heart attacks.

14 Q. Did he have any respiratory issues?

15 A. Well at this point, he's on a ventilator, and he's a
16 hundred percent oxygen, so the machine's doing all the
17 work.

18 Q. Now after the procedure when he came out, did he
19 remain on the respirator?

20 A. Yes.

21 Q. And why did he need a respirator?

22 A. In a patient who's critically ill at this point, we
23 know he had an infection in the abdomen, he had two major
24 surgeries three days apart, the amount of trauma that the
25 body has gone through, just going through two surgeries

1 like this, you throw in an infection, and the CAT scan also
2 showed that he had developed at that time, at the time of
3 the CAT scan, he had developed pneumonia. You would never
4 want to take a person off a ventilator because going in we
5 knew he was having breathing problems. We knew it was
6 going to be a long haul until he cleaned up or his body
7 healed the insides. So we leave the patient on the
8 ventilator usually in this scenario because we believe that
9 this is in -- the insult to the body is just beginning.

10 Q. Now you called in a cardiologist from the Sanger
11 Clinic?

12 A. Correct.

13 Q. And what was the conclusion about a heart attack?

14 A. They thought the same thing we thought, that maybe
15 he's had a heart attack. So they discussed it with the
16 family, discussed that he should have a heart cath. And he
17 actually underwent a heart cath the day of his second
18 surgery, and it was found to be completely negative. So we
19 never found out why he had EKG changes. The cardiologist
20 never knew why.

21 Q. Doctor, if you had put off the surgery what would have
22 happened?

23 A. The second surgery?

24 Q. Put off -- No, put off the entire first -- put off the
25 first surgery.

- 1 A. Never did surgery?
- 2 Q. Never did surgery.
- 3 A. What would have happened in --
- 4 Q. At some point in time if you did it again, can you say
- 5 it would go without complications?
- 6 A. No.
- 7 Q. And why not?
- 8 A. Because -- Well for several different reasons. Those
- 9 -- Those risks I discussed apply every single time I do an
- 10 operation. Every time you do an operation, those risks
- 11 will apply. Is that what you're asking?
- 12 Q. Yes.
- 13 A. Okay. So nothing had changed by waiting any period of
- 14 time.
- 15 Q. Do you know what COPD is?
- 16 A. Yes, I do.
- 17 Q. And what is COPD?
- 18 A. Chronic obstructive pulmonary disease.
- 19 Q. And is COPD reversible?
- 20 A. No.
- 21 Q. It wouldn't cure itself?
- 22 A. No.
- 23 Q. Now Ms. Beard testified that she confronted you and
- 24 said all of this came from the first surgery and that you
- 25 acknowledged you shouldn't have done the second one.

1 A. That's the testimony.

2 Q. That's what?

3 A. That's her testimony.

4 Q. That's her testimony?

5 A. Yes.

6 Q. Do you agree with her?

7 A. No, I do not.

8 Q. You do know Ms. Beard?

9 A. Yes.

10 Q. Did you have conversations with her?

11 A. Very many conversations.

12 Q. Tell me the nature of those conversations.

13 A. I like to pride myself -- With the nature of the
14 conversation, I like to pride myself that I want to make
15 sure I communicate. And specifically what I tried to do
16 with Mr. Sexton is to communicate because I knew he had
17 trouble understanding this -- the big talk. So I try to
18 really make it understandable for him. And in a like
19 fashion, I don't expect families to be surgeons, so I don't
20 explain that to them. So I like to, especially in a case
21 like this that's complex where there is complications going
22 on, I like to make sure I really make sure that everyone's
23 on the same page, that there is no one left out of the
24 loop. And so the nature of the conversations were one of
25 daily updates, what's going on. And as she said, I'd call

1 her at home, got her cell phone number because I knew she
2 was concerned. She was the main person, even though Mrs.
3 Sexton was there, she had a lot of the questions for me
4 Mrs. Beard did. And so I liked to make sure that she was
5 satisfied with whatever information was going on. So I
6 liked to make sure I got that across to her.

7 Q. Did she ever appear to you to be angry?

8 A. Never.

9 Q. Now, Mr. Sexton continued to see you after he got out
10 of rehab?

11 A. Yes.

12 Q. Doctor, what caused the complications that came out
13 the second surgery?

14 A. The complications? It's educated guesses that I can
15 give you --

16 MR. MCGOWAN: With respect then, if it's not to a
17 reasonable degree of medical certainty, then it's not
18 relevant for the purposes of this case.

19 THE COURT: Rephrase the question.

20 BY MR. KING:

21 Q. Doctor, based upon a medical certainty, do you know
22 what caused the complications that came out of the second
23 surgery?

24 A. The complications of the second surgery was the fact
25 that he had two major surgeries and an intra-abdominal leak

1 of bacteria with pneumonia.

2 Q. That's the anastomotic leak that you're talking about?

3 A. Correct.

4 Q. So you have a leak that develops septic?

5 A. Yes.

6 Q. He developed pneumonia. Correct?

7 A. Yes.

8 Q. And he had two surgeries?

9 A. Yes.

10 Q. Is that what caused him to get sicker?

11 A. Yes. If those occurred to any of us in this room,
12 this would be a possible course that we would go through.

13 I don't care how healthy you are.

14 Q. And are any of these complications out -- Are they all
15 possible with this type of procedure?

16 A. Yes.

17 Q. Excuse me just a minute, Doctor.

18 (PAUSE.)

19 Q. Dr. Espinal, did you tell Mrs. Beard in any form that
20 you should not have performed the first surgery?

21 A. No.

22 Q. Thank you, Doctor.

23 THE COURT: Members of the jury panel, we're going to
24 stop for lunch. It's almost a quarter till One, so we're
25 going to break till 2:30. Have a pleasant lunch. Keep in

1 mind my admonitions about not discussing the case. You are
2 not yet in a position to do that or yet make up your own
3 mind. Don't let anyone discuss the case with you. So
4 we'll see you back in the jury room at 2:30. Thank you.

5 (JURY EXITS COURTROOM FOR LUNCH RECESS AT 12:40 PM.)

6 THE COURT: Anything from the Plaintiff?

7 MR. MCGOWAN: Would Your Honor mind, I know Mr. King
8 wouldn't do this, but just instruct the witness not to
9 discuss his testimony with anybody, with Mr. King or
10 anybody else.

11 THE COURT: Doctor, you are subject to cross
12 examination, so you can't discuss your testimony --
13 obviously with your spouse or whatever, but -- And of
14 course do talk to your attorney about when to be back and
15 those sort of things. But you can't discuss your testimony
16 because you are subject to cross examination at this time.

17 THE WITNESS: Okay.

18 THE COURT: Anything else before we break for lunch?

19 MR. MCGOWAN: No, sir.

20 THE COURT: All right. Thank you.

21 (COURT IN LUNCH RECESS AT 12:44 PM.)

22 (COURT BACK IN SESSION AT 2:30 PM)

23 THE COURT: Anything before the jury comes in?

24 MR. MCGOWAN: Nothing from the Plaintiff.

25 MR. KING: Nothing, Your Honor.

26 THE COURT: Dr. Espinal, if you'll come back up and

1 take the stand.

2 (WITNESS RETURNS TO WITNESS STAND.)

3 THE COURT: Bring in the jury.

4 (JURY REENTERS COURTROOM AT 2:33 PM.)

5 THE COURT: Members of the jury panel, we are now in
6 cross examination, and that extra-long lunch hour was my
7 probably missing the class in kindergarten when they taught
8 you how to tell the time. I didn't mean to take that long.

9 MR. MCGOWAN: Thank you, Your Honor.

10 CROSS EXAMINATION

11 DOCTOR ALEX ESPINAL BY MR. MCGOWAN:

12 Q. Dr. Espinal, I want to start off by talking to you
13 about issues of credibility and consistency.

14 A. All right.

15 Q. And to do that, I'm going to ask you to remember what
16 you said in your direct examination. And there were two
17 issues. The first of which was you testified, and if I'm
18 wrong please correct me, that you had a conversation with
19 Mr. Sexton on March 8th about the importance of keeping the
20 oxygen mask on because the oxygen is required for healing.

21 A. Yes.

22 Q. And you testified about a conversation with the
23 anesthesiologist prior to the procedure; is that right?

24 A. Yes.

25 Q. Could you find for me in the medical records where

1 those conversations are documented or noted?

2 A. No.

3 Q. Okay, why not?

4 A. They never are documented.

5 Q. Well, here's the issue. You understand that during
6 the course of this litigation, we get to exchange
7 paperwork? You know that?

8 A. Yes.

9 Q. And this is not my first rodeo. And so we asked you a
10 question in your interrogatories, Number 18. And I'm going
11 to put it up here because it's your statement. And we
12 asked the question, because you can imagine how someone
13 like me would be concerned about someone like you saying
14 new things in trial that we hadn't heard before. You can
15 understand that concern?

16 A. Yes.

17 Q. And so we asked a question that says, "Identify any
18 observations, diagnoses, or treatments of John Sexton which
19 are not reflected in the medical records. And in answering
20 this interrogatory, please describe in detail the
21 observation, diagnosis, and the treatments." And your
22 answer was "Defendants made reference to the medical
23 records of care and treatment of John Sexton." All right.
24 And then we have question 19 which says, "Describe your
25 understanding of the condition of John R. Sexton as relayed

1 by him in prior --

2 A. I can't see that. I can't see that.

3 THE COURT: Well --

4 THE WITNESS: He just needs to move it back.

5 MR. MCGOWAN: Sorry.

6 THE COURT: Oh, I'm sorry.

7 Q. This one says, "Describe your understanding of the
8 condition of John R. Sexton as relayed by any prior or
9 subsequent treating physician." Like the anesthesiologist
10 would be prior. Right? Or subsequent?

11 A. Or subsequent, yes.

12 Q. Yeah. "And for each such relay, identify the date,
13 time, and place of statement where statements were made."
14 And then to the "A" part, you say, "Beg reference to the
15 medical records." And is referred to Dr. -- to you by Dr.
16 Scott Richardson of Digestive Disease. But you don't
17 mention anything about this conversation with the
18 anesthesiologist in this answer. Right? You say, "Look to
19 the medical records." Is that right?

20 A. My attorney prepared this. I didn't write those
21 questions, those answers out. I don't -- I mean, "Beg
22 reference" sounds, that's lawyer-speak.

23 Q. Okay.

24 A. So I didn't sit down and write any of these answers or
25 type them myself.

1 Q. Well you understand that these from a legal standpoint
2 are your answers?

3 A. I suppose.

4 Q. So, but nobody told us in this document about these
5 conversations you allegedly had with Mr. Sexton on that
6 March 8th, and the anesthesiologist. Because we refer, you
7 agree, to the medical records. Right?

8 A. Yes.

9 Q. And they're not in the medical records. True? Those
10 conversations?

11 A. True.

12 Q. Okay. And then we took your deposition.

13 A. Yes.

14 Q. Eight-something pages in my office, under oath, the
15 court reporter, the whole bit. Right?

16 A. Yes.

17 Q. And did you ever say those things to us in your
18 deposition about this conversation with the
19 anesthesiologist beforehand and/or the conversation with
20 Mr. Sexton on March 8th?

21 A. No.

22 Q. So the first time we've heard that is today in this
23 courtroom?

24 A. Yes.

25 Q. Now, you also told us today that you had -- Well, let

1 me talk about alcohol. Your lawyer referred to Mr. Sexton
2 as a terrible alcoholic. Do you consider a man who's been
3 sober for twelve years a terrible alcoholic?

4 A. Yes. Once an alcoholic, Mr. McGowan, always an
5 alcoholic. That's the basic fundamental of AA and all
6 their teachings.

7 Q. Did you make a moral judgment about Mr. Sexton based
8 upon his twelve-year history of sobriety?

9 A. No.

10 Q. Is he entitled to any less --

11 A. I applaud him for it.

12 Q. Is he entitled to any less healthcare or a lower
13 standard of care because of his history of alcoholism?

14 A. Absolutely not.

15 Q. And in fact, to imply such would be improper. Right?
16 Because they're patients who deserve the same general care
17 regardless?

18 A. Absolutely.

19 Q. Now let's talk about something. You testified that
20 you specifically asked Mr. Sexton if he smoked. Right?

21 A. Yes.

22 Q. And you testified that he specifically told you that
23 he did not.

24 A. Yes.

25 Q. In your records from that day, Exhibit Three if you

1 need to look at it, do you see any reference where it says,
2 "Patient denies smoking"?

3 A. No.

4 Q. And in fact, is Exhibit -- Do you have that book up
5 there? You do.

6 A. Yes.

7 Q. Is Exhibit 33 your chart?

8 A. Yes.

9 Q. Okay, good. Let's -- Let's go through a few things.
10 We have -- Some of these are in that chart, and some of
11 them aren't, but we'll get to that in a second. We have a
12 record here from the gastroenterologist where he was asked
13 and he says, "Do you smoke," and he says, "Yeah." And
14 there he puts very little. Right?

15 A. Yes.

16 Q. So the gastroenterologist asks him and he said, "Yeah,
17 I smoke." Right?

18 A. Yes.

19 Q. And then we have the day of the surgery. This happens
20 to be Exhibit Number 7. This is a pre-anesthesia
21 questionnaire done by the anesthesiologist the very day you
22 were going to do the surgery. Right?

23 A. Yes.

24 Q. And they ask and say, "Do you smoke," and he says,
25 "Yeah, one pack a day for forty years." Right?

1 A. Yes.

2 Q. And then the next surgery, March 10th, it's on this
3 one also. This is page -- not page, but Exhibit 11, which
4 says he's a smoker. Right?

5 A. Right.

6 Q. And then you, in fact, prescribe nicoderm to him on
7 March 7th ---

8 A. Correct.

9 Q. --- which is nicotine patch. Correct?

10 A. Correct.

11 Q. And he told Dr. -- Or somebody told Dr. Denenberg, the
12 amount we can dispute, but Dr. Denenberg knew that Mr.
13 Sexton was a smoker?

14 A. Correct.

15 Q. And is it your testimony that Dr. -- You asked Mr.
16 Sexton a specific question about smoking, and he denied to
17 you that he ever smoked even though for every other doctor
18 that had looked at him and asked the question, he was very
19 forthright about it?

20 A. That is.

21 Q. All right well, let's look at Exhibit Number 33 which
22 is your actual records; isn't that right?

23 A. Yes.

24 Q. Did you read these records?

25 A. Yes.

1 Q. Well it's in here a couple of times. And it's called
2 -- There's a record here that was in your chart DDA-36.

3 A. Where is that?

4 Q. Well it's in Exhibit 33.

5 A. That's not in my chart. DDA is Digestive Disease
6 Associates?

7 Q. Well that's why I asked the question. If I'm wrong
8 about it -- See here is Exhibit 33. And I'm wondering
9 which of these, these have little fact things up at the
10 top. Which of these records are yours?

11 A. Those you just had in your hand.

12 Q. Oh. Just the three pages?

13 A. Yes.

14 Q. And that's it?

15 A. Yes.

16 Q. Well according to the --

17 A. Under Tab 33 that's the only ones.

18 Q. Got you, fair enough.

19 But according to this record, the doctor asked him,
20 and he smokes twenty to thirty cigarettes a day.

21 A. What doctor is that?

22 Q. I think that's Digestive Disease.

23 A. Okay.

24 Q. So apparently he was asked, and he told this doctor
25 how much he smoked, and the alcohol, and all that. Right?

1 A. Yes.

2 Q. So you would have us believe that when asked by you,
3 he denied smoking; whereas, when asked by every other
4 doctor, he was very straightforward about it. Is that the
5 jest of it?

6 A. Yes.

7 Q. Okay. Let's talk about the rules that apply. You
8 agree that a surgeon can never expose their patient to
9 unnecessary danger?

10 A. Correct.

11 Q. And if you do that, you are below the standard of
12 care?

13 A. Correct.

14 Q. You also believe that it's your duty, the standard of
15 care requires you to, it's a rule that you must inform
16 yourself of your patient's condition. Correct?

17 A. Yes.

18 Q. And it's also required that you re-examine the patient
19 prior to surgery?

20 A. No.

21 Q. Great. What are you going to call it? You have to
22 update the examination?

23 A. Yes.

24 Q. All right, well fine, we'll call it that. You were
25 required to update your examination prior to procedure.

1 Yes?

2 A. Yes.

3 Q. And if there's an increase risk by any particular
4 circumstance of the patient, then it is your duty,
5 obligation that the standard of care requires, and it's a
6 rule that you have to tell your patient to make sure they
7 know what they're getting into.

8 A. Say that again, please.

9 Q. If you have a patient with a particular medical
10 condition that makes their situation more risky than
11 others, then you have to tell the patient. Yes?

12 A. Yes.

13 Q. And they have to sign off on the increased risk.
14 Right?

15 A. It depends what the risk is.

16 Q. Well, like bad lungs in a laparoscopic procedure.

17 A. I don't come in, and if a blood pressure is high, I
18 don't make the patient sign a blood pressure reading that
19 they acknowledge that they're going to surgery by because
20 the blood pressure's high. I chalk that up to their
21 condition or whatever because it doesn't -- It doesn't
22 require a written statement that the patient acknowledges
23 he stumped his toe this morning, and he was going to go
24 have his colon removed, or whatever the case may be. It
25 has to -- There's nothing that just can be signed off on.

1 The sign-off is an update which is me coming and get a
2 general -- the best word for it would be a general constal
3 of what's going on with the patient. This has been the
4 argument our medical staff has over and over again because
5 of this particular reason is that it says we're not
6 expected to come in and do a full history and physical, but
7 it can be looked at that way and try to be -- We try to be
8 by a counselor that we have to do a full history and
9 physical then why even come to the preoperative visit in my
10 office. I'll just do it that morning if I'm going to spend
11 a whole day doing a history and physical. A history and
12 physical is there because we're thorough in the office.
13 We're not as thorough on the day of the surgery unless
14 something presents itself that makes us have to be
15 necessarily more in depth.

16 Q. I have gotten you in the weeds, and I apologize. My
17 question was different.

18 A. Pardon?

19 Q. We have seen through this case these signed consent
20 forms. You've seen Exhibit Number 29. Right?

21 A. Yes.

22 Q. And that was apparently signed on March 6th according
23 to the date. Yes?

24 A. Correct.

25 Q. And at that time, there was no medical evidence that

1 Mr. Sexton had impaired lung function. True?

2 A. Correct.

3 Q. But the day of the surgery, there was evidence of
4 that.

5 A. No, there wasn't.

6 Q. So an O2 Sat of eighty-five percent, diminished lung
7 sounds bilaterally and atelectasis is not dealing with his
8 lung function?

9 A. I need to parcel that into pieces to explain my
10 answer.

11 Q. Okay.

12 A. What was the first thing again? Low-oxygen
13 saturation?

14 Q. Let me --

15 A. Do you want to start there?

16 Q. Let me back the bus up a little bit more. Do you
17 consider the fact that he had a lung situation that changed
18 between the time in your office and the time in your
19 hospital?

20 A. No.

21 Q. Okay.

22 A. Could -- What lung function change are you referring
23 to? Can you name one?

24 Q. Did you have any evidence in your office record that
25 Mr. Sexton read an eighty-five percent O2 sat?

1 A. No. No surgeon I know has a pulsox. Pulsoxymetrie is
2 not carried in the office. The only ones that have them
3 are pulmonologists.

4 Q. Now is that --

5 A. It's done in the office for that reason because that's
6 -- because its an expensive machine. Now it's cheap to do
7 once the hospital has the machine. Put a little clip on
8 your finger, doesn't hurt. The point of it is that's not
9 part of the standard work up of a patient preoperatively,
10 especially one who denies smoking. I wouldn't even order
11 blood work on a certain person unless they had indications
12 that -- We used to order blood work and chest x-ray on
13 everybody. EKGs for everybody. But we know that those are
14 wasted dollars if they're not indicated so insurance
15 companies don't let us do that anymore. So we have to be
16 very smart and choosy about what we choose and order.

17 Q. I appreciate all of that, but that wasn't my question.

18 A. Okay.

19 Q. You had no evidence that he had impaired O2 saturation
20 in your office?

21 A. No, I did not.

22 Q. And in fact on your physical examination, his lungs
23 were clear.

24 A. Yes.

25 Q. On both sides?

1 A. Yes.

2 Q. And there was no indication that you had of either
3 prominence of the interstitial, nor of atelectasis in both
4 basis?

5 A. No, I did not.

6 Q. So you walk into -- So, is it your testimony then that
7 the patient who in your office five days earlier, however
8 many it was, has no indication of lung issues at all based
9 upon what you examined?

10 A. Yes.

11 Q. That he now has an eighty-five percent O2 sat. He has
12 diminished breath sounds both sides, and he has
13 demonstrated prominence in the interstitium and atelectasis
14 is not a change in condition of the patient?

15 A. There's a change in condition, but I'm not aware of
16 that. I'm not aware of any of those conditions they are
17 asserting.

18 Q. Don't you see that as a problem and the reason we're
19 here?

20 A. Yes.

21 Q. Okay.

22 A. But there's not a problem because those issues are not
23 -- If I may, as oxygen -- Do you want to talk about the
24 chest X-ray or -- You proceed. I'll let you talk.

25 Q. All right. Lungs are important for laparoscopic

1 procedures. Right? Especially --

2 A. Any surgery.

3 Q. But in a laparoscopic procedure, in this case, what
4 you did is you inflated the abdomen with air, CO2. Right?

5 A. Yes.

6 Q. And that has a tendency to put unusual amounts of
7 pressure on the lungs that you would not have in an open
8 procedure. Is that fair?

9 A. You would not have positive pressure on the lungs in a
10 laparoscopic procedure, but open surgery is way more worse
11 on a pulmonary cripple, way more worse.

12 Q. I understand.

13 A. Once you make the incision, you cause so much severe
14 pain, patients wince. They can't breathe because their
15 stomach hurts so bad. That's what the reason why
16 laparoscopy exists. It's so much better for pulmonary
17 cripples. I've had a pulmonologist tell me, you're the guy
18 who does laparoscopic colons. Not everyone in my town does
19 that. This guy specifically needs it because he has bad
20 lungs. The only time that comes into play is
21 intraoperatively if the patient comes to surgery has such
22 poor lung function that his CO2 may go up. But as far as
23 oxygen saturations, it puts pressure on the lungs, but it
24 really doesn't affect it that much.

25 Q. You need to be, as a surgeon to perform the procedure

1 safely, you need to be worried about your patient's lung
2 condition?

3 A. Yes.

4 Q. And ultimately, whether to have the procedure or not
5 is your call; isn't that right?

6 A. Mine and the anesthesiologist.

7 Q. As you testified, the anesthesia is concerned mostly
8 with whether the anesthesia can be administered safely.
9 Right?

10 A. And the -- the aftereffects.

11 Q. And your concern is supposed to be at least for the
12 patient from the time they walk in to the time they walk
13 out. Right?

14 A. Correct.

15 Q. And that includes the healing process, the recovery
16 process, the whole bit. Yes?

17 A. Yes.

18 Q. And it is your responsibility to make sure it can
19 happen safely. Yes?

20 A. Yes.

21 Q. Now, wet's talk about the first rule that you must
22 inform yourself of the condition of the patient before a
23 surgery.

24 A. Yes.

25 Q. In this case, you did not know that his O2 sat was

1 eighty-five percent, that he had diminished lung sounds
2 bilaterally, and that he had atelectasis and a prominent
3 interstitium prior to the procedure. Right?

4 A. Correct.

5 Q. If you are supposed to know these things because
6 that's what the rule requires, and you didn't, how is it
7 that you were not negligent?

8 A. Can we take them into parts, and I'll explain it to
9 you?

10 Q. Explain however you need to, Doctor. I just want to
11 know ---

12 A. Okay.

13 Q. --- if the rule says this, and you did that, how
14 you're not negligent.

15 A. The nurse's find diminished breath sounds. They're
16 clear, they're diminished. That means the way you are
17 breathing right now is diminished. When you breathe like
18 this.

19 (WITNESS DEMONSTRATES BREATHING)

20 A. Those are normal breath sounds. So right now, you all
21 have diminished breath sounds. This is -- It's very
22 common. So the point is, the anesthesiologist walks in,
23 listens to the lungs and finds there is no diminished
24 breath sounds, and tells me that on the way out, and says
25 he's fine. But the anesthesiologist orders a chest X-ray.

1 I do not order the chest X-ray. She did that because of
2 the eighty-five percent. The radiologist calls the
3 anesthesiologist with a report.

4 Can you put the X-ray report up? Is that possible?

5 Q. I reckon.

6 A. I just want to point something out, I think it's kind
7 of important, and it will save us a lot of round-and-round
8 talk here. From the 7th. It may answer this question.

9 Q. So far you haven't, but I'm going to ask it again.

10 A. All right.

11 (X-RAY DISPLAYED.)

12 A. If I may the key -- the key is right down...

13 MADAME COURT REPORTER: Don't get far from that mic,
14 Doc.

15 THE WITNESS: Do you want me to just talk real loud?

16 MADAME COURT REPORTER: Back up to that mic. I don't
17 know if the jury can see you either.

18 A. This is the type report. I know what it says now. I
19 don't know at the time of the procedure because
20 transcription -- The printed date and time when it enters
21 the chart is the 8th. So I'm not privy to this
22 information. I know the night that the phone call, the
23 phone call goes to my anesthesiologist who is eventually
24 the one who listens to the lungs. He said there's nothing
25 wrong with him. There's no diminished breath sounds, and

1 there's no complication in surgery.

2 Q. Where's that in the chart?

3 A. Where's what in the chart?

4 Q. That conversation you had with the anesthesiologist.

5 A. It's not.

6 Q. Okay, that's the same problem we had before about us
7 asking you about this before. The first time we hear that

8 --

9 A. But -- But there is no reason to -- We don't chart
10 every single conversation I have with every single doctor
11 in the hospital.

12 Q. I'm with you. That's why we ask you the question, if
13 there were any other conversations. And you said look to
14 the medical records. Do you see the problem that I'm
15 having here?

16 A. I guess.

17 Q. All right well, let me get back to my question. That
18 was all very informative, but non responsive. The standard
19 rule, the standard of care requires you to inform yourself
20 of your patient's conditions prior to surgery. And you
21 didn't know about the O2 sat, you didn't know about the
22 diminished breath sounds, and you did not know about the
23 prominent interstitium, and the atelectasis?

24 A. Before I went to surgery, I knew about that the
25 patient was clear for surgery. Those were nonissues at the

1 time I took him to surgery. His oxygen sat was ninety-two
2 percent, minimal oxygen. Dr. Lupo had said that he does
3 not have diminished breath sounds. She has personally
4 examined the patient, and she -- the anesthesiologist --
5 she always does the morning of procedure. And she's got
6 the phone call. So she -- I look at her and she says, "X-
7 ray's fine. I even did an X-ray just to make sure
8 everything is okay. Nothing acute. You're good to go."
9 And it's in the chart that she said, "Clear for surgery."
10 I don't know what else I could do in this scenario.

11 Q. Let me try my question again, Doctor.

12 A. Okay.

13 Q. If you are required to inform yourself of your
14 patient's condition prior to surgery, which you are. Yes?

15 A. Yes.

16 Q. You did not know his O2 sat, diminished breath sounds,
17 nor the results of that X-ray report. Correct?

18 A. Yes.

19 Q. So how is it that you say you are not negligent by not
20 knowing those three things before surgery when you have
21 just told us that, that is a requirement that you must
22 fill?

23 A. I also don't have knowledge of what the dietician said
24 on Day 30 of the hospitalization. I mean, there's a lot of
25 things in the medical chart that you don't know as a

1 treating physician.

2 The issue is those were already prepared by the time I
3 showed up for the procedure. He's fixed, he's fine. Not
4 fixed, but he's clear for surgery. And that's why we use
5 an anesthesiologist because they listen to lungs every
6 single day. It's like me telling a cardiologist I hear --
7 I hear a murmur. And they say, "I don't." I can't out
8 rule them and start reading echo-cardiograms and things
9 like that. I mean, and if I refer this guy to a pulmonary
10 for -- As you're assuming that I should have done, sent him
11 to a lung doctor I would probably be laughed out of the
12 lounge. He would say, "Well, what do you want us to do?
13 COPD? It's not reversible." All their gonna -- and he has
14 good function. He has good function. That's the key.
15 Pulmonary rehabilitation only works for symptoms. If
16 you're short of breath, if you're -- if you're having
17 issues, you can't walk from here to the car, there's things
18 that they can do. There's medications that can be given to
19 improve the functioning of the patient. Once he's at
20 eighty-five percent, he's at eighty-five percent. I wish I
21 could go over there and take a pulse ox right now and put
22 it on the finger. I bet you could see at least eighty-five
23 percent or lower.

24 Q. My question is simple. You didn't know those things

25 --

1 A. I did not know those things.

2 Q. And you said you were supposed to in order to meet the
3 standard of care. If you're supposed to and you didn't,
4 doesn't that mean that you were negligent ---

5 A. No.

6 Q. --- because you didn't do what you were supposed to?

7 A. No. I don't know how many periods are in his chart
8 either. Does that mean I'm negligent because I don't know
9 every single fact and detail of the chart? I know the
10 pertinent facts. I know the facts that pertain to his
11 outcome.

12 Q. Do you think the lung function of a patient is
13 pertinent to his surgical outcome?

14 A. Yes, and his was fine. Good enough to undergo
15 surgery. It was not great. Yes he had COPD, but I have a
16 specialists in the field of anesthesia telling me I cannot
17 tell you not to take this person to surgery. And if you
18 want to go and talk about the oxygen saturation in healing,
19 if a person has an eighty-five percent oxygen in their
20 blood as they sit there, and if it's such bad healing that
21 it's going to take the colon and not allow it to heal;
22 guess what it's gonna do when you cut yourself shaving, you
23 skin your knee.? It's not going to heal either. So
24 obviously eighty-five percent is adequate blood to heal an
25 anastomosis. It's the 60's, it's the 70's and the 50's,

1 the low, low numbers like that. We don't walk around with
2 sixty percent oxygen. You can't. So when the oxygen
3 levels drop, when the oxygen masks come off -- That's why
4 it was so critical to put them back on because when he
5 dropped, that's when the damage was done.

6 Q. Whoa, hold up. So now you're saying because he was
7 fiddling with the mask, he caused the --

8 A. No, I'm just saying because he had moments where his
9 oxygen dropped, for whatever the reason may be, that's is
10 part -- that played into why he had an anastomotic leak.

11 Q. Okay, well, that's the first time we've heard that in
12 this whole case, two plus years. You understand that?

13 A. No.

14 Q. Let's talk about your examination. Now you told us in
15 deposition that you did not do an examination of the
16 patient between the time of your office visit and the time
17 of the procedure. That's what you said. Right?

18 A. Yes, that's right. That's correct.

19 Q. And in fact we've seen this before, and I'm going to
20 put it up again. If you need your original up there, let
21 me go ahead and hand it to you in case you need it.

22 A. Can you let me get this out?

23 Q. Yes.

24 MR. MCGOWAN: Your Honor, may he open that?

25 THE COURT: Yes, sir, go ahead.

1 A. And what -- And tell me the page number.

2 Q. Ninety-one.

3 A. Sometimes things are -- Okay, go ahead.

4 Q. The rule of the requirement of the standard of care is
5 that you do another examination of the patient before the
6 procedure to make sure nothing has changed. Is that right?

7 A. Define "examination" before I answer that.

8 Q. You have to make sure that nothing has changed with
9 your patient between the time you last saw him and the time
10 you're going to do --

11 A. Nothing significantly has changed.

12 Q. And in order to do that, you need to do an examination
13 of the patient. Yes?

14 A. A cursory examination in conjunction with the full
15 anesthesia evaluation.

16 Q. All right. So I asked you if you did another physical
17 exam of the patient before the procedure, and you said no.
18 Right?

19 A. Yes. And I realize I said no again. Yes.

20 Q. So if the requirement is that you did do, examine your
21 patient to make sure nothing's changed, and you didn't do
22 it, that would be negligent. Yes?

23 A. I'm -- I'm examining -- examining you right now, but
24 as far as a full history and physical, I did not do that.
25 But I could still could be considered an examination by

1 examining a patient.

2 Q. So are you going to --

3 A. The intent of that form is to make sure the doctor
4 comes in, sees the patient, make sure they have any
5 questions. And if there's anything relevant, the patient
6 says, "You know what? I do have the flu. Should I have
7 the surgery?" That's when it's picked up. That's the
8 intent of the form. The intent of the form is not to have
9 two complete physical examinations. A physical examination
10 takes like twenty minutes, and on top of all of the
11 paperwork, that we'd be operating all day and all night
12 because we'd have to do physical examinations left and
13 right.

14 Q. Well, what it says -- This is what the people that
15 certify hospitals requires, and this is what is required of
16 you. Is it not? Did you have to certify that the attached
17 H&P, which is the same one from your office. Right?

18 A. Yes.

19 Q. Has been reviewed?

20 A. Yes.

21 Q. And the contents accurately reflect the patient's
22 condition today.

23 A. Yes.

24 Q. Without any additions or revisions to the original
25 document?

1 A. Correct.

2 Q. Did you examine the patient to know whether or not
3 your H&P, your History and Physical was in fact accurate
4 without any additions or revisions?

5 A. Yes. The mode of examination is different.

6 Q. But it's not accurate. Wasn't it? Because at office,
7 you found clear lung sounds, and in the hospital, there
8 were diminished lung sounds.

9 A. Well my anesthesiologist did not find diminished
10 breath sounds. That was a nurse. No offense to nurses,
11 but if the anesthesiologist doesn't hear decreased breath
12 sounds, I'm done. I mean, I have no concern about the
13 lungs anymore.

14 Q. Did you check, yourself?

15 A. No.

16 Q. So you certified that there was nothing significantly
17 different without even looking at the chart to know about
18 the O2 sat, the x-ray report, or listening to the patient's
19 lungs?

20 A. That is correct.

21 Q. Isn't that a recipe for somebody to get hurt because
22 just --

23 A. A recipe for somebody to get hurt is doing exactly
24 what you said and not talking to the individuals who
25 actually perform the procedures, who actually can tell you

1 what they found. I'd much rather hear from a nurse say "He
2 doesn't look too good to me." That carries a lot of weight
3 to me versus a check box saying, "No cough." Do you
4 understand what I'm saying? There are intangibles that I
5 get from a human being that are -- She can tell me, "Hey, I
6 found decreased breath sounds. He doesn't look quite
7 right." This form would have just been decreased breath
8 sounds. So, I don't rely on the chart. You guys rely on
9 the chart, but I rely more on coming in and speaking to the
10 people who are involved in the care of the patient. When I
11 make rounds with patients in the hospital, I look at the
12 chart. I mean that's where I get the fever, the
13 temperature, and things, but I'd much rather hear from the
14 nurse who's taking care of the patient around the clock
15 because she's going to tell me things that aren't in her
16 notes because she has to write those out. So it's way
17 safer to actually talk to the individuals than go pouring
18 through the minutia of this chart. As you can see, we
19 couldn't see -- Doctor Salymvari couldn't see if the thing
20 was checked. We couldn't read the ninety-two percent. It
21 was ninety-five, ninety-three. And that's why I talk to
22 people about it. I go right there.

23 Q. How is it that you are supposed to certify that the
24 patient's condition has not changed without examining the
25 patient?

1 A. By talking to them and looking at them.

2 Q. So it is your standard everyday practice to not look
3 at the chart. And it's not a big chart when you get in
4 there because the patient's been --

5 A. Oh yes, it is.

6 Q. Oh so, you're telling me that the chart -- Well let me
7 back this up.

8 A. You see how many boxes there are on those pages?
9 There were tons of check marks.

10 Q. Are you telling me that you normally do procedures on
11 patients where you don't even pick up their admission
12 database chart and look at it? Is that --

13 A. I look at it. I look at it. You asked me in my
14 deposition had I ever seen this page with the eighty-five
15 percent on it before that. And I said no. I answered your
16 question. Today I'm telling you, I didn't see the eighty-
17 five percent because I knew he had the ninety-two with two
18 oxygen -- two liters of oxygen and the anesthesiologist
19 telling me everything is fine. I'm completely comfortable
20 healing anything I've done intraoperatively with a ninety-
21 five percent, or an eighty-five percent at that. Now if
22 the anesthesiologist who put oxygen on him when he was
23 eighty-five percent, she would have said, "Ha, he's at
24 eighty-five percent, you sure you want to go on?" And I
25 probably would have said no. But if he comes up that

1 easily with such a teeny amount of oxygen, for all I know
2 maybe he clears, maybe he really lives around ninety
3 percent. Maybe his regular oxygen level may be ninety
4 percent. He just does ---

5 (WITNESS DREW IN HIS BREATH.)

6 A. --- a couple of times. We don't know that. And when I
7 come in to see him preoperatively, I see a big fat ninety-
8 two percent on that monitor they hook you up to, and blood
9 pressure and temperature is good. I hear nothing about a
10 cough or a flu. I don't know what about this case
11 presentation I could do -- I don't know why I would want to
12 cancel it.

13 Q. Ninety-two percent oxygen on two liters of O2 is not
14 normal. You agree?

15 A. It's not normal, but it's still adequate to undergo an
16 operation.

17 Q. Well, let's talk about that, Doctor. There's no doubt
18 that this was an elective procedure. It could have
19 happened that day or any day reasonably within the next
20 thirty. Fair?

21 A. Fair.

22 Q. And you have a patient that -- The only evidence that
23 you have is that his lung status is completely normal based
24 upon your office visit. Right?

25 A. Yes.

1 Q. And now you have evidence to suggest just based upon
2 knowing he's got ninety-two O2 sat with oxygen even without
3 looking at anything else, that there's something not normal
4 about his lungs. Right?

5 A. Correct.

6 Q. It could be something chronic, or it could be
7 something acute. Yes?

8 A. Correct.

9 Q. And you know that this is an elective procedure?

10 A. Correct.

11 Q. You could put it off until tomorrow or the next day.

12 A. Sure.

13 Q. And you know that patients who have bad lung
14 conditions, either acutely or chronically, have different
15 sets of risks with surgeries. Yes?

16 A. Correct.

17 Q. And if the cardinal rule is never to expose your
18 patient to unnecessary risk, doesn't a reasonable, careful
19 doctor say, "Time out. We don't know that this is normal
20 for him. It may be acute. It may be chronic."

21 A. Sure.

22 Q. "We don't know. So what we're going to do is we're
23 going to stop this now, figure it out, and then try again
24 later."

25 A. That was done.

1 Q. But it wasn't done because you did the procedure.

2 A. It was done by my anesthesiologist. I don't need a
3 pulmonary -- a pulmonologist, if that's what you're
4 inferring, that I send them to a medical doctor, that some
5 magical thing is done called pulmonary rehabilitation so
6 they'll come back and be a hundred percent and running in
7 marathons. And it just is not going to work. It just
8 doesn't happen that way. So my anesthesiologist is the one
9 who provides that opinion. If she didn't feel comfortable
10 and said, "No, I think he really needs a lung doctor. It's
11 beyond the scope of what I do." No problem. I could do it
12 anytime, like you said. It was never a concern. I want to
13 make that abundantly clear. It was never a concern. Oh my
14 gosh, you think we should? I mean, sometimes instructions
15 like that happen. They may not read the chart or reach the
16 chart. Not at any point in any of this was there ever an
17 issue, was there ever an inkling from the patient, from the
18 family, from myself that this should not be done. And I
19 still see no evidence to this day that there is any.

20 Q. You've already told us the anesthesiologist's job is
21 to make sure that the anesthesia can be done safely.

22 Right?

23 A. Yes.

24 Q. And your job is to make sure the whole procedure can
25 be done safely including the healing period. Yes?

1 A. Correct.

2 Q. So if you were doing your job, if you were caring
3 about this patient, if you are doing what you're supposed
4 to be doing, aren't you required to stop and say, "Listen,
5 this lung stuff is new. We need to get this figured out."

6 A. I did. The act of me doing this is saying, "Dr. Lupo,
7 what do you think" is doing that. And as soon as she tells
8 me, "I don't see any contra indication to surgery. I've
9 listened to his lungs. I checked a chest X-ray, and his
10 oxidation is adequate. He's fine from my standpoint to go
11 to surgery." Then I automatically respond and say, "Okay,
12 there's nothing that contra indicates my surgery."

13 Q. So what I'm hearing you say now is that you don't do
14 any independent evaluation of the patient. You just say,
15 "Anesthesiologist, it's good, it's good." Is that it?

16 A. No. If I walk in and the patient's hocking up all
17 kinds of stuff and the anesthesiologist -- You'll hear her
18 tomorrow. It's not like some flunky I'm working with.
19 She's a very capable physician, and I respect her opinion
20 on the medical condition of the patient. I don't
21 understand -- Why would I even use an anesthesiologist if I
22 didn't care what they say? If they clear a patient for
23 surgery I'm fine with it. I believe -- I do my own
24 evaluation. Then when you get to anesthesiology, if I find
25 something that I don't like, I don't even bring them to

1 surgery. I say, "Listen, you've got a lot of issues going
2 on here with your lungs. You can barely get into this
3 office. You're short of breath. Let's get your normal
4 doctor who knows you best to evaluate you." And that's
5 what I do.

6 Q. Do you --

7 A. If I don't have that feeling, I let the anesthesia
8 make the call unless there's something that crops up the
9 day of surgery.

10 Q. Do you understand that in this case, the anesthesia
11 was safely done, and he didn't die during the procedure?

12 A. I know he didn't die during the procedure.

13 Q. And do you understand that his problem was in the
14 healing period in the days afterward?

15 A. Immediately afterward -- There is a spectrum here. It
16 doesn't end where as soon as he wakes up, their not clear.
17 They round on the patients the next couple of days, the
18 anesthesiologist does. Because they want to see what
19 effects being put to sleep has on the patient. And if
20 there's anything they can do from a pulmonary standpoint to
21 help out, they do that. Just like I follow the patient all
22 the way until they're in my office saying, "Hey, I want to
23 go back to work." And then I'm -- I release them. They
24 don't just wake up and the anesthesiologist throws me the
25 keys and says, "Good luck."

1 Q. Are you responsible for this patient's care in that
2 hospital or not?

3 A. Yes.

4 Q. And you are responsible to make sure that, that
5 surgery is done properly, and that the patient can heal
6 from it. Right?

7 A. That is correct.

8 Q. And in this case, you've told us that the reason it
9 didn't heal properly was the low oxygen. Right?

10 A. Low oxygen was a contributing factor, yes.

11 Q. A substantial contributing cause is what we
12 determined. Right?

13 A. Correct.

14 Q. And so it's your view -- I'm having a hard time giving
15 your responsibility to the patient for the whole process
16 with what you're telling me in terms of the
17 anesthesiologist says it's okay, you do it. Do you
18 fundamentally understand the scope of the
19 anesthesiologist's responsibility?

20 A. I believe I do.

21 Q. And do you fundamentally understand the scope of your
22 responsibility?

23 A. I believe I do.

24 Q. Did you ever discuss -- Well let's just use this
25 informed consent business. Did you ever discuss with Mr.

1 Sexton between the 6th when he signed the form and the time
2 that you took him back for the procedure, did you ever
3 discuss with him the fact that he did have these lung
4 issues going on?

5 A. I can't recall that specifically.

6 Q. It's certainly not in the chart.

7 A. It may not be.

8 Q. And if you didn't know, you certainly could not have
9 discussed it with him. Right?

10 A. But my problem is, if I came in and I saw him on
11 oxygen with ninety-two percent, that is so a non-issue. I
12 can't remember if I said anything to him specifically "Oh,
13 look you're on oxygen" or if I just went "Oh great, he's
14 ninety-two percent. We're fine." But to actually have
15 said that to him, I cannot recall.

16 Q. That wasn't my question. If you didn't know about the
17 O2 problems, and the diminished breath sounds, and the
18 atelectasis, and interstitium, and all that, you could not
19 and therefore did not discuss it with Mr. Sexton
20 beforehand?

21 A. I cannot recall. I can't -- I know I didn't discuss
22 the X-ray report with him because that was printed out the
23 next day, and I told you I didn't know about it at the
24 time. I just incurred that he was fine. I didn't discuss
25 the decreased breath sounds because that was addressed by

1 my anesthesiologist. And the nurse slapped on some oxygen,
2 and he was up to ninety-two percent. So I didn't need to
3 discuss with him anything.

4 Q. Well you didn't -- You did not discuss with him the
5 fact that his lungs were not functioning normally; is that
6 right?

7 A. That's correct.

8 Q. And the patient is entitled to know because normally
9 functioning lungs is a risk factor if they're abnormal, for
10 any surgery. Right?

11 A. There's a degree of abnormality which he wasn't even
12 in preoperatively.

13 Q. It is true that you expected normal O2 sat to be
14 ninety-four, ninety-five plus?

15 A. Like I said, we accept ninety-two percent and greater
16 as a whole, in general, in patients that are in the
17 hospital like anybody in this room. If you had a ninety-
18 two percent -- If you were ninety-three, ninety-four, and
19 you had oxygen on, we would take the oxygen off. And as
20 long as you were above ninety-two, ninety-two percent or
21 greater, we'd be fine. Some -- Some doctors even go down
22 to ninety percent. So eighty-five is real close. He could
23 maybe just cough up a hocker and maybe be eighty-nine. I
24 don't know. I'm just saying that, it's not that bad. And
25 then if you throw in the forty pack year history smoking,

1 it's actually pretty darn good to be eighty-five percent.
2 He's -- He's accommodated very well to that. I mean, I'm
3 surprised he's able to carry on like he does if he has this
4 poor lung function. He passed all his lung function tests.
5 He's made of good stuff I guess.

6 Q. Ninety-two percent on oxygen is a material abnormality
7 for the purpose of a surgery. Isn't it?

8 A. It's an abnormality, but it's not prohibitive. Not at
9 all.

10 Q. Is that a material abnormality that the patient has a
11 right to know that they have an increased risk because
12 their O2 is only ninety-two percent on oxygen?

13 A. No.

14 Q. The patient doesn't have a right to know?

15 A. He doesn't have an increased risk.

16 Q. If oxygen is critical for healing, and if in this case
17 the lack of oxygen was a substantial contributing cause,
18 and if in this case he did have decreased oxygen, isn't it
19 by definition a material risk going to --

20 A. Ninety-two percent is acceptable. That's what I'm
21 saying. Ninety-two percent is acceptable.

22 Q. Have you changed anything about the way you practice
23 surgery here in town? Do you do this --

24 A. I don't understand the question.

25 Q. As a result of this whole case, the fact that we

1 brought this up, that we've been talking to you about this
2 for the last two years, have you done anything to change
3 the way that you practice medicine? Do you look at the
4 chart now?

5 A. Yes.

6 Q. Okay. So that's a good thing to do. Right? Look at
7 the chart.

8 A. Sure.

9 Q. And you do it now?

10 A. I always do it.

11 Q. But you didn't then?

12 A. Not that particular situation, I didn't.

13 Q. Don't you think that's being a little flippant, a
14 little negligent about the care of this patient?

15 A. No I do not. Who would you want -- rather want -- Who
16 would you rather have evaluate your lung function? Me or
17 an anesthesiologist?

18 A. A pulmonologist.

19 MR. MCGOWAN: Thank you, Doctor.

20 THE COURT: All right, redirect.

21 MR. KING: Nothing, nothing further.

22 THE COURT: You can step down. Thank you.

23 (WITNESS LEAVES WITNESS STAND.)

24 THE COURT: Anybody else today?

25 MR. MCGOWAN: Not today, Your Honor. The two witnesses

1 I anticipate tomorrow morning.

2 THE COURT: We have two witnesses lined up in the
3 morning so we'll take those up starting at 9:30, and once
4 we're through with those, we'll be able to have the
5 attorneys make their closing arguments for you, and I'll
6 charge you the law, and we'll have the case in your hands,
7 and that should be around lunchtime tomorrow, and if it is
8 around lunchtime, we'll order lunch in so you won't have to
9 go out and interrupt your deliberations. So keeping in
10 mind my admonitions, have a pleasant evening, and we'll see
11 you back at 9:30 in the morning.

12 (JURY EXITS COURTROOM AT 03:17 PM.)

13 THE COURT: Why don't we take a short break and then
14 we can have in-chambers, take a look at the verdict forms,
15 and the request to charge. That helps utilize this time
16 better tomorrow.

17 (COURT IN RECESS AT 03:20 PM.)

18 (COURT BACK IN SESSION WEDNESDAY, AUGUST 3, 2011 AT
19 09:45 AM.)

20 THE COURT: Thank you. Good morning. Take your
21 seats.

22 Anything from the Plaintiff before we get the jury
23 in?

24 MR. MCGOWAN: No, sir.

25 THE COURT: Anything from the Defense?

1 MR. KING: No, sir.

2 THE COURT: All right. Bring in the jury.

3 MR. KING: May we approach? Judge, can we approach
4 just a minute?

5 THE COURT: Yes, sir.

6 (SIDE BAR OFF THE RECORD AT 09:46 AM.)

7 (JURY REENTERS COURTROOM AT 09:46 AM.)

8 THE COURT: Good morning.

9 Counselor.

10 MR. KING: May it please the Court. Give me a minute
11 to set up.

12 (PAUSE.)

13 MR. KING: Your Honor, Defense calls Doctor Susan
14 Lupo.

15 THE COURT: Please come up and be sworn.

16 MADAME CLERK: Doctor, can you come this way?

17 THE COURT: Yes, ma'am, over here.

18 MADAME CLERK: If I can get you to stop here, Doctor,
19 and place your left hand on the Bible and raise your
20 right.

21 (WHEREUPON: DOCTOR SUSAN
22 LUPO, BEING FIRST CALLED AND DULY SWORN, TESTIFIED AS
23 FOLLOWS:)

24 MADAME CLERK: Thank you. Come around and have a
25 seat please.

1 DIRECT EXAMINATION

2 DOCTOR SUSAN LUPO BY MR. KING:

3 Q. Good morning, Doctor Lupo?

4 A. Good morning.

5 Q. I'm Spencer King, I met you and I have subpoenaed you
6 on behalf of Doctor Espinal to be a witness in this case.

7 Do you understand?

8 A. Yes, sir.

9 THE COURT: You need to speak up please, ma'am, ---

10 A. Okay.

11 THE COURT: --- into the mic.

12 Q. You are a medical doctor are you not please, ma'am?

13 A. Yes, sir, that's correct.

14 Q. And what is your medical speciality?

15 A. Anesthesiology.

16 Q. And what is anesthesiology?

17 A. Anesthesiology is a sub-speciality of medicine
18 whereby we make patients insensitive to pain, we put
19 patients to sleep, we provide amnesia and appropriate
20 conditions for the conduct of surgery.

21 Q. Would it be that you do some type of pain management
22 in some instances?

23 A. Most -- Certainly most often that it would be
24 postoperatively.

25 Q. And you sleep patients?

1 A. That's right. General anesthesia means putting a
2 patient to sleep; that's correct.

3 Q. And are you with a group?

4 A. I am.

5 Q. What is the group?

6 A. The group is Anesthesia Associates of Rock Hill.

7 Q. Okay. And does your group provide anesthesiology for
8 the operative procedures at Piedmont Hospital?

9 A. That's correct.

10 Q. And how many physicians are in your group?

11 A. Seven physicians.

12 Q. And how long have you been with that group?

13 A. For twenty-one years.

14 Q. And give the jury just a kind of a capsule of your
15 education and medical training please, ma'am.

16 A. Certainly. I have a Bachelor's degree in Biology
17 from Wake Forest University in Winston-Salem, North
18 Carolina. I have a medical doctor degree from Wake Forest
19 University School of Medicine also in Winston-Salem. I
20 did an internal medicine residency at North Carolina
21 Baptist Hospital which is the hospital affiliated with
22 Wake Forest. And then I followed that with a anesthesia
23 residency at the hospital of the University of
24 Pennsylvania in Philadelphia. And then lastly I did a
25 clinical cardiac fellowship for a six month period of time

1 which means that I did procedures in the operating room
2 but did not do a research component to a fellowship.

3 Q. Okay. And you know Doctor Alex Espinal?

4 A. I do; that's right.

5 Q. And there are cases through the years in which you
6 have been the anesthesiologist that slept the patient that
7 Doctor Espinal was doing surgery on?

8 A. We work together regularly yes, sir.

9 Q. All right. Do you know Doctor Espinal socially?

10 A. No. No.

11 Q. Now you were involved according to the medical
12 records from Piedmont, you were involved actually in both
13 the operative procedures involving Mr. Sexton on March the
14 7th of 2007 and the one on 2010; what that -

15 A. March the 10th.

16 Q. Okay. Let me ask you if you will, the Exhibit
17 Notebook is next -- up on the bar in front of you. If you
18 will look at that please, ma'am. And let me ask you to
19 look at Tab 7.

20 A. I have it.

21 Q. Okay now, Tab 7 has two pages. One is Piedmont-00099
22 and the other one is PMC-00098. And the first page, on
23 the second number 99, is designated Pre-Anesthesia
24 Questionnaire.

25 A. That's correct.

1 Q. And tell me about that form. When does that form
2 generate?

3 A. This form is generated in our pre-operative clinic.
4 We have a clinic where patients who are coming to surgery
5 will come to two or three days before surgery. It is
6 staffed by RN's from the hospital and it is also staffed
7 by RN's who are employees of my group and trained by us to
8 interview patients pre-operatively from the anesthetic
9 standpoint.

10 Q. And what is the role of the anesthesiologist? What
11 is your role?

12 A. In the completion of this particular form?

13 Q. Yes, ma'am.

14 Q. Typically what happens is that a patient will come to
15 the clinic a couple of days ahead of time. The patient
16 primarily will complete the left hand side of this
17 questionnaire to the left of that dark vertical bar. The
18 check marks usually, you know, indicate a condition that
19 the patient reports having. Some of the notations on the
20 right of that box are written by the RN, my RN employed by
21 my group, as she interviews the patient. The information
22 to the right of the vertical bar is written by my nurse.
23 And then on the day of surgery usually, most usually, on
24 the day of surgery sometimes on the afternoon of surgery
25 prior to surgery the anesthesiologist, me in this case,

1 will review this information. We usually do it the day of
2 surgery when we have access of course to the patient.
3 We'll ask additional questions and give additional
4 information that we feel is necessary.

5 Q. Let me ask you.

6 A. Sure.

7 Q. You review these records. Correct?

8 A. Correct.

9 Q. And you interview the patient?

10 A. That's correct.

11 Q. Okay. Go ahead and proceed from there.

12 A. And that usually happens on the day of surgery,
13 sometimes prior to the surgical procedure, usually an hour
14 or an hour and a half prior to the patient going to the
15 operating room. And then we complete this by signing it
16 and dating it because the RN, the RN in our pre-op clinic
17 is not a qualified MC provider and cannot complete the
18 anesthetic questionnaire or the anesthetic pre-op. The
19 anesthesiologist has to do that.

20 Q. Now does this form, is this form routinely used at
21 Piedmont operating procedures?

22 A. This is our old form we have recently updated it and
23 it's a whole lot more involved but yes.

24 Q. 2007 was this the form -

25 A. On every patient yes, sir.

1 Q. And is it your routine and that of other
2 anesthesiologist before you make a decision about
3 proceeding with anesthesia, general anesthesia, to review
4 this information?

5 A. That's correct.

6 Q. And that was done in this case?

7 A. That's correct.

8 Q. All right. And then on the right hand side below the
9 lower portion, the block, the block on the right side that
10 talks about reviewer's notes, is that your signature?

11 A. At the very bottom is my signature yes. And the
12 date.

13 Q. Okay. And that's 3/7/07?

14 A. 3/7/07.

15 Q. Looking above that can you read what was checked? I
16 see starting at Risk. Would you read that to the jury.

17 A. There is an X in the box and then it says, "Risk,
18 benefits, alternatives and potential complications of
19 anesthesia were discussed with the patient and/or guardian
20 who agree to proceed with the anesthetic plan. All
21 questions answered." And then the anesthetic plan is GA
22 standing for general anesthesia. And then my signature
23 and the date.

24 Q. What is the significance of your signature?

25 A. Well as I said my signature completes the anesthetic

1 evaluation. That is a requirement for my involvement in
2 the anesthetic. Primarily that's a CMS requirement.

3 Q. And is that signature are you concluding the patient
4 is a suitable candidate for general anesthesia?

5 A. Having reviewed this questionnaire in this form and
6 signed it generally speaking that is what -- yes I have
7 concluded the patient's medical status is stable to
8 proceed.

9 Q. Now we have been told, the jury has been told that
10 you the anesthesiologist can stop an operative procedure;
11 is that correct?

12 A. I would never do that unilaterally. If I feel that a
13 patient's medical condition is unstable, that something is
14 new or changed about a patient's status, then I would
15 discuss that with the operative surgeon.

16 Q. And the operative surgeon can stop a procedure?

17 A. That's right.

18 Q. Now, before you noted that in your opinion Mr. Sexton
19 proceed with surgery, what information did you know about
20 him?

21 A. Well based on the information primarily on the left
22 hand side of his form, he indicated to us that he was a
23 fairly active gentleman, that he could -- that there is a
24 check mark in a box that says that he was able to climb
25 stairs, walk briskly, do heavy house work including moving

1 furniture and heavy manual labor, and that is a given a
2 metabolic rating of four to ten. That's actually a
3 cardiomasculat, a measure of cardiomasculat fitness, and
4 that's a pretty fit person who can do greater, greater
5 than what we call four minutes of activity.

6 Q. Let me stop you. You're looking at upper - -

7 A. Yes, sir.

8 Q. - - - left hand corner. One, two, three.

9 A. That's right.

10 Q. That's where you're talking about?

11 A. That's right. And then in the second, question
12 Number 2, the patient admitted to having shortness of
13 breath at times with some of those activities. The third
14 question is for us to try to discern if patients are being
15 actively followed by a cardiology, cardiologist. We
16 weren't sure exactly or the patient wasn't sure who his
17 cardiologist was because ti had been a few years since he
18 had seen a cardiologist. Shall I continue about that?

19 Q. Yes please, ma'am.

20 A. So the next question Number 4, primarily deals with
21 cardiac issues and it says that he had a left heart
22 cauterization the year 2000 and had a stint placed at that
23 time. You know that is a stint into one of the coronary
24 arteries because he had -- he must have had a coronary
25 artery that had what they call a flow contusion and they

1 put a stint, deployed a stint, and the stint holds the
2 artery open. Again he denied any chest pain but did
3 report occasional shortness of breath on exertion that
4 would be consistent with the information above about being
5 able to do heavy manual labor, moving furniture. He
6 reported hypertension. He reported that he smoked
7 cigarettes and someone in the pre-op clinic would have
8 written this one pack per day times forty years. I think
9 one of the reviews, maybe the nurse, who helped him fill
10 this form out may have written that. And then he reported
11 a recent cold or respiratory infection, a head cold with
12 no fever. There was a prior history of a bleeding ulcer
13 in 2004. And then there was a history of alcohol abuse.
14 And then the last thing in that box says that the patient
15 denied having ever had a problem with the anesthesia
16 medications or his family having a problem.

17 Q. Down at the bottom it talks in terms of medication he
18 had taken?

19 A. That's right. He was on a blood pressure medication
20 which we determined to be verapamil, ER which stands for
21 extended relief. And Nexium which is for stomach acid.

22 Q. Prior operation?

23 A. He had had an appendectomy, I think that's bilateral.
24 Ear surgeries and a tonsillectomy. And that's where that
25 question about whether or not he ever had any trouble with

1 any specific anesthesia medicines which we want to know
2 that to avoid anything that we knew he could have problems
3 with in the past.

4 Q. And then in the upper right hand corner it talks in
5 terms of vital signs.

6 A. Vital signs; that's right. And these were the vital
7 signs that were done that day when he was in the pre-
8 operative clinic.

9 Q. And what are those?

10 A. Blood pressure 149 over 99. Pulse of 72. His weight
11 was 73 kilograms and he's 5'9".

12 Q. Any of those a concern?

13 A. No.

14 Q. Now, Doctor Lupo, that morning did you learn that on
15 the presentation to the hospital that Mr. Sexton's oxygen
16 saturation was 85?

17 A. What I will tell you is that I don't remember
18 anything about -- I have no recall of this patient or his
19 hospitalization. And what I have -- What I am doing is
20 putting together what I surmise or what I think happened
21 based on my review of the record. And what it shows is
22 that his oxygen saturations is 85 when he presented the
23 morning of the 7th for his surgery.

24 Q. And that's low?

25 A. That is an oxygen saturation that would cause the

1 nurse to call one of the doctors.

2 Q. And did you do something that morning in response to

3 ---

4 a. I did.

5 Q. --- the issue of oxygenation?

6 A. I have to assume that the intake nurses in the pre-
7 operative area, I'm sorry, the outpatient area where
8 patients come in for, you know, to get ready for surgery,
9 that the nurse called me about that oxygen saturation.

10 Q. And what did you do?

11 A. I ordered a chest x-ray.

12 Q. And chest x-ray, I believe under Tab 16.

13 A. Right.

14 Q. Tab 16, Piedmont 1212, and that was read by Doctor
15 Salman who is a radiologist?

16 A. That's right. Yes.

17 Q. And when the radiologist reviews the report, do you
18 get a copy of the report immediately?

19 A. No.

20 Q. What do you get after the radiologist reads it?

21 A. Well this was all happening about Seven o'clock in
22 the morning because Mr. Sexton was scheduled for a first
23 case, a 7:30 procedure and he would have gotten to the
24 hospital at 5:30 or soon thereafter. So I would have
25 ordered, I would have given a verbal report to the nurse

1 for a chest x-ray and there is a record of the fact that
2 he went over to the radiology department for the x-ray and
3 he returned to outpatient pre-operative area. And then at
4 that time of the day we would have received a verbal
5 report. The way that it happens is that someone in
6 radiology, it's probably either a radiology tech who has
7 shown the film to the radiologist and the radiologist tech
8 calls to the outpatient nursing desk with a verbal report
9 of the chest x-ray and it was reported -- In just knowing
10 how these things happen, I don't remember what the report
11 was, but it was reported as no acute process or -- That's
12 usually what they say, no acute process.

13 Q. And tell the jury what no acute process means to you
14 as a physician?

15 A. Well in order to -- I was -- An oxygen saturation of
16 85 and Mr. Sexton was a little bit lower than I might
17 expect. Patient's that we see who are heavy smokers as
18 Mr. Sexton was, have, they have COPD by virtue of a long
19 history of smoking. And they get a lot of mucous and
20 secretions that kind of layer along the airways and cause
21 closure of the small air sacs in the distal part of the
22 lung, out in the lung fields. And when those small -

23 MR. MCGOWAN: Your Honor, I'm going to have to object
24 to the relevance of any of this. There is no evidence in
25 any record anywhere that Mr. Sexton was diagnosed with

1 COPD and this is all speculation on the part of this
2 witness and therefore irrelevant.

3 MR. KING: I think the records do indicate that he
4 was diagnosed with COPD.

5 THE COURT: I'm going to over rule the objection and
6 allow it. There was a lot of testimony yesterday about
7 COPD and I don't know where it came from, the genesis of
8 it. I over rule the objection.

9 BY MR. KING:

10 Q. Proceed if you would, Doctor Lupo.

11 A. Diagnoses of COPD is a clinical diagnoses in anyone
12 -- Mr. Sexton reported to us that he had -- that he
13 smoked a pack a day for forty years. When the
14 pulmanologist saw him the next day he told him he smoked
15 two packs a day. So if he smoked somewhere between one
16 and two packs a day for forty years that's what we call
17 eighty packs years of smoking history and that person has
18 got COPD period. It's a critical diagnoses. And I expect
19 that someone with that kind of history is going to run
20 oxygen saturation on room air of 89, 90, maybe 91, so 85
21 was a little bit low. And I wanted to make sure that
22 morning that there wasn't something else that was causing
23 his oxygen saturation to be low. And there are a whole
24 host of things that could do that. The most common would
25 be congestive heart failure. This gentleman had a history

1 of coronary disease, neurothorax, a pulmonary embolus,
2 collapsed lung, a big lung cancer sitting in his chest
3 that was undiagnosed. Any number of things -

4 Q. Like pneumonia?

5 A. And pneumonia..

6 MADAME COURT REPORTER: I'm sorry, Mr. King, I could
7 not hear you.

8 MR. KING: I'm sorry. Pneumonia.

9 A. And of course pneumonia would be -- pneumonia and
10 congestive heart failure would be the two most common
11 things. But all those other things could also cause his
12 oxygen saturation to be lower than we would expect. So I
13 ordered the chest x-ray to make sure there wasn't
14 something else that's going on. And when it was reported
15 to me as no acute process, then I made the determination
16 that his oxygen saturation and his pulmonary status was
17 stable to proceed with an necessary operation. In the
18 meantime he had been placed on two liters of nasal oxygen
19 and his oxygen saturation had come up nicely to about
20 ninety-two percent I think. And the other thing that I
21 did according to the records is I ordered a nebulizer
22 treatment, an inhaled nebulizer treatment and that, I did
23 that to help reexpand the lung, you know, to get, to
24 encourage the patient to cough and deep breath and to do
25 what we call recruitment maneuvers to try to reexpand

1 those atalechepatic closed areas of the lung. And it was
2 my feeling that based on his response to those therapies
3 and the fact that the chest x-ray showed nothing new, that
4 he was stable from his pulmonary standpoint to undergo
5 what was a necessary operation.

6 Q. Doctor Lupo, you've reviewed all the medical records
7 in this case have you not?

8 A. I think I have yes.

9 Q. And do you see any records in there where you or
10 anyone else directed that this surgery be postponed?

11 A. For the first operation?

12 Q. The first operation, the one we're talking about on
13 the morning of the 7th.

14 A. No.

15 Q. If there was a decision, a consideration, would there
16 not be records?

17 A. Maybe not. No.

18 Q. You have no memory, you have not found anything where
19 anyone considered putting off the procedure?

20 A. On that morning that's correct, no.

21 Q. You've told us you would not put it off without
22 conferring with the physician?

23 A. Absolutely not.

24 Q. Now do you remember talking to Doctor Espinal before
25 the surgery?

1 A. No, no, sir.

2 Q. All right now, looking under that same tab, let's go
3 back to Tab. Have you fully told the jury about the
4 information contained on PMC-0099? We discussed that.
5 Correct?

6 A. I couldn't hear you, I'm sorry.

7 Q. We discussed all the information on PMC-99, the pre-
8 anesthesia questionnaire?

9 A. Pretty much. We didn't talk about the airway exam or
10 his ASA classification III.

11 Q. Tell us about that, tell us about ASA III.

12 A. The A stands for the American Society of
13 Anesthesiology. There is a five level grading system that
14 we use on every patient. And it's actually widely used in
15 the surgical field as well to score a patient's degree of
16 health severity essentially.

17 Q. And it was greater than III?

18 A. At a five.

19 Q. What is III.

20 A. Let me start at the beginning. ASA Class I is a
21 person with no concurrent medical problems. Healthy
22 twenty-year old. A Class II patient is a person with mild
23 to moderate systemic disease that should not be limited,
24 should not interfere with activities of life; like treated
25 hypertension, mild asthma. A Class III patient is a

1 person, is a patient with moderate to severe disease that
2 would require treatment. And pretty much anyone who has
3 a history of coronary artery disease falls into that Class
4 III. And that would have been the way that he was rated
5 as a Class III.

6 Q. What is four?

7 A. Class IV is a patient with concurrent medical
8 conditions that are a constant threat to life. For
9 instance a patient in renal failure requires dialysis or a
10 patient with an acute MI, in the coronary unit of a
11 hospital. And then a Class V patient is a patient with
12 medical conditions that are likely to be fatal regardless
13 of whether the patient has the operation or not.

14 Q. In this case Mr. Sexton was given a Class III?

15 A. Class III.

16 Q. Class III. Now, going on to the next document which
17 looks to me like it's a graph.

18 A. That's right.

19 Q. Tell the jury what that is. This is PMC-98. Tell
20 the jury about that.

21 A. This is the intra-operative anesthesia; we call it
22 the anesthesia record. A lot of people call it the graph.
23 But this is where the anesthesia providers, all of the
24 notations that we make in the operating room during the
25 surgery.

1 Q. The patient here is asleep?

2 A. When they come into the operating they are not.

3 Q. They are put to sleep?

4 A. That's correct.

5 Q. And then you are monitoring their responses, their
6 vitals and their responses to anesthesia during the
7 procedure?

8 A. That's right. Now, I think it's important to note
9 that part of a requirement for general anesthesia, for a
10 entra-abdominal procedure like this was; this was a
11 laprascopic procedure, is that we have to intubate the
12 trachea, put a breathing tube in the trachea and breath
13 for the patient; or the patient during a procedure like
14 this is on a ventilator that's connected to our anesthesia
15 machine and that is routine for an entra-abdominal
16 procedure. So he would have been - he would have been
17 induced, we put the patient to sleep we induce anesthesia
18 and we intubate the trachea and place the patient on
19 ventilator in the operating room for the -- I think the
20 surgery took an hour and fifteen minutes.

21 Q. And, Doctor, I see a fair amount, kind of like on
22 most -- the middle of this page, I see checks and what
23 looks like kind of an up down mark, okay.

24 A. Right.

25 Q. Are those blood pressure markings?

1 A. Those are blood pressure markings.

2 Q. So you are measuring the diastolic and systolic blood
3 pressures throughout the procedure?

4 A. Every three minutes.

5 Q. And then down below that there are a number of
6 things, vitals, temperature, ECG. Correct?

7 A. That's right.

8 Q. And they are also being measured?

9 A. That's correct.

10 Q. And what were the O saturations during the surgical
11 procedure?

12 A. The first oxygen saturation that is recorded is a
13 ninety-six percent. And I think that would have been
14 before he went to sleep. And once he went to sleep and
15 was ventilated, on a ventilator, his oxygen saturation was
16 a hundred. And it was a hundred, ninety-eight, ninety-
17 nine, ninety-two, or ninety-seven, ninety-seven, ninety-
18 seven throughout the procedure.

19 Q. Are those the -- are those the expected range?

20 A. Yes.

21 Q. Anything in this operative procedure that's reflected
22 on this record that showed any type of a complication?

23 A. I consider this to be a routine anesthetic.

24 Q. Now, did your involvement with Mr. Sexton end on the
25 7th, I understand you are going to see him later, but as

1 of the 7th did your involvement with him as a patient end
2 at the conclusion of the operative procedure?

3 A. I -- part of my responsibility, part of the
4 definition of anesthetic care involves following and
5 managing patients in the recovery room, what we call the
6 PAC Unit, stands for Post Anesthesia Care Unit. So I was
7 helping to manage, manage him in the recovery room and we
8 do that; we're providing a medication, fluid management,
9 whatever is needed while a patient recovers from
10 anesthesia until they are ready to be discharged to the
11 next level of care. Whether they're an outpatient and
12 they go back to outpatient and go home or if they've been
13 admitted to the hospital.

14 Q. Now, do you know that following day, a pulmanologist,
15 Doctor Denenberg, was called in and consult by Doctor
16 Espinal?

17 A. That's right. I do know that. I've seen that.

18 Q. Have you reviewed that consult note?

19 A. Yes, sir.

20 Q. Anything that Doctor Denenberg reported in that
21 consultation -

22 MR. MCGOWAN: Your Honor, I object, this calls now
23 for an expert opinion from this witness, she's talking
24 about what other doctor's notes and what not.

25 MR. KING: I haven't -

1 THE COURT: I think he can ask what the notes
2 reflect.

3 BY MR. KING:

4 Q. My question to you, Doctor Lupo, is there anything in
5 Doctor -- Excuse me, Doctor Denenberg's consult that gave
6 you any information that you didn't already have?

7 A. Can you tell me where that is?

8 Q. I'm sorry, Tab 26. Three pages, PMC-5, 6 and 7.

9 A. Which tab is it?

10 Q. I'm sorry, 26.

11 A. Okay. May I have the question again?

12 Q. The question is, is anything Doctor Denenberg
13 reported in his consult note that you did not already
14 know?

15 A. That is a very thorough consult. I do -- it didn't
16 add anything to my understanding of Mr. Sexton's
17 condition.

18 Q. Now, you're not involved actively in the care and
19 treatment over the next rest, the rest of the 8th and the
20 9th?

21 A. That's correct.

22 Q. Now you do get involved in his care yet again on the
23 10th?

24 A. That's correct.

25 Q. Is that correct?

1 A. Yes.

2 Q. And those anesthesiology notes -- Doctor, I believe
3 we're under Tab 11 and Tab 30. Now do you understand at
4 this point this is on the morning of the 10th an
5 anastomotic leak has been diagnosed. I understand you're
6 not a surgeon, but would you agree this is an emergency
7 surgical procedure?

8 A. I would.

9 Q. And what was your involvement in that procedure?

10 A. I happen to be on call that Saturday so it was my
11 responsibility to take care of Mr. Sexton again when he
12 came to the operating room for this emergency surgery.

13 Q. And from an anesthesiologist standpoint, a
14 respiratory standpoint, what would have been done for Mr.
15 Sexton during this procedure?

16 A. Well the anesthetic for this operation was not unlike
17 the anesthetic from the first operation. We had to induce
18 anesthesia, put Mr. Sexton to sleep. He came down to us
19 with a face shield oxygen so we would have had to entubate
20 the trachea again, put him on a ventilator again in the
21 operating room, so our part really, yes it's quite similar
22 to the first operation.

23 Q. And he is put on a ventilator in that procedure?

24 A. That's right.

25 Q. Does he remain on the ventilator following discharge

1 from the OR?

2 A. That's correct. We left him on the ventilator and
3 took him to the PAC.

4 Q. What are the complications that develop in that
5 procedure?

6 A. Mr. Sexton was very sick by the time he came back for
7 his second operation. He apparently getting sick for
8 some period of time before a decision was made that he
9 needed a second operation. But we brought him into the
10 operating room and as is routine we connected our monitors
11 and using the first monitor that we put on the five EKG's
12 so we could see the heart rhythm and we saw that his ST
13 segments which are the part of the EKG tracing were highly
14 elevated on our monitor in the operating room. And it
15 looked to us like he was having a heart attack. The first
16 thing that you think about when you see that kind of ST
17 segment elevation is an acute coronary syndrome.

18 Q. Anything else that developed?

19 A. Well I again don't remember this; I don't remember
20 what I did, what I did, but I can tell you what my
21 practice is and I would have gone to Doctor Espinal and
22 said this is what this patient looks like now, he's very
23 sick, it looks to me like he's involving an MI and we
24 discussed -- we would have discussed it and decided that
25 the operation needed to proceed. And my note says that.

1 That the operation needed to proceed even under those
2 circumstances.

3 Q. That was done?

4 A. And we did proceed; that's right.

5 Q. Now a coronologist at the conclusion of the procedure
6 was called in was it not?

7 A. While the patient was in the PAC Unit. Once we got
8 to the PAC Unit; that's correct.

9 Q. He remained on the ventilator?

10 A. He did.

11 Q. And management of the ventilator would not be your
12 responsibility after he goes to the PAC Unit?

13 A. I typically will manage the ventilator while their in
14 the PAC Unit yes.

15 Q. Did that end your involvement in the treatment of Mr.
16 Sexton?

17 A. Once he left the PAC Unit, yes.

18 Q. I may be through.

19 (PAUSE.)

20 MR. KING: Thank you. Thank you, Doctor. Would you
21 answer any questions from Mr. McGowan.

22 CROSS EXAMINATION

23 DOCTOR SUSAN LUPO BY MR. MCGOWAN:

24 Q. While all this stuff gets going, Doctor, I want to
25 talk first about your day to day working relationship with

1 Doctor Espinal. You would see him on a weekly basis even
2 to this day. Right?

3 A. That's right.

4 Q. And you worked with him on a weekly basis.

5 A. That's right.

6 Q. And because he practices surgery at Piedmont, and
7 because your practice is the only practice that provides
8 anesthesia services at Piedmont, that means that for every
9 procedure that Doctor Espinal preforms either you or one
10 of your partners is providing the anesthesia.

11 A. That's right.

12 Q. So it would be very uncomfortable for you
13 professionally to give any kind of testimony that would
14 hurt Doctor Espinal because of this close day to day
15 working relationship wouldn't it?

16 A. Not if it weren't true.

17 Q. Okay. And in fact today, this morning, when you came
18 in you got here around Nine o'clock; is that right?

19 A. Uh - that's right.

20 Q. And sat right down to Doctor Espinal and chit chat
21 with him. Right?

22 A. We were talking yes, sir.

23 Q. Okay. And that's not unusual between professional
24 colleagues that work together on a regular basis. Right?

25 A. I wouldn't say so.

1 Q. Now in between your time of your deposition and the
2 time of this testimony, have you spoken to anybody about
3 ths case?

4 A. No.

5 Q. You didn't speak with Doctor King, Doctor King.
6 I'm sorry, Mr. King.

7 You didn't speak with Mr. King or anybody from his
8 office about this?

9 A. Well we had the deposition so of course we talked
10 about it at that time, yes.

11 Q. But between then and now you haven't talked to
12 anybody about your testimony in this case?

13 A. Specifically between when and when?

14 Q. At the time of your deposition and now.

15 A. I haven't talked with anyone other than Mr. King;
16 that's correct.

17 Q. But you did talk to Mr. King?

18 A. Sure I talked to Mr. King.

19 Q. All right. Now, on Exhibit 7 which is your pre-
20 anesthesia questionnaire there is no doubt that Mr. Sexton
21 did report a recent cold and respiratory infection.
22 Right?

23 A. That's right.

24 Q. Let's talk about orders for a minute. When you issue
25 an order for a patient like a chest x-ray, there are three

1 ways that's done. Right? You can physically write it in
2 the chart. Right?

3 A. That's correct.

4 Q. You can ask a nurse to do it and that's called a VO,
5 a verbal order?

6 A. That's right.

7 Q. Right? But if you're not there and you need to issue
8 an order you do that's called a TO, a telephone order.
9 Right?

10 A. That's right.

11 Q. So in this case let's turn to Exhibit Number Fifteen,
12 and it's the last page of Exhibit Fifteen. And I'll put
13 it up.

14 (EXHIBIT DISPLAYED ON OVER HEAD.)

15 Q. This says, and this is at 06:50, March 7th. Do you
16 see that? PA Lateral Chest X-ray T.O. Doctor Lupo. So
17 this was a telephone order of yours at 06:50 hours, March
18 7th. Right?

19 A. Yes that's right.

20 Q. So because it's a telephone order and not a voice
21 order or an order that you personally wrote, that means
22 that you weren't even there at the time doesn't it?

23 A. That's probably right. I mean it's 6:50 in the
24 morning. That's right.

25 Q. Okay. So you're issuing orders and providing care to

1 a patient when you're not even there?

2 A. I am ordering a laboratory test that I think would be
3 important to know the results of.

4 Q. All right. And that laboratory test is the chest x-
5 ray that we've talked about?

6 A. That's right.

7 Q. And your testimony was that you were told there were
8 no acute changes on the films; is that right?

9 A. That's right.

10 Q. But that's not what the radiologist said is it?

11 A. I did not have access to the written report.

12 Q. Well I understand that but the way this works isn't
13 it true, Doctor, is that the -- Well let me ask you this.
14 Are you telling me that an employee of the hospital is
15 going to give you something other than the impression of
16 the radiologist after the film is ready?

17 A. Well I think as I mentioned earlier what I was
18 interested in learning from the chest x-ray is whether
19 there was something obvious and dramatic and acute that
20 could explain a slightly lower oxygen saturation. To find
21 out that he -- to find out that the final chest x-ray is
22 read as showing some atelectasis doesn't surprise me at
23 all because that's why -- that's why patients with COPD
24 have low oxygen saturations. By definition they have
25 atelectasis. That's what I was talking about that small

1 air way closure. That's what atelectasis is. And so I
2 wasn't surprised to see that x-ray report. And that's not
3 the kind of thing I was looking for -

4 Q. That wasn't my question, Doctor. My question was
5 simple. Are you telling this jury that it's at the
6 hospital that if you seek to determine the result of a
7 chest film that you have ordered, that the person telling
8 you about that chest film will not give you the impression
9 of the radiologist?

10 A. It was my understanding that I was being given a
11 report that came from the radiologist.

12 Q. All right. Well - -

13 A. And -- yeah.

14 Q. Is it routine for the people you speak with in the
15 radiology department to say things that the radiologist
16 didn't say?

17 A. I have no idea about that.

18 Q. Well if they did you would be up in arms about it
19 that. Right? If they told you one thing and the other
20 thing was something else was true.

21 A. Well of course we expect that they are giving us
22 correct information.

23 Q. All right. Well according to the radiologist, and
24 this is Exhibit Number Sixteen, the impression here is
25 different than what you claim you were told. Because this

1 says, and I'm just gonna read it, "patient does
2 demonstrate mild prominence of the interstitium. I do not
3 have any prior studies to know if this is related to
4 chronic changes or acute changes. There are areas of
5 atelectasis seen at both lung bases without evidence of
6 focal consolidation. Recommended clinical correlation and
7 follow-up studies would be advised to document clearing."

8 This does not say that there were no acute changes.

9 A. Yes it does.

10 Q. Well in fact -- Well let just read the sentence then,
11 Doctor. It says, "I do not have any prior studies to know
12 if this is related to chronic changes or acute changes."

13 Right?

14 A. That's what the report says; that's right.

15 Q. So were you given a bum steer by whoever you talked
16 to in radiology; they said there was nothing acute when
17 the truth is the radiologist says I don't know if its
18 acute or not?

19 A. No I don't think so. Because the radiologist
20 understands what it is I'm looking for and a chest x-ray
21 that's done preoperatively at that time of the day -- This
22 report as I said is consistent with what I would expect in
23 a chest x-ray in someone with Mr. Sexton's smoking
24 history. So this doesn't -- again, doesn't give me any
25 additional information that I didn't have. What I was

1 looking for was something that would be much more dramatic
2 than this on the report.

3 Q. Let's talk about your role in this. Your job is to
4 make sure the anesthesia can be administered safely; isn't
5 that right?

6 A. That's right. My role is to make sure that the
7 patient is sufficiently stable; that all of his medical
8 conditions are sufficiently stable to undergo the
9 procedure.

10 Q. Now to undergo the procedure or to withstand the
11 anesthesia required by it?

12 A. You know at some point you can't separate one from
13 the other. And the preoperative period the effects of the
14 anesthesia and the effects of the surgery are one in the
15 same.

16 Q. You are not evaluating the patient's readiness for
17 the surgical procedure; isn't that true?

18 A. I am not making a decision about the surgical
19 procedure.

20 Q. That is not your job, that is Doctor Espinal's job?

21 A. That's the surgeon's job; that's right.

22 Q. And so whether Mr. Sexton is a fit candidate for the
23 surgical procedure and what follows thereafter is up to
24 the surgeon and your job is to make sure the patients
25 successfully and safely undergo the surgical procedures

1 itself which would start from induction through his
2 exiting of the post-anesthesia care unit?

3 A. That's right.

4 Q. So it is not right for a surgeon to say I did this
5 procedure because the anesthesiologist said it was okay if
6 there is a problem that develops after the anesthesia is
7 off?

8 A. I'm not sure I understand.

9 Q. Well one of the issues in this case is Doctor Espinal
10 says ha, Doctor Lupo said it was fine so I defer to her.
11 That's not the way this works is it? Because it's the
12 surgeons job to make sure the procedure itself is done
13 properly and the healing process and the rehab and
14 everything else is safe. Right?

15 A. That's surgical management.

16 Q. All right. And one last thing. We've been talking
17 about O2 saturations and all that sort of thing. You've
18 seen an O2 saturation monitor before?

19 A. I have.

20 Q. And it's measured by a little clip placed on the
21 patients finger just like this?

22 (ATTORNEY MCGOWAN DEMONSTRATED TO JURY AND WITNESS.)

23 A. That's right.

24 Q. Right? And this is a pulse oximeter?

25 A. It is a pulse oximeter.

1 Q. Which is I'll check it out.

2 MR. KING: Your Honor, we object to a diagnostic test
3 on --

4 THE COURT: I sustain the objection.

5 He's not on the stand.

6 MR. MCGOWAN: I'm gonna ask her the question. I'm
7 not asking Mr. Sexton anything.

8 THE COURT: Well I'm not going to allow it, the
9 demonstration using the defendant -- the plaintiff. I
10 sustain the objection.

11 BY MR. MCGOWAN:

12 Q. Well the way this works is the patient just places
13 their finger in it. Right?

14 A. That's right.

15 Q. And it comes up with a number, the pulse rate and all
16 that stuff?

17 A. It does.

18 Q. And that's what it takes to determine -- Mine says
19 99. Is that about normal?

20 A. That's normal for a healthy person breathing room
21 air.

22 Q. Okay. And that's what it takes to measure pulse
23 oxidine?

24 A. That's right.

25 Q. And this is the way its done in the hospital?

1 A. That's right.

2 Q. You tape this thing on so it doesn't fall off but
3 that's what it takes?

4 A. That's right.

5 Q. How abnormal does it need to be? What would you
6 expect? 85 is low. Right?

7 A. Eighty-five is lower than we usually see; that's
8 right.

9 Q. And that's why you were concerned about it enough to
10 get an x-ray and get a treatment. Right?

11 A. I think because the pulse oximetry reading was
12 something less than 90 it generated a call from the nurse.
13 You know it would have been a nurse who did the original
14 vital signs that morning and it generated a call to me.
15 And because of that, again, I don't know where I was at
16 that time of the morning, I may still have been driving in
17 at 6:50 but in order to keep things sort of moving and get
18 -- rather than having to wait until I got there I did do
19 -- give the verbal order for the chest x-ray as I said to
20 make sure that there wasn't something else going on.

21 Q. Would you have expected a surgeon to -- Is it routine
22 at Piedmont that surgeons don't know the condition of
23 their patient before procedure?

24 MR. KING: Objection to the form of the question.

25 THE COURT: I sustain the objection.

1 BY MR. MCGOWAN:

2 Q. Based on your experience working up there I assume
3 you maybe worked yesterday and probably later today.
4 Right?

5 A. Yes.

6 Q. Is it the normal standard practice of the surgeons at
7 Piedmont Medical Center to inform themselves of the
8 patient's condition before surgical procedure?

9 A. It varies from surgeon to surgeon.

10 Q. So some don't?

11 A. Some surgeons do not see their patients before
12 surgery.

13 MR. MCGOWAN: Thank you, Doctor.

14 MR. KING: Nothing on redirect, Your Honor.

15 THE COURT: You may be excused and we thank you for
16 your time.

17 MR. KING: Did you excuse Doctor Lupo?

18 THE COURT: Yes.

19 MR. KING: Thank you, Doctor Lupo, you're free to go.

20 (WITNESS LEAVING WITNESS STAND.)

21 THE COURT: Call your next witness.

22 MR. KING: Doctor Eric Bour.

23 THE COURT: If you'll come around.

24 MADAME CLERK: Doctor Bour, can I have you place your
25 left hand on the Bible and raise your right.

1 (WHEREUPON: DOCTOR ERIC BOUR,
2 BEING FIRST CALLED AND DULY SWORN, TESTIFIED AS FOLLOWS:)

3 MADAME CLERK: Come around and have a seat please.

4 MADAME COURT REPORTER: Mr. King, would you flip that
5 mic back around toward you, sir?

6 (ATTORNEY KING COMPLIED.)

7 MADAME COURT REPORTER: And I thank you.

8 MR. KING: That's the fourth time. I've never been
9 admonished for not talking loudly.

10 DIRECT EXAMINATION

11 DOCTOR ERIC BOUR BY MR. KING:

12 Q. Good morning, Doctor Bour.

13 A. Good morning.

14 Q. Give us your name please, sir, your full name.

15 A. Eric Bour, B-o-u-r.

16 Q. Okay. And you are a medical doctor practicing in
17 Greenville, South Carolina?

18 A. That's correct.

19 Q. Correct? Okay. And what -- You are a general
20 surgeon?

21 A. Yes, sir.

22 Q. Do you practice with a group?

23 A. I practice with part of Greenville Hospital System as
24 a University Medical Group.

25 Q. And you are -- Is your practice limited to general

1 surgery?

2 A. I do general and bariatric surgery.

3 Q. And what falls within the broad definition of general
4 surgery?

5 A. General surgery is typically any surgery that
6 involves the abdomen, small bowel, colon, stomach,
7 pancreas, liver, kidneys, spleen, hernias, et cetera.

8 Q. You do colon surgeries?

9 A. Yes.

10 Q. Do you remove polyps from the colon?

11 A. On occasion yes.

12 Q. Okay. And how long have you been practicing general
13 surgery?

14 A. I completed my training in 1993, so eighteen years.

15 Q. Okay. And again, could you give the jury just kind
16 of a Reader's Digest version of your education and level
17 of training?

18 A. I went to undergrad -- got my undergraduate education
19 at Emory University in Atlanta. I went to medical school
20 at Penn State University in Hershey, Pennsylvania and
21 subsequent did my residency there in surgery. Did a year
22 of cardio-thoracic research fellowship during my
23 residency. After I completed my residency at Penn State I
24 stayed on the faculty there and also as the Chief of
25 Surgery at the VA in Lebanon, Pennsylvania doing general

1 surgery, trauma surgery. Left there in the late '90's to
2 go to Columbia, South Carolina where I practiced on the
3 University of South Carolina for several years as a
4 general surgeon and ran the general surgery clinic and the
5 breast clinic as well. And then left Columbia to move to
6 Greenville in 1999 and I was in private practice in
7 Greenville with a group called Carolina Multi-Speciality
8 Associates, subsequently with Internal Medical Associates
9 which was a multi-speciality group. And then in 2006
10 joined Greenville Hospital System as part of the
11 University Medical Group.

12 Q. Okay. Now, did I understand that in your background
13 you have been on two medical faculties; one being at Penn?

14 A. At Penn State yes, sir.

15 Q. You were on the teaching faculty?

16 A. Yes.

17 Q. And you will teach interns, residents; who would you
18 be teaching?'

19 A. We had medical students and residents.

20 Q. And would that be a classroom setting or would that
21 be rounding, assisting in procedures? What would be the
22 method of teaching?

23 A. All of those. We did -- were assigned certain
24 lectures that we would give. We also were involved with
25 teaching on rounds and with surgical training based on the

1 level of the individual or the surgical resident with
2 varying degrees as to what part of the surgery they would
3 participate in.

4 Q. Okay. And then when you went to -- You were first at
5 South Carolina. Correct?

6 A. Yes.

7 Q. And you were on the faculty there also?

8 A. That's correct.

9 Q. And what type of teaching were you involved in there?

10 A. Same. The same. And they also had medical students,
11 residents. And I was also on the faculty at the VA as
12 well as we would rotate there at the Dorn VA in Columbia.

13 Q. Okay. Now, in being a member of the Greenville
14 Hospital System, that's your current employer?

15 A. That's correct.

16 Q. Now, Greenville Hospital System -- I'm not sure what
17 the proper terminology is -- has an affiliation with the
18 University of South Carolina Medical School also; does it
19 not?

20 A. Yes. We are a University Medical Center affiliated
21 with the University of South Carolina; that's correct.

22 Q. And you have medical students in Greenville do you
23 not?

24 A. We have third and forth year medical students and we
25 also have a full general surgery residency program and a

1 fellowship program, several fellowship programs.

2 Q. And are you involved in teaching in that capacity?

3 A. Yes.

4 Q. Okay. And you see patients do you not; surgical
5 patients?

6 A. That's correct.

7 Q. All right. And where do you have privileges,
8 surgical privileges in Greenville currently?

9 A. Through the Greenville Hospital System. There are
10 five hospitals and hospital system we carry privileges for
11 all the hospitals.

12 Q. You're licensed by the state of South Carolina?

13 A. I am.

14 Q. You are?

15 A. Yes.

16 Q. Any other states?

17 A. My -- I'm licensed in the state of Pennsylvania but I
18 have it on a temporary hold since I'm no longer in
19 Pennsylvania.

20 Q. Are you active in the medical community, Doctor?

21 A. Yes.

22 Q. You hold offices or members of organizations?

23 A. Yes.

24 Q. Tell the jury what; what?

25 A. I'm part of the Greenville Medical Society in the

1 South Carolina Medical Association, the American Medical
2 Association, the American College of Surgeons, the
3 American Society for Metabolic and Bariatric Surgery, a
4 group called SAGES, Society for Laparoscopic Surgery; those
5 are multiple.

6 Q. Okay. You are board certified?

7 A. Yes I am.

8 Q. In?

9 A. General surgery.

10 Q. Doctor, have you testified in medical mal-practice
11 cases such as this?

12 A. Yes.

13 Q. And how many times?

14 A. Twice.

15 Q. Okay. Have you looked at cases for me?

16 A. Yes.

17 Q. Do you know how many times?

18 A. This is the third. This will be the third case I've
19 looked at for you.

20 Q. Had you're charging for your time in this case?

21 A. I do.

22 Q. How much are you charging?

23 A. Two Hundred and Fifty Dollars per hour.

24 Q. Doctor, the colon has been described to the jury, but
25 your definition, how would you describe the colon?

1 A. The colon is otherwise known as the large intestine.
2 It's the final part of the intestinal tract which begins
3 at the mouth and ends at the anus. And the small
4 intestine is the first part of the intestine that comes
5 out of the stomach as that turns into the colon in the
6 right lower quadrant where the appendix is that's the
7 first part of the colon called Cecum. And then
8 subsequently the remainder of the colon is as you see on
9 that diagram.

10 Q. Okay. And you understand that Mr. Sexton was
11 referred to Doctor Espinal to remove a polyp. Correct?

12 A. That's correct.

13 Q. And what type polyp was he to remove?

14 A. It was a sessile polyp in the ascending colon.

15 Q. Okay. And there has been -- Doctor Espinal when he
16 testified drew through where the polyp was in his
17 procedure. Is that your understanding?

18 A. Yes, sir.

19 Q. And what basically are your understanding of the
20 facts in this case?

21 A. Mr. Sexton underwent a colonoscopy in 2007 performed
22 by one the gastroenterologist in Rock Hill. They found at
23 that time several colon polyps which were removed and one
24 polyp in the ascending colon could not be removed. That
25 polyp was fairly large, the gastroenterologist estimated

1 at that time two to three centimeters in diameter and it
2 was sessile; in other words, it was fixed to the wall of
3 the colon, it doesn't have a stalk on it. So as a result
4 of that they could not remove the polyp at that time but
5 the colonoscope for reasons of safety of trying to take
6 something that large out and not much of a circumference
7 with the diameter of the colon they tabooed it and
8 referred the patient to Doctor Espinal for surgical
9 removal of the -- for surgical treatment because of the
10 inability to remove the polyp. They did biopsy the polyp
11 at the time but the biopsies did not show any malignancy;
12 however there was a tubular adenoma biopsies.

13 Q. Okay.

14 THE COURT: Can you all hear?

15 Okay. Go ahead. Got a little trouble. I got noise
16 above me.

17 BY MR. KING:

18 A. And, Doctor, you have reviewed the medical records
19 from Piedmont Medical Center in connection with this
20 treatment?

21 A. Yes I have.

22 Q. And other medical records?

23 A. Yes.

24 Q. In connection with Mr. Sexton?

25 A. Yes.

1 Q. Have you reviewed the depositions of other witnesses
2 in this case?

3 A. Yes I have.

4 Q. Is there any documents that you think you haven't
5 seen that you would need to formulate opinions in this
6 case?

7 A. No.

8 Q. And you have been ask to give opinions in this case
9 as an expert witness as to standard of care and causation
10 have you not?

11 A. That's correct.

12 Q. Are you prepared to do that - - -

13 A. Yes.

14 Q. - - - at this time? At this time we tender Doctor
15 Bour as an expert witness in the field of general surgery.

16 THE COURT: Any voir dire?

17 MR. ANDREWS: No, sir.

18 THE COURT: I find he is qualified.

19 BY MR. KING:

20 Q. Now, again going back. How did Mr. Sexton become a
21 patient of Doctor Espinal?

22 A. He was referred to Doctor Espinal following the
23 colonoscopy by a gastroenterologist.

24 Q. And in looking at the Exhibit Notebook that you have,
25 let me ask you to look at Tab 1 and Tab 33.

1 A. Okay.

2 Q. Are those the records that you reviewed in connection
3 with generated by Doctor Espinal's office?

4 A. Yes, sir.

5 Q. Okay. And are those typical records that would be
6 generated by a general surgeon on the initial history and
7 physical of the patient?

8 A. Yes, sir.

9 Q. And you've reviewed the intake sheets that were
10 signed off by the patient?

11 A. Under Tab 33 yes, sir.

12 Q. And what's the purpose of the history and physical
13 that is done in initially when a surgeon sees a patient?

14 A. The history and physical that we as the surgeon does
15 or the patient completes himself?

16 Q. Both.

17 A. We ask all of our patients to complete a form that at
18 least describes their medical history; the medications
19 they take, their allergies, any previous surgeries,
20 reactions that they have to certain medications. Anything
21 else important about their history for patients who are
22 looking for weight loss surgery we ask about diet
23 histories and different diets that they've tried so there
24 is a variety of information that we ask the patients to
25 provide to us in their own handwriting in what we consider

1 or call something similar to an intake form.

2 And then subsequent to that after we've seen the
3 patient and examined the patient, examined the records,
4 identified the issues and the problems, then we will
5 either handwrite, dictate or use an electronic medical
6 record to generate something called a history and physical
7 which is essentially a history of the problem, the
8 physical examination and then typically the assessment and
9 the plan. In other words the assessment is what's
10 happening with the patient and the plan is what are we
11 going to do with the patient. So that's all generated at
12 the time of the patient's visit into the office for their
13 initial visit.

14 Q. Okay. And a portion of the initial visit is to or at
15 least before the procedure is for the physician to discuss
16 risk and complications of the procedure with the patient?

17 A. If the patient that sees us in the office is going to
18 undergo a procedure we do in fact discuss the risk and
19 complications and benefits of the procedure and often
20 times the alternatives if there are more than one option.

21 Q. And is one of the complications or risk of this
22 procedure an anastomotic leak?

23 A. Yes.

24 Q. And what is an anastomotic leak?

25 A. Anytime that we remove or rearrange any portion of

1 the intestine whether it be stomach, small bowel, large
2 intestine, and we are reconnecting something that's termed
3 an anastomosis. That's a connection between two parts of
4 the bowel. And when we create that anastomosis we're
5 using a variety of different devices often times staplers
6 or sutures or a combination of both. At the time we do
7 that there's a possibility that where we reconnect the
8 bowel to itself that could leak.

9 Q. Doctor, now going to the morning of the 7th which was
10 the day of the surgical procedure, have you reviewed the
11 records that were generated by the nursing staff from

12 ---

13 A. Yes. Yes I have.

14 Q. --- the anesthesiology staff?

15 A. Yes, sir.

16 Q. And those are shown as actually at Tab 3, 4, 5 and 6
17 of the notebook that you have and the jury has. Correct,
18 Doctor?

19 A. That's correct.

20 Q. All right. In summary what do they tell you about
21 Mr. Sexton's condition when he reported to Piedmont early
22 on the morning of the 7th?

23 A. He arrived sometime prior to his scheduled surgery.
24 One of the notes I believe says 5:50 on one of the notes.
25 But he was in the hospital as our patients would typically

1 would arrive prior to their surgical procedure around an
2 hour, hour and a half early. That gives the pre-operative
3 nurses a chance to assess the patient, make sure that
4 everything is okay, start the IV's; get any pre-medication
5 orders that anesthesia may have ordered, et cetera. At
6 the time of his arrival he evidently had an oxygen
7 saturation measured at eighty-five percent which generated
8 a phone call to the anesthesiologist who subsequently
9 ordered a chest x-ray which is reported with no acute
10 findings. The patient responded to nasal causal oxygen
11 and had an increase in his oxygen saturations. With the
12 smoking history that's not unusual but see a low oxygen
13 saturation in a patient who is somewhere between a forty
14 and eighty year pack history of smoking and the patient
15 went on to surgery from that point.

16 Q. And do you see any fever reported?

17 A. No.

18 Q. If Mr. Sexton was suffering from flu, would you
19 expect there to be a fever?

20 A. Typically yes.

21 Q. All right. Anything you see in the medical records
22 generated by others other than Doctor Espinal that makes
23 Mr. Sexton a questionable candidate for this procedure?

24 A. No.

25 Q. Okay. Now, he has -- he had low oxygen saturations.

1 Correct?

2 A. Yes.

3 Q. If the surgery had been put off, now how long can you
4 put off the surgery?

5 A. There is no real way to tell. No one knows how long
6 it takes for a colon polyp to turn malignant and that's
7 part of the issue is that was the polyp, was the portion
8 of this very large polyp that could not be removed
9 malignant to begin with in which case it needs to be
10 removed as by then it's turned to cancer. Or is it going
11 to convert to malignancy which most or many colon polyps
12 do. And so the answer is you don't really know how long
13 that is and I think that any patient who has a very large
14 polyp like this, a sessile polyp that cannot be removed
15 with a colon scope they would be typically referred to
16 surgery and that surgery would be scheduled for some time
17 in the near future; whether that be a week, ten days, two
18 weeks. No one really knows the exact time frame for that.
19 The majority of patients that I've taken care of over the
20 years who have a breast mass or a colon polyp, they really
21 don't want to sit around and wait.

22 MR. ANDREWS: Your Honor, I object.

23 THE COURT: Let's don't go into what most patients we
24 deal with.

25 BY MR. KING:

1 Q. Go ahead.

2 A. Generally that's driven by the fact the polyp is
3 there and it needs to be removed and that needs to be done
4 at some reasonable time frame.

5 Q. And there is diagnoses of COPD?

6 A. Yes.

7 Q. And what is COPD?

8 A. Chronic Obstructive Pulmonary Disease.

9 Q. Okay. And is that reversible?

10 A. Typically not reversible but it will stop if a
11 patient stops the behavior that causes the COPD. I mean
12 it will stop progressing if they stop the behavior that
13 causes the COPD.

14 Q. And surgery had been delayed for a day, a week, or
15 whatever. Is Mr. Sexton's medical condition going to
16 change?

17 A. Likely not.

18 Q. So you have any objection to proceeding to the
19 surgery as scheduled on the morning of the 7th?

20 A. No.

21 Q. Now, describe the surgical procedure that was done by
22 Doctor Espinal.

23 A. Doctor Espinal performed a Laparoscopic partial colon
24 resection; in other words, Laparoscopic means with a small
25 instrument and small incisions. It's performed under

1 general anesthesia where the patient goes all the way to
2 asleep with a breathing tube in place as Doctor Lupo said.
3 The abdomen is entered with small portals called trow cars
4 which provide access to put instruments in and out,
5 through the abdominal wall and at that point a portion of
6 the colon that contained the polyp was removed. The upper
7 and lower parts of the polyp are put -- I'm sorry, the
8 colon are put back together and the patient, the surgery
9 had ended at that point.

10 Q. Doctor, this procedure can be done in either - I
11 don't want to use the word traditional or the old way.
12 You can do this procedure in an open, in an open fashion.
13 Correct?

14 A. That's correct.

15 Q. Or you can do it Laparoscopic?

16 A. That's correct.

17 Q. Correct? And are there advantages at doing it
18 laparoscopically?

19 A. I think what's happened over the course of the last
20 fifteen years in surgery is the majority of surgeries that
21 we now do laparoscopically. We found significant advantages
22 in patients recovery. So that the surgery is exactly the
23 same whether it's done open or Laparoscopic. The part of
24 the bowel that's removed is the same. The way it's
25 reconnected is the same. The only thing different is the

1 fact that there's not a large incision. The patients
2 recover better from that, there's less wound healing, less
3 issues with wound problems, shorter hospital stays,
4 quicker return to normal activity and subsequently to
5 work, et cetera. So I think there are clear advantages to
6 Laparoscopic surgery for many of the surgeries that we
7 treat traditionally are done with larger incisions.

8 Q. Now, how big was the actual polyp?

9 A. Two centimeters by the pathology report.

10 Q. Okay. And is that a little polyp, big polyp? I mean
11 how would you - -

12 A. That's a fairly large polyp and the fact that it was
13 sessile, in other words it didn't have a stalk on one end,
14 it was flat against the wall of the colon was the reason
15 that it needed to be removed surgically. And that's a
16 fairly large sessile polyp.

17 Q. Could you remove -- In your opinion would it be
18 prudent to just remove the polyp and not remove any other
19 tissue?

20 A. I don't know that there is any way to really do that
21 because the description by the -- on the colonoscopy the
22 polyp took out took off about half of the circumference of
23 the colon; half of the diameter of the colon. So to
24 really be able to open the colon and remove the polyp
25 would be fairly difficult. In essence what you're doing

1 is you're opening the colon anyway, you're going to wind
2 up removing a part of the colon that has the polyp on it
3 because it's stuck to the wall of the colon and then
4 putting it back together. So you're still creating an
5 anastomosis, you're just not doing it. You still have to
6 sew the bowel back together it's just not a formal
7 anastomosis but there is still sutura lines or staple
8 lines in your bowel.

9 Q. Okay. Doctor, the tissue that was removed by Doctor
10 Espinal is sent to the pathologist and that was done in
11 this case.

12 A. That's correct.

13 Q. Would you look at Tab 10. What does that tell you
14 the surgeon about what tissue Doctor Espinal removed?

15 A. It says that Doctor Espinal removed a segment of the
16 colon ten by three centimeters in size. There is a two to
17 three centimeter rim of tissue of the mesenteric meaning
18 were the blood supply lymphatic come from the colon. The
19 pathology evaluation of the segment of the colon
20 identified a tubular adenomatous polyp, flat, two
21 centimeters in size. So if the pathologist is saying that
22 the colon itself is three centimeters in diameter and the
23 polyp is two centimeters in size it's about two thirds of
24 the circumference of the bowel which was what the -- with
25 the colonoscopy report stated. He did not see, he or

1 she, the pathologist did not see malignancy but did see
2 moderate atypia so there were stypical cells in the polyp.

3 Q. What is the significance of atypical cells polyp?

4 A. Atypical cells become malignancy. They can turn
5 cancerous.

6 Q. Now, there is -- the mesentery supplies the blood to
7 the colon does it not?

8 A. Yes.

9 Q. The jury's heard about this yesterday, the yellow
10 colored area in the middle of the colon with the red
11 arteries, that's the blood supply that's going to the
12 colon?

13 A. That's correct.

14 Q. Okay. And how much mesentery was removed?

15 A. I believe he said three centimeters or so.

16 Q. Okay. Doctor, do you have any criticism of Doctor
17 Espinal's surgical procedure up until this point?

18 A. No.

19 Q. Okay. In your opinion did he meet or equal the
20 appropriate standard of care?

21 A. He met the objective of removing the polyp with clear
22 margins of the colon; mesentery, lymph nodes and
23 reconnecting the colon.

24 Q. And what is standard of care to mean to you, Doctor?

25 A. It means that the polyp is removed in its entirety;

1 that there is a sampling of the mesentery and that the
2 colon is reconnected together.

3 Q. And as to the standard for the physician, what does
4 standard of care mean?

5 A. Sorry.

6 Q. What does standard of care mean to you the physician?

7 A. Not -- Just in general?

8 Q. Just in general.

9 A. It means the care that being provided by most
10 providers given the same situation.

11 Q. Okay. Is what?

12 A. That's standard of care.

13 Q. Is equal to what a reasonable surgeon with that
14 training would do?

15 A. Exactly.

16 MR. ANDREWS: Your Honor, based on his response I'm
17 making an objection because that's not the standard of
18 care.

19 THE COURT: You can cross examine him.

20 MR. ANDREWS: I'm sorry, I couldn't - -

21 THE COURT: You can cross examine him.

22 MR. ANDREWS: Yes, sir.

23 THE COURT: He's subject to cross examination.

24 BY MR. KING:

25 Q. Does this procedure carry with it a name? Is a

1 sleeve resection a name?

2 A. Some may refer to it as a sleeve resection; partial
3 colectomy. There is a variety of different names.

4 Q. Can a -- is a leak of an anastomotic -- is an
5 anastomotic leak a known complication of this procedure?

6 A. Yes.

7 Q. Can it occur without there being negligence?

8 A. Yes.

9 Q. What are the causes of a leak?

10 A. We typically look at anastomotic leaks as several
11 different causes. Technical causes, in other words we're
12 using devices like staplers and suturing devices which
13 could malfunction. We expect them to function properly
14 but at some point mechanical things can malfunction. It
15 can be areas of infection, there can be areas of low blood
16 flow, there can be ulcers that may form. There is a
17 variety of different reasons.

18 Q. Okay. Now, following the procedure Mr. Sexton was
19 admitted first to the floor and describe if you will by
20 looking at the medical records how he progressed over the
21 next three days.

22 A. Initially when he was in the recovery room he was not
23 terribly much willing to wear his oxygen according to the
24 recovery room nurse's notes. They had him on a face tent
25 which is kind of a large almost like a mask but not

1 completely over the face which is kind of under the chin
2 to try to keep his oxygen saturations up. They felt that
3 he was stable enough to leave the pack and his oxygen
4 saturations were sustaining, elevated. He was admitted to
5 the floor and then, then subsequently over the next -- on
6 the 8th had a temperature to I believe about 98 or 99
7 degrees. By the 9th his temperature had gone up and his
8 heart rate was elevated he was having more trouble
9 maintaining his oxygen levels and he was transferred to
10 the intensive care unit per Doctor Espinal's orders.

11 Q. Okay. And when did Mr. Sexton start having troubles?

12 A. It appeared to be sometime early on the 9th.

13 Q. And what was done -- what was the troubles first?

14 A. He was not maintaining his oxygen saturations, he had
15 very low fever that day. I'm sorry, the day prior and his
16 temperature had gone up. His white count was around 12,
17 000 as I recall from the record. And at that point when
18 he was transferred to the intensive care unit Doctor
19 Espinal noted that he was concerned about pneumonia or
20 something going on with his abdomen.

21 Q. Okay. And what diagnostic studies were done to
22 confirm whether or not there was a leak on going?

23 A. They did the chest x-ray and then subsequently
24 ordered a CT Scan of the abdomen, an adomenial series and
25 then later that afternoon a CT Scan of the abdomen.

1 Q. Actually there was two CT's done with contrast?

2 A. There was one done the evening of the 9th roughly
3 between Four and Five o'clock is best as I can tell. And
4 at that time when the CT Scan was read by the radiologist,
5 there had not been enough contrast in -- contrast enough
6 had progressed to the area where the connection was made.
7 You can imagine this is very far down the intestinal
8 tract. We have the whole stomach and the entire small
9 intestine until we get to the large intestine so the
10 contrast had not made it there by the evening of the 9th
11 so they really couldn't tell anything because the dye had
12 not made it to the area of the anastomosis. And
13 subsequently on the morning of the 10th Mr. Sexton was
14 taken back down to CAT Scan, back down to CT where they
15 re-CAT scanned him and at that point the contrast made it
16 to the area of the anastomosis. Doctor Espinal identified
17 that there had been a leak and took him back to the
18 operating room shortly thereafter.

19 Q. And what is leaking from where and leaking into
20 where?

21 A. The area, the dye that is given orally through the
22 mouth goes through the intestinal tract gets to the area
23 where the bowels go back together and then leaks out
24 through the area where the bowel is reconnected or
25 presumably somewhere in that location into the area around

1 the bowels. And what you see on the CT Scan is you see
2 dye or contrast outside of the bowel or all the dye
3 contrast should be inside the bowel.

4 Q. And what was the surgical procedure that was done to
5 prepare it?

6 A. He took -- Doctor Espinal took Mr. Sexton back to the
7 operating room, identified the area of concern and
8 resected that part of the colon and then reconnected the
9 colon. I'm sorry, reconnected the end of the small bowel
10 to the transverse colon removing that whole area where the
11 leak had occurred; irrigated the area out well to kind of
12 wash out any remaining bacteria and that was the end of
13 the procedure.

14 Q. Okay. And do you have any criticisms of that
15 procedure?

16 A. Not at all.

17 Q. Okay.. Do you have any criticisms of that procedure?

18 A. Not at all.

19 Q. Okay. Do you have any criticism that the procedure
20 was not done until the 10th?

21 A. No. There really is no way to tell on the 9th, I
22 mean there are changes on the CAT Scan which appear to be
23 co-surgical changes or talking about someone who is two
24 days after a Laparoscopic surgery. During Laparoscopic
25 surgery we put air into the abdomen or carbon dioxide into

1 the abdomen to make room to work. So that carbon dioxide
2 makes it's way through the tissues; we're moving things
3 around to try to remove that part of the colon so we're
4 dividing where it's attached on both the right and left
5 sides of that diagram if you will. And so as that gas
6 travels into those airways you're going to see gas in
7 those areas on a CAT Scan two days after surgery anyway.
8 Because the contrast had not made it to the area in
9 question there really wasn't any way to tell whether there
10 was an actual leak at that point.

11 Q. And Mr. Sexton did have some complications with the
12 second surgery?

13 A. Yes.

14 Q. Okay. And what complications did he have?

15 A. There was some concern about his EKG tracing during
16 the operation and he subsequently had a cardiac
17 evaluation, cardia-cath which was normal.

18 Q. And he remained on a respiratory?

19 A. Yes.

20 Q. And, Doctor, what in your opinion is the cause of
21 those complications?

22 A. I can't speak on behalf of the cardiac complications
23 because I don't know that there really was a complication
24 per se. I think he just had some EKG changes. But as far
25 as the ventilator issue goes and remaining on the

1 ventilator, someone who's fairly sick that we take back to
2 the operating room on an emergency basis has a fairly high
3 likelihood of remaining on the ventilator for a period of
4 time because their body is reacting to that illness and it
5 may not be safe at that time to remove the breathing tube.

6 Q. In your opinion was the care and treatment rendered
7 to Mr. Sexton by Doctor Espinal proper?

8 A. Yes.

9 Q. Is anything you found that he did improper?

10 A. No.

11 Q. And are the opinions that you have given to this jury
12 are they based upon a probability of medical certainty?

13 A. Yes.

14 MR. KING: Thank you, Doctor.

15 CROSS EXAMINATION

16 DOCTOR ERIC BOUR BY MR. ANDREWS:

17 Q. Good morning, Doctor Bour.

18 A. Good morning.

19 Q. It's good to see you again.

20 A. Good to see you too.

21 Q. Now let's talk about the rules of the standard of
22 care. First of all let's talk about the standard of care.
23 Earlier you said that's what most physicians do and that's
24 not what the standard of care is. Right? The standard of
25 care is what a physician, a reasonable prudent physician

1 in the same field would do under reasonable -- reasonably
2 similar circumstances; isn't that right?

3 A. That's fair.

4 Q. Similar circumstances. Okay. Now let's talk about
5 some rules. I want to tell you, I know you weren't here.
6 You know who Doctor Solymvari is. Right?

7 A. I know the name yes.

8 Q. And you've read his deposition?

9 A. Yes.

10 Q. Okay. And of course you know Doctor Espinal?

11 A. Yes.

12 Q. They both testified that the following were the rules
13 when it came to medicine and the standard of care. Number
14 One: That you never expose a patient to unnecessary harm.
15 You agree with that don't you?

16 A. Yes.

17 Q. Number Two: A doctor must inform himself of the
18 patient's condition before he operates. You agree with
19 that too don't you?

20 A. Yes.

21 Q. Number Three: And this is the JCO standard. You
22 must reexamine the patient before the surgery.

23 A. Yes.

24 Q. You agree with that.

25 A. Uh-huh.

1 Q. And Number Four: If there are any increased risk
2 that the doctor has to go over the risk of the procedure.
3 And especially if there are any increased risk and inform
4 the patient so he can sign off giving his informed
5 consent. You agree with that as well don't you?

6 A. I'm not sure exactly what you're referring to.

7 Q. Doesn't the doctor have to inform the patient of the
8 risk associated with procedures?

9 A. Yes.

10 Q. Does he have to inform him so that he can make a
11 meaningful decision as to whether or not he wants to go
12 forward with this or not?

13 A. Yes.

14 Q. Okay. Those are the rules. That's the standard of
15 care. Right?

16 A. Yes.

17 Q. And these aren't lawyer rules are they?

18 A. No.

19 Q. These are doctor rules. These are common sense
20 rules. Right?

21 A. Sure.

22 Q. Sure. And if these rules, these standard of care are
23 not followed by the doctor, and someone gets hurt, then
24 the doctor is responsible for that. Right?

25 A. The doctor is responsible for not following the

1 rules?

2 Q. Yeah if he hurts somebody.

3 A. That's your definition? Yes.

4 Q. Right?

5 A. That's what you say. Yes.

6 Q. It's not my definition it's what -- you agree with
7 that though. Right?

8 A. In general principle yes.

9 Q. Okay. You've never testified either by way of
10 deposition or in a court of law that a doctor deviated
11 from the standard of care have you, Doctor?

12 A. Uh - no.

13 Q. Okay. You charge a fee for your services and that's
14 fine, you expect to get paid. Correct?

15 A. As you do yes.

16 Q. Yes, sir, just as Doctor Solymvari expects to get
17 paid. We all expect to get paid for our services and I
18 have no problem with that. This isn't the only case that
19 you served as an expert witness and retained by Mr. King
20 is it?

21 A. No.

22 Q. In fact you're a repeat customer; isn't that right?

23 A. He's ask me to review other cases.

24 Q. Okay. In fact you've defended Doctor Espinal before
25 haven't you?

1 A. I believe that's true.

2 Q. Does he have you on retainer?

3 A. I'm sorry.

4 Q. Does he have you on some type of retainer?

5 A. Does he have me on a retainer?

6 Q. Doctor Espinal.

7 A. I've never met Doctor Espinal.

8 Q. You've never met him?

9 A. No.

10 Q. But you've represented him but you testified on his
11 behalf before?

12 A. Yes.

13 Q. And before this case?

14 A. Yes. Yes.

15 Q. Okay.

16 A. I'm sorry. Would you repeat that question? I have
17 not testified on his behalf prior to this. I've given a
18 deposition on his behalf.

19 Q. Testimony under oath or testimony in court, you had
20 testified you've been retained as an expert witness on his
21 behalf before?

22 A. Yes.

23 Q. And you testified in a deposition before on his
24 behalf?

25 A. In a deposition yes.

1 Q. Okay. Do you think it's appropriate for a doctor to
2 sign off on a medical document stating that he did
3 something when in fact he didn't do it? Do you think
4 that's appropriate?

5 A. I need a specific example.

6 Q. Okay. I'll give you an example.

7 Do you have Exhibit Thirty-four? I don't have a
8 copy.

9 MADAME COURT REPORTER: Plaintiff'?

10 MR. ANDREWS: Yes, ma'am.

11 Just wait one second; we got to let this warm up.

12 (ATTORNEY ANDREWS ADJUSTING OVER HEAD.)

13 BY MR. ANDREWS:

14 Q. All right. And the basis behind this, Doctor, you
15 agreed earlier that J-CO requires you to reexamine the
16 patient; patient like Doctor Espinal and Mr. Sexton?

17 A. They require us to update the history and physical
18 before the surgery within seventy-four hours; that's
19 correct.

20 Q. Okay. This is the Exhibit Thirty-four PMC 27.
21 Doctor, if you can't read it I'm gonna read it to you,
22 where it's checked and signed by Doctor Espinal 3/7/07.
23 "The attached history and physical has been reviewed."
24 And the history and physical we're talking about is the
25 one that he did on 3/2/07. Okay. All right. And you've

1 seen that one?

2 A. I have.

3 Q. "And the contents accurately reflect the patient's
4 condition today without any additions or revisions to the
5 original document." Right?

6 A. Yes.

7 Q. This requires the doctor, Doctor Espinal, to do a
8 followup examination history and physical doesn't it?

9 A. It requires us to see the patient prior to surgery;
10 that's correct.

11 Q. And to see if any things changed about his condition?

12 A. That's correct.

13 Q. From the last time that you saw him. Right?

14 A. Uh-huh.

15 Q. And to note such changes?

16 A. That's correct.

17 Q. Okay. And he's saying nothings changed.

18 A. That's exactly what he says.

19 Q. And in fact that's not true is it because prior to
20 the surgery we know from the pre-anesthesia record that
21 Mr. Sexton has diminished breath sounds.

22 MR. KING: Your Honor, objection to the form of the
23 question. Can we take up a matter of law with the Court?

24 THE COURT: Well let's take a break. We been at it
25 for a while, this is probably a good time to take a break

1 anyway so we'll take our morning break.

2 (JURY EXITS COURTROOM AT 11:20 AM.)

3 THE COURT: Yes, sir.

4 MR. KING: Your Honor, this is taking the -- this is
5 misquoting the testimony. Doctor Espinal was ask about
6 this yesterday. And when he went in and saw Mr. Sexton
7 before surgery the monitor was showing he was on oxygen,
8 the monitor was showing O SATS of 92. That he spoke with
9 Doctor Lupo and Doctor Lupo said I ordered a chest x-ray
10 and everything is good to go. He says he did not know
11 about diminished breath sounds at that point in time. So
12 trying to say that Doctor Espinal is incorrectly filled
13 out this form this is taking information that he did not
14 know at that point in time.

15 THE COURT: I thought the point was that he filled
16 out without doing any examination, not that he did
17 something that he didn't put on there.

18 MR. KING: Well that has to speak to what he said he
19 did yesterday.

20 He said he did a limited -- he said he did a limited
21 examination is what I understood him to say yesterday,
22 counsel.

23 THE COURT: What is your objection?

24 MR. KING: My objection is that I'm saying that he
25 had diminished breath sounds; asking this witness is

1 telling him something that Doctor Espinal says he did not
2 know at that point in time.

3 THE COURT: Well I over rule the objection. This is
4 cross examination, you can certainly explain that in
5 closing arguments.

6 We'll take a short break. I know you all got a lot
7 to do. I do have some suggestions, new verdict forms for
8 you all to take a look at while we're taking a break.

9 MR. MCGOWAN: Yes, sir.

10 THE COURT: I think I got everything on the charge
11 and we'll go over that briefly.

12 (WITNESS REMAINED ON WITNESS STAND.)

13 (COURT IN RECESS AT 11:22 AM.)

14 (COURT BACK IN SESSION AT 11:35 AM.)

15 THE COURT: Be seated.

16 Bring in the jury.

17 (JURY REENTERS COURTROOM AT 11:39 PM.)

18 THE COURT: You may proceed.

19 MR. ANDREWS: Thank you, Your Honor.

20 CROSS EXAMINATION - CON'T

21 DOCTOR ERIC BOUR BY MR. ANDREWS:

22 Q. Doctor Bour, we were looking at Exhibit Thirty-four
23 when we took a break. And you agree with me that -- I'm
24 gonna go back over some of the stuff just to get to the
25 next question -- do you agree with me that Doctor Espinal

1 had a duty and obligation to reexamine the patient after
2 his first examination on 3/2 prior to the surgery?

3 A. Yes.

4 Q. Okay. And we know that he didn't do that?

5 A. I don't know that.

6 Q. Okay. Well I'm gonna show you. This is the
7 deposition of Doctor Espinal and it's at Page 91 and I'm
8 gonna go to Question 17. "All right, so did you do
9 another physical examination of the patient before the
10 procedure?"

11 Answer: "No." Okay. That's his testimony.

12 A. Okay.

13 Q. All right. So he did not do an examination of the
14 patient as required by J-CO prior to the second surgery
15 did he?

16 A. Based on his deposition that's what you've told me.

17 Q. And that would be negligent, he breached the standard
18 of care.

19 A. Is that a question?

20 Q. Correct?

21 A. That's according to him he did not examine the
22 patient.

23 Q. And that would be a breach of the standard of care.
24 Correct?

25 A. The standard of care is to ensure that the patient

1 has not had a change in their condition prior to surgery.

2 Q. And he did not do that.

3 A. I don't know that he didn't.

4 Q. He said he didn't examine the patient, Doctor.

5 A. But that doesn't mean he did not discuss with the
6 patient whether there was any change in their finding.

7 Q. Doctor, you don't know that. Okay?

8 A. Correct.

9 Q. There's nothing in the record that says he discussed
10 anything with anybody. He has an obligation to examine
11 the patient according to J-CO. Correct? We've already
12 agreed to it.

13 A. Okay.

14 Q. Okay. He didn't do it. He testified to his
15 deposition. Correct?

16 A. According to his deposition.

17 Q. He was negligent. Correct?

18 A. According to his decoction he did not reexamine the
19 patient.

20 Q. And therefore he's negligent.

21 A. That's your definition that's correct. If that's
22 what you're saying.

23 Q. Its not my definition. We established these rules
24 when I came up there and I said these aren't lawyer
25 created rules, these are doctor created rules and you

1 agreed with everyone of them. We'll move on.

2 Doctor, I heard your testimony earlier that - about
3 the surgery and it -- you agree it wasn't an emergency
4 surgery?

5 A. Which surgery, sir?

6 Q. The first, I'm talking about the first surgery. I'm
7 not gonna talk about any other surgery. I'm talking about
8 3/7.

9 A. Okay.

10 Q. The first surgery was not an emergent surgery.

11 A. An emergency surgery; that's correct.

12 Q. Emergency. Either way that's correct. Correct?

13 A. Yeah.

14 Q. Okay. It could have been done a couple of weeks
15 later?

16 A. It could have been done at any period of time.

17 Q. Right. And according to Doctor Espinal in his own
18 testimony thirty days later.

19 A. Okay.

20 Q. Okay. And you agree that the oxygen saturation rates
21 at eighty-five percent were low?

22 A. They were lower than would be expected; that's
23 correct.

24 Q. Okay. And you also agree that it's the surgeon's
25 obligation and duty to call off the surgery, that's his

1 responsibility isn't it?

2 A. We are -- We can call the surgery off if we feel it's
3 necessary to do so; that's correct.

4 Q. And if it's necessary to do so that's your obligation
5 and your duty to the patient.

6 A. Correct.

7 Q. Because if it's not an emergency surgery and you've
8 got changes in condition which create increased risk, you
9 don't want -- you don't want to harm the patient, that's
10 your obligation isn't it?

11 A. Yes.

12 Q. All right. You were aware that Doctor Espinal never
13 reexamined the patient. You saw that testimony.

14 A. You stated that yes.

15 Q. You read this deposition and you are aware that he
16 didn't even look at the chart. Right?

17 A. Okay.

18 Q. And you agree with me that one of the rules is that
19 if there are any increased risk, changes, before you -
20 when you did 3/2 and what your condition is like on 3/7
21 that you must inform the patient, so he has an opportunity
22 to give an informed consent. Correct?

23 A. The consent was obtained prior to 3/7.

24 Q. Right.

25 A. We don't re-consent the patient the day of surgery.

1 Q. Okay. So what you're telling me is that if you --
2 you examine the patient on 3/2 and you found clear lung
3 sounds and no problems, and then on 3/7 there's diminished
4 breath sounds.

5 A. Based on - -

6 Q. There's low oxygen saturation. Right? And there's a
7 chest x-ray that's abnormal where in the radiologist says
8 I don't know if this is acute or not. Are you telling me
9 that's not a change in condition?

10 A. I don't know that that's a change in condition
11 because at the time Doctor Espinal examined the patient,
12 his saturations were ninety-two percent and he -- there
13 was no chest x-ray report.

14 Q. Look, I'm talking about the time on 3/2 when Doctor
15 Espinal examined him and the time on 3/7 what we knew
16 prior to surgery. Okay?

17 A. Okay.

18 Q. And what Doctor knew on 3/2 was he didn't have any
19 breath -- he didn't have any lung problems. He was fine.
20 He didn't test his O2 rates. Didn't do a chest x-ray.
21 His breathing was fine. And when somebody has -- his
22 breathing is fine and they're not complaining of breathing
23 problems you would expect that his oxygen saturation rates
24 would be normal. Right?

25 A. Normal for the patient.

1 Q. Okay. Well you don't know what normal for that
2 patient because you haven't taken a base line.

3 A. Exactly.

4 Q. Okay. But those were changes.

5 A. Changes stated by the patient yes.

6 Q. Well they weren't changes stated by the patient.
7 They were clinical observations made by the hospital and
8 the doctors.

9 A. Okay.

10 Q. Right?

11 A. I'm not sure where you're going with this. I don't
12 understand what the question is.

13 Q. Well just try to follow me.

14 A. I'm trying.

15 Q. 3/2 Doctor Espinal examines him, his lungs are fine.
16 Right?

17 A. Yes.

18 Q. Okay. 3/7 diminished breath sounds, low oxygen
19 saturation rates, and an abnormal chest x-ray that doesn't
20 say whether they know whether the changes are acute or
21 chronic.

22 A. Okay.

23 Q. Those are changes in the condition of the patient are
24 they not?

25 A. Okay. Yes.