

ORIGINAL

IN THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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

Appellants,

v.

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

Respondents.

RECORD ON APPEAL
(Volume 2 of 3; Pages 401 - 800)

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Faye Atkinson - Direct Examination by Mr. Corbin

1 trust him?

2 A Yes, sir.

3 Q Did you have any basis to not believe him?

4 A No, sir.

5 Q When Dr. Williams told you that you would need
6 surgery, did he tell you any way you could avoid surgery?

7 A No, sir.

8 Q Did he give you any alternative treatments besides
9 going in the operating room?

10 A No, sir.

11 Q Did he tell you -- were you post menopausal at
12 that time?

13 A Yes, sir.

14 Q Did he mention anything to you about ovarian
15 masses that show up for the very first time in post
16 menopausal women?

17 A No, sir.

18 Q Did he tell you anything about the test that you
19 could do besides surgery to calculate whether or not you
20 probably have cancer?

21 A I don't know if he mentioned it or not, but I know
22 I am aware that there was a CA-125 test performed.

23 Q In Hartsville?

24 A Yes, sir, in Hartsville.

25 Q Did Dr. Williams tell you that the CA-125 -- and

Faye Atkinson - Direct Examination by Mr. Corbin

1 expert witnesses talked about that, it's a cancer type
2 test. Did Dr. Williams tell you that cancer test that your
3 doctor did in Hartsville came back very low, indicating you
4 probably don't have cancer?

5 A No, sir.

6 MR. MCDOW: I'm going to object to that question,
7 Your Honor.

8 THE COURT: Yes, sir.

9 MR. MCDOW: Related to the, you probably do not
10 have cancer, that's not what the testimony was yesterday.
11 His expert related what the CA-125 was and that's a
12 mischaracterization of the testimony.

13 MR. CORBIN: I will rephrase it.

14 THE COURT: All right. The objection is sustained.

15 MR. CORBIN: Yes, sir.

16 BY MR. CORBIN:

17 Q Did Dr. Williams tell you that the CA-125 test
18 came back normal?

19 A No, sir.

20 Q Did you receive an ultrasound in Hartsville?

21 A I don't recall.

22 Q Did Dr. Williams discuss the findings on that CT
23 scan that he didn't take, but they took in Hartsville?

24 A Would you repeat that, please?

25 Q Did he discuss the CT scan with you and what it

Faye Atkinson - Direct Examination by Mr. Corbin

1 showed to him?

2 A No, sir.

3 Q Did you feel the only choice you had was surgery?

4 A Yes, sir.

5 Q Did Dr. Williams talk about the dangers of
6 surgery?

7 A Yes, sir.

8 Q What did he say?

9 A He said there was a possibility of blood loss and
10 that I might have to take blood and the normal risks.

11 Q How long did he say -- well, did he discuss
12 whether or not he felt the surgery would be difficult,
13 normal, complex, or dangerous?

14 A No, sir.

15 Q How long did he say it would take him to do the
16 surgery?

17 A He said it would be about a 20 minute procedure.

18 Q How long -- did he tell you how long to anticipate
19 your family would have to come from Hartsville to stay in
20 Columbia while you were in the hospital?

21 A No, sir, he told me that I might stay three to five
22 days.

23 Q Any other dangers or warnings that Dr. Williams
24 provided to you?

25 A No, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q If Dr. Williams would have told you, I anticipate
2 this to be complex surgery. I anticipate I could injure
3 your intestines. I anticipate I could have to surgically
4 cut out portions of your intestines, I anticipate you might
5 have infections, abscesses and surgical complications and
6 you could die, or we could postpone the surgery?

7 A Postpone the surgery.

8 Q Did Dr. Williams tell you anything about -- did he
9 have any clue was that mass getting bigger or smaller or
10 staying the same?

11 A No, sir.

12 Q Did Dr. Williams say anything about let's take
13 another ultrasound or CT scan 90 days down the road to see
14 what this mass is doing?

15 A No, sir.

16 Q If Dr. Williams would have hold you, instead of
17 this complex, dangerous surgery, another option you have is
18 let's do another CT scan in 90 days and see how it's doing,
19 do you know what you would have done?

20 A Yes, sir.

21 Q What would you have done?

22 A I would have said let's wait.

23 Q Did Dr. Williams tell you because of what happened
24 12 years earlier, the prior surgeries and the hysterectomy,
25 even before 12 years, because of that, you're at a higher

Faye Atkinson - Direct Examination by Mr. Corbin

1 risk of having holes in your bowel where I might have to
2 take it out. Did he tell you that?

3 A No, sir.

4 Q Would you prefer another CT scan or facing all
5 those dangers?

6 A What do you --

7 Q Which choice would you pick? Let's do a CT scan
8 or let's go in the operating room?

9 A Let's do a CT scan.

10 Q What happened next, please.

11 A I had surgery on April 25th.

12 Q Let me ask you a question while we're on the first
13 office visit.

14 A Okay.

15 Q Did Dr. Williams tell you that you had a right, as
16 his patient, you have a right to know about the
17 alternatives besides surgery. Did he tell you that?

18 A No, sir.

19 Q Did he say, Faye, you make the choice, I don't?

20 MR. MCDOW: Your Honor, I've let the questions go
21 pretty good, but now he's starting to testify, so I would
22 ask him to rephrase the question, please.

23 MR. CORBIN: I can rephrase that.

24 THE COURT: All right.

25 MR. MCDOW: I object in that respect.

Faye Atkinson - Direct Examination by Mr. Corbin

1 THE COURT: Objection is sustained.

2 BY MR. CORBIN:

3 Q Tell the jury what happened next, please.

4 A I had surgery.

5 Q How quick after you stepped in Dr. Williams'
6 office did he have you in the operating room?

7 A I was in his office on April the 13th and we did --
8 he did the first surgery on April 25th.

9 Q What did you understand, based upon what Dr.
10 Williams told you what would happen during that first
11 surgery? What was he going to do?

12 A He was going to remove the mass and he said at my
13 age, since I no longer needed my tubes and ovaries he would
14 remove them too. And he did ask me did I agree to that and
15 I said yes.

16 Q When he asked you that did you know you had the
17 option not to have surgery?

18 A No, sir.

19 Q Okay. Now, the first surgery, tell the jury how
20 you were after Dr. Williams' first surgical procedure?

21 A I was -- I got sicker. I vomited and vomited. I
22 had nausea.

23 Q Did Dr. Williams have a discussion with you after
24 this first surgery and did he tell you what he had done to
25 you?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A I asked Dr. Williams if it was cancer and he said
2 the mass had been sliced diced and chopped and that it was
3 not cancer. And that's what he told me that he had done.

4 Q Did Dr. Williams ever indicate to you between the
5 first and second surgeries that he had complications in the
6 first surgery?

7 A No, sir.

8 Q Were you ever aware that during the first surgery,
9 you had feet of your bowel removed?

10 A No, sir.

11 Q If, during the first surgery, Dr. Williams removed
12 feet of your bowel, do you feel like you had a right to
13 know that?

14 A Yes, sir.

15 Q If Dr. Williams, during the first surgical
16 procedure, caused a hole in your small bowel, did he tell
17 you?

18 A No, sir.

19 Q Do you feel as a patient, Faye, if a surgeon puts
20 a hole in your bowel, you have a right to know that?

21 A Yes, sir.

22 MR. MCDOW: I object to that, Your Honor. It calls
23 for -- that's a medical question.

24 THE COURT: And it's leading, sustained.

25 ///

Faye Atkinson - Direct Examination by Mr. Corbin

1 BY MR. CORBIN:

2 Q Would you want to know that kind of information?

3 A Yes, sir.

4 Q You know the reason Dr. Williams would not tell
5 you?

6 A No, sir.

7 Q After the surgery -- did Dr. Williams ever mention
8 the term to you extensive adhesiolysis?

9 A No, sir.

10 Q Did Dr. Williams indicate to you he had run your
11 bowel and received all of these adhesions?

12 A No, sir.

13 Q After the first surgery --

14 MR. CORBIN: Court's indulgence, Your Honor?

15 THE COURT: Yes, sir.

16 (WHEREUPON there was a pause in the proceedings.)

17 BY MR. CORBIN:

18 Q Faye, I'd like to focus on what happened to you
19 between the first and second surgeries. And how many days
20 lapsed between the two. Thirty-three?

21 A Yes, sir.

22 Q Thirty-three days. In evidence, Plaintiff's
23 Exhibit No. 4, it is a summary to make it a little easier
24 to digest 2000 pages of medical records, but it indicates
25 between your first and second surgery you had 65 episodes

Faye Atkinson - Direct Examination by Mr. Corbin

1 on at least 25 separate days, despite nausea medication
2 that you got every day, where you had nausea and vomiting.
3 Do you remember that?

4 A Yes, sir.

5 Q Did you have any idea that this 65 episodes of
6 vomiting could be a red flag, you have a hole in your
7 bowel?

8 MR. MCDOW: I'm going to object to that Your Honor.

9 THE COURT: Yes, sir?

10 MR. MCDOW: I want to object to that. That calls
11 for a medical conclusion.

12 THE COURT: Mr. Corbin?

13 MR. CORBIN: There has been testimony, Your Honor,
14 that these are red flags that when --

15 THE COURT: What was the exact question again?

16 MR. CORBIN: These episodes -- did you have any
17 idea at all these could be warning signs or red flags of a
18 perforation.

19 MR. MCDOW: And I object to that question.

20 THE COURT: Overruled.

21 BY MR. CORBIN:

22 Q These 65 episodes of nausea and vomiting, did you
23 have any idea at all that these could be warning signs or
24 red flags you have a hole in your bowel?

25 A No, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Did Dr. Williams tell you after the first surgery
2 because of what happened to you, you could be as much as a
3 50 percent risk of having a hole in your bowel?

4 A No, sir.

5 Q Did you have any idea about the significance of a
6 patient having a hole in the bowel which could even cause
7 death?

8 A No, sir.

9 Q If you were at a high risk, as much as 50 percent,
10 of having a condition that could kill you, would you want
11 to know?

12 A Yes, sir.

13 Q If there were warning signs or red flags of these
14 particular conditions -- and we're talking about the
15 perforation now, the holes. If there are warning signs for
16 that during those 33 days, would you want to know what to
17 look for?

18 A Yes, sir.

19 Q Did Dr. Williams tell you what warning signs or
20 red flags to look for?

21 A No, sir.

22 Q Faye, and I don't want to go too much into this,
23 but tell the jury some of the worst episodes you had of
24 nausea and vomiting -- was it easy to ignore?

25 A This was while I was in the hospital?

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Yes, between the first and second surgeries, focus
2 on that, please. The nausea and vomiting that you had,
3 would it be easy for someone just to ignore it?

4 A No, sir. That was the foulest smelling vomit I
5 have ever smelled in my life.

6 Q When would you get nauseated and throw up? How
7 many times a day?

8 A Both day and night, even in the bed, yes, sir.

9 Q Did you have a conversation with Dr. Williams
10 about your vomiting?

11 A Yes, sir.

12 Q Sometimes the records indicate it was feculent?

13 A Yes, sir.

14 Q When you would tell Dr. Williams --

15 A Can I have just a moment?

16 Q Yes, ma'am, you can take as much time as you want.
17 Any time you need to leave, you tell us. Would you like
18 some water?

19 A No, sir.

20 (WHEREUPON there was a pause in the proceedings.)

21 BY MR. CORBIN:

22 Q Okay. Faye?

23 A Yes, sir.

24 Q No indication from Dr. Williams feculent vomiting
25 is a warning sign? Did he give you any warning about that?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A No, sir.

2 Q There are references in the medical records in
3 evidence that for 30 separate days out of these 32 or 33,
4 for 30, including 27 days in a row, you had what doctors
5 call abdominal distension. Tell this jury what that is
6 from a patient's perspective?

7 A It's swelling in the abdomen and it becomes firm
8 and it's very painful.

9 Q Painful?

10 A (Witness nodded head.)

11 Q How did Dr. Williams treat the nausea and
12 vomiting? He gave you medication?

13 A Yes, sir.

14 Q Did it cure your nausea and vomiting?

15 A No, sir.

16 Q Didn't work?

17 A No, sir.

18 Q Did he tell you about any alternative treatments
19 besides medication that wasn't working?

20 A No, sir.

21 Q The records indicate sometimes you would try to
22 take the pill for nausea and vomiting and throw it back up?

23 A That's correct.

24 Q If there were an alternative treatment and if --
25 you indicated the nausea and vomiting bothered you. If

Faye Atkinson - Direct Examination by Mr. Corbin

1 there was an alternative treatment besides the pills that
2 weren't working, would you want to know?

3 A Yes, sir.

4 Q Did you want the horrible vomiting to stop?

5 A Yes.

6 Q Did you ask Dr. Williams to help me stop the
7 horrible vomiting?

8 A Yes, sir.

9 Q If Dr. Williams -- well, let me ask you this:
10 Nasal gastric tube decompression, NG tube, did you have an
11 NG tube between the first and second operations?

12 A No, sir.

13 Q Right before the second surgery, did you have an
14 NG tube down your nose?

15 A I had an NG tube near the end of that time frame,
16 but I don't know specifically what time.

17 Q Okay. If Dr. Williams, during these 20 -- well,
18 do you know if an NG tube almost immediately relieves
19 nausea and vomiting?

20 A Yes, sir.

21 MR. MCDOW: Your Honor, I'm going to object. He's
22 leading and he's testifying.

23 THE COURT: Sustained. You can rephrase it.

24 MR. CORBIN: Yes, sir.

25 ///

Faye Atkinson - Direct Examination by Mr. Corbin

1 BY MR. CORBIN:

2 Q If Dr. Williams would have given you the option of
3 a way to stop your nausea and vomiting, would you have
4 selected it?

5 A Yes, sir.

6 Q If Dr. Williams would have given you an option to
7 relieve your abdominal distension, would you have chosen
8 it?

9 A Yes, sir.

10 Q The medical records also indicate, Plaintiff's
11 Exhibit No. 3, that you had what surgeons like to call
12 tachycardia which is a heart rate above 100. Did anybody
13 tell you between that first and second surgery, tachycardia
14 is a red flag that you have surgical complications?

15 A No, sir.

16 MR. MCDOW: Judge, I'm going to object. That's an
17 improper question for this witness based on her --

18 THE COURT: Her expertise?

19 MR. MCDOW: That's right.

20 THE COURT: Overruled.

21 BY MR. CORBIN:

22 Q Did anybody, including Dr. Williams during those
23 30 separate days of tachycardia, ever tell you, that's a
24 red flag, warning sign you've got surgical complications?

25 A No, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q For 30 days -- it looks like maybe a hundred
2 references, 30 days, 27 in a row, perhaps as much as 100
3 times if somebody would have told you, Doris, that's a sign
4 you could be having surgical complications, would you want
5 to know?

6 A Yes, sir.

7 Q Are you aware of Dr. Williams doing anything to
8 treat your tachycardia?

9 A No, sir.

10 Q Plaintiff's Exhibit No. 19, the operation was on
11 April 25th?

12 A The first surgery was on April 25th.

13 Q Were you aware two days later, April 27th, that
14 from your wound into the drainage bag, it was draining
15 green, brown, four-smelling drainage?

16 A No, sir.

17 Q Did Dr. Williams ever express any concern to you
18 at all that two days after your first surgery, you had
19 drainage bag, draining green, brown, four-smelling
20 drainage? Any concern?

21 A No, sir.

22 Q Did Dr. Williams ever tell you that green
23 drainage, brown, foul smelling is suggestive of a surgical
24 complication?

25 A No, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Faye, if you would have been told about green
2 stuff coming out of your surgical wound and if you would
3 have been told that's an indication of a surgical injury,
4 would you want to know?

5 A Yes, sir.

6 Q Who spent time in your hospital room with you
7 between the first and second surgeries, so that's 33 days?

8 A My husband, my daughter and my son.

9 Q You mentioned the NG tube. You recall having it
10 later between the first and second surgeries?

11 A Yes, sir.

12 Q The records indicate April 27th, the day before
13 the surgery you had an NG tube placed. What happened then?

14 A Immediately the container attached to the wall
15 filled with a like greenish-black gook coming from my
16 stomach and I felt better.

17 Q Faye, did anybody tell you that the purpose of the
18 NG tube is to do exactly what it did? It removes all the
19 black-smelling gunk from your abdomen?

20 MR. MCDOW: I'm going to object. He's leading
21 again. He's testifying. He needs to ask a question.

22 THE COURT: Rephrase it.

23 MR. CORBIN:

24 Q Did Dr. Williams ever tell I the purpose of the NG
25 tube?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A No, sir.

2 Q Did Dr. Williams ever mention to you NG tube could
3 do exactly what it did, take the stuff out of your
4 stomach --

5 MR. MCDOW: Same objection.

6 THE COURT: Okay. Sustained.

7 BY MR. CORBIN:

8 Q Did Dr. Williams say one peep about the NG tube to
9 you?

10 A Not what it would do.

11 Q The day before the second surgery, NG tube
12 inserted, you indicated you felt better. At that point in
13 time, did Dr. Williams have discussions with you about
14 continuing with NG tube to avoid surgery?

15 A No, sir.

16 Q If Dr. Williams would have told you the day before
17 the second surgery after the NG tube worked, you have an
18 option, we can avoid this complex, difficult surgery with
19 all these risks, including potential death, or let's do the
20 NG tube again tomorrow, would you have done it?

21 A I would have continued with the NG tube.

22 Q The second surgery -- we're 33 days after the
23 first. Did Dr. Williams ever tell you what your condition
24 was?

25 A No, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Did Dr. Williams tell you, if you have a small
2 bowel -- well, did he mention anything about small bowel
3 obstructions or what he thought your condition was?

4 A No, sir.

5 Q If you would have known -- whatever condition you
6 had, it was important if you needed surgery, it's safer to
7 do it in the first two weeks, would you want to know that?

8 A Yes, sir.

9 Q If whatever condition you have, going to surgery
10 after a couple of weeks, especially 30 days later, it makes
11 it a lot more dangerous and risky, would you want to know?

12 A Yes, sir.

13 Q Did Dr. Williams tell you that?

14 A No, sir.

15 Q The hospital records indicate that you were
16 anxious about more surgery; is that true?

17 A Yes.

18 Q Did you feel like you were doing well between the
19 first and second surgeries?

20 A No, sir.

21 Q Did you want a second surgery?

22 A No, sir.

23 Q Did you tell Dr. Williams you were anxious and did
24 not want the second surgery?

25 A I said I wanted help.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Were you afraid of the second surgery?

2 A Yes, sir.

3 Q In fact the nurses notes the day you were wheeled
4 into the operating room, you said you were anxious. Were
5 you scared?

6 A Yes, sir.

7 Q If there was a reasonable way to avoid that second
8 surgery, would you have done it?

9 A Yes, sir.

10 Q The second surgery, you had, according to Dr.
11 Williams' findings, you had numerous enterotomies. Do you
12 know what an enterotomy is?

13 A No, sir.

14 Q Assume it's a hole in your bowel. The surgical
15 record of Dr. Williams of the second surgery indicates that
16 he caused multiple holes in your bowel. Did he tell you
17 that?

18 A No, sir.

19 Q The second surgical report of Dr. Williams
20 indicates when he went inside your belly the second time he
21 found what doctors call a probable pocket of extravasated
22 dye. Did he discuss that you with?

23 A No, sir.

24 Q Do you know what -- has anybody ever told -- well,
25 did Dr. Williams tell you anything about the dangers of

Faye Atkinson - Direct Examination by Mr. Corbin

1 barium leaking outside your intestines?

2 A No, sir.

3 Q If Dr. Williams in the second operative report
4 indicates that you had barium outside your intestines would
5 you want to know?

6 A Yes.

7 Q Faye, during the second surgical procedure, Dr.
8 Williams indicates in his operative record and will testify
9 it was very complex, difficult, dangerous because your
10 intestines were kind of matted together. It was hard to
11 tell where the intestines were, the organs were. If Dr.
12 Williams would have known that before the surgery, would
13 you want to know that?

14 A Yes, sir.

15 MR. MCDOW: Object to the hypothetical.

16 THE COURT: All right. Could you restate the
17 question?

18 MR. CORBIN: Yes, sir.

19 THE COURT: I had some difficulty understanding
20 exactly what the question was.

21 MR. CORBIN: Yes, sir. Yes, sir.

22 BY MR. CORBIN:

23 Q Did anybody tell you before the second surgery --
24 well, let's focus on Dr. Williams. Did Dr. Williams tell
25 you before the second surgery that he anticipated it would

Faye Atkinson - Direct Examination by Mr. Corbin

1 be very complex, difficult and dangerous?

2 A No, sir.

3 Q Did Dr. Williams tell you before the second
4 surgery that he anticipated when he got inside you, you
5 would have either more adhesions and it would be more
6 complex and more dangerous than even the first one?

7 A No, sir.

8 Q Did Dr. Williams ever tell you that he had to
9 remove a significant portion of your small intestines
10 during the second surgery?

11 A No, sir.

12 Q If Dr. Williams removed feet of your bowel in the
13 second surgical procedure, would you want to know?

14 A Yes, sir.

15 Q If Dr. Williams, when he went inside your belly
16 the second time and encountered what he says he encountered
17 in the operative report -- if at that point in time Dr.
18 Williams had the option to continue with the operation or
19 to stop it and wait until your belly heeled a little bit
20 better, would you want to know?

21 A Yes, sir.

22 MR. MCDOW: Objection, Your Honor. Just -- she's
23 in the operating room, she can't answer that question at
24 the time. That calls for speculation.

25 THE COURT: You -- I'll overrule that. You address

Faye Atkinson - Direct Examination by Mr. Corbin

1 that with her on redirect, but that objection is overruled.

2 BY MR. CORBIN:

3 Q You were unconscious in the operating room?

4 A Yes, sir.

5 Q Would you want to know that Dr. Williams, during
6 the second surgery, whether or not he had two or three
7 options, one continue with your operation, causing numerous
8 holes in your bowel and removing a significant portion of
9 it or to stop; put in an NG tube and continue with your
10 tube feeding, is that information you would want to know?

11 A Yes, sir.

12 Q Do you know which option you would have selected
13 if you were given a choice?

14 A Yes, sir.

15 Q Which one?

16 A I would have continued with the NG tube.

17 Q Did Dr. Williams ever tell you before the second
18 surgery, Faye, this is elective, this is an elective
19 surgery?

20 A No, sir.

21 Q If Dr. Williams would have told -- if Dr. Williams
22 knew the second surgery was elective, would you want to
23 know that information?

24 A Yes, sir.

25 Q Did you give Dr. Williams permission to disregard

Faye Atkinson - Direct Examination by Mr. Corbin

1 your right to choose?

2 A No, sir.

3 Q Did he do anything to honor your right to choose
4 whether or not to have a second surgery?

5 A No, sir.

6 Q Did he give you any -- did he honor your right to
7 choose?

8 A No, sir.

9 Q About anything?

10 A No, sir.

11 Q The second surgery, you have numerous holes in
12 your bowel. You had feet of your bowel removed. Tell the
13 jury what Dr. Williams told you in the next couple of days
14 after the surgery. Did it go well?

15 A I don't recall what he said, but I did not do
16 better, I got worse after the second surgery.

17 Q Three or four days after your second surgery, Dr.
18 Williams went on vacation?

19 A I think so.

20 Q Tell the jury what happened three or four days
21 after Dr. Williams' second surgery. What happened to you?

22 A I got worse. The nausea and the vomiting continued
23 and it was worse. And I recall Dr. Smith coming in. I
24 remember him touching me on my arm.

25 Q What did he say?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A He said I'll pray for you. He was a very nice
2 doctor. He said he was going to help -- get some help.

3 Q Did he get Dr. Williams to help?

4 A No, sir.

5 Q Who helped?

6 A Dr. Parker.

7 Q Dr. Parker, a surgeon at Palmetto Health Richland?

8 A Yes, sir.

9 Q Tell the jury your feelings about Dr. Parker?

10 A In one sentence, Dr. Parker saved my life. I
11 honestly thought I would have died.

12 Q After Dr. Williams got back from -- well, what did
13 Dr. Parker do to save your life?

14 A Dr. Parker did surgeries.

15 Q How many?

16 A Four.

17 Q How far apart?

18 A I know they started around the first part of June
19 and they went a week or so.

20 Q Did -- how many surgeries did you have with Dr.
21 Parker?

22 A Dr. Parker did four surgeries.

23 Q Based upon your conversation with Dr. Williams the
24 first day in his office, did you have any indication from
25 him to anticipate six surgical procedures with removal of

Faye Atkinson - Direct Examination by Mr. Corbin

1 the ovarian cyst?

2 A No, sir.

3 Q Eventually you got out of the hospital?

4 A Yes, sir.

5 Q Let me ask you about Dr. Parker. When is the
6 first time you remember Dr. Parker discussing with you your
7 condition?

8 A It was on the afternoon before he did the first
9 surgery.

10 Q Assume on June 2nd is when Dr. Parker did his
11 first surgery, how soon before that do you think you recall
12 seeing him the first time?

13 A To the best of my recollection -- I'm confused, Mr.
14 Corbin.

15 Q That's okay. Take your time?

16 A Just give me a minute here.

17 Q Yes, ma'am.

18 A I need a little air.

19 (WHEREUPON there was a pause in the proceedings.)

20 THE WITNESS: Could you repeat the question?

21 BY MR. CORBIN:

22 Q Try to remember as well as you can, Dr. Parker did
23 the surgery June 2nd. How soon before that did you -- do
24 you remember meeting him the first time, if ever?

25 A I only remember the day before the surgery.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Around June 1st?

2 A Yes, sir.

3 Q Sixty-two days in the hospital. Did you have to
4 have additional medical treatment after you left Palmetto
5 Health Richland in Columbia, or were you cured?

6 A No, sir. I'm still having problems.

7 Q Still receiving medical care and treatment?

8 A Yes, sir.

9 Q Faye, in the evidence, Plaintiff's Exhibit No. 28,
10 it's a summary of your medical expenses. And to make it
11 easier to follow your medical expenses, which is a volume,
12 there's a summary on the front consisting of three pages
13 and the current total medical bills that you've incurred
14 because of this incident is \$571,058.62, and the jury will
15 have this. Is that your recollection?

16 A Yes, sir.

17 Q Now, attached to the summary, Faye, looks like
18 documentation for every single reference of your charges;
19 is that true?

20 A Yes, sir.

21 Q If somebody were to say, Faye, you're faking about
22 your short bowel syndrome, or prove it, what would you do?

23 A I'm not faking anything. If they wanted to live
24 with me one day, they would see what I have to tolerate.

25 Q Yes, ma'am. Do you think you're ever going to get

Faye Atkinson - Direct Examination by Mr. Corbin

1 better?

2 A I've come a long way, but I will never be well.

3 MR. CORBIN: Bill, would you please help me move
4 this table up? I'm sorry to ask you to do that?

5 MR. MCDOW: Sure.

6 MR. CORBIN: The cord just won't reach the monitor.
7 Thank you, Bill.

8 MR. MCDOW: Okay.

9 THE COURT: Of course, you can get to where you
10 need to be where you see.

11 MR. MCDOW: Yes, sir.

12 MR. CORBIN: Your Honor, we're just going the
13 discuss photographs already in evidence.

14 THE COURT: All right. Can you just give me
15 numbers so I --

16 MR. CORBIN: Yes, sir.

17 THE COURT: -- can make notes?

18 MR. CORBIN: Yes, sir.

19 BY MR. CORBIN:

20 Q Faye, you have a husband, two adult children. Do
21 the adult children live with you in your household?

22 A No, sir.

23 Q Who lives with you in your household?

24 A My husband.

25 Q You physically need help to do something, upon

Faye Atkinson - Direct Examination by Mr. Corbin

1 whose shoulders do you rest?

2 A Now?

3 Q Yes, ma'am.

4 A Now, I have to ask my children.

5 Q Okay. Before Buck got sick, upon whom did you
6 depend?

7 A Buck.

8 Q Your children live where?

9 A One lives in Jefferson, South Carolina and one
10 lives near Florence, South Carolina.

11 Q This photograph, Plaintiff's Exhibit 32 B?

12 THE COURT: 32 B?

13 MR. CORBIN: Yes, sir. 32 B as in boy.

14 BY MR. CORBIN:

15 Q Appears to be a pretty happy family. I'd like to
16 hand it to you, please. And can you identify your husband,
17 Bucky?

18 A Yes, sir, he's behind me with the hat on.

19 Q He wears a hat a lot, don't he?

20 A Yes, sir.

21 Q And your son?

22 A He's sitting on the left, holding the child.

23 Q The child is?

24 A His son.

25 Q What is that little fellow's name?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A His name the Will.

2 Q Your daughter, is she in this photograph?

3 A Yes, sir.

4 Q And that is Angie sitting in the courtroom?

5 A Yes, sir, she's sitting by me (indicating) in the
6 picture, I'm sorry.

7 Q And in Angie's arms is a baby?

8 A Yes, sir.

9 Q And who is that baby?

10 A That's her son.

11 Q And the other people in the photograph?

12 A Beside my husband is my son-in-law. Beside my son
13 is my daughter-in-law and the elderly lady is my late
14 mother-in-law.

15 Q That photograph was taken in 2003, four years
16 before your first surgery?

17 A Yes, sir.

18 Q Back in those days, four years before you
19 initially met Dr. Williams, tell the jury a little bit
20 about your interactions with your family, your grand kids
21 and how you felt about doing that?

22 A First of all, I love my family. I don't think
23 there's anything I won't try to do to help my family. I'm
24 proud of my daughter and my son. I have five grandchildren
25 now and one great grandchild. We love to get together. We

Faye Atkinson - Direct Examination by Mr. Corbin

1 love to eat, play games, have fun. --

2 Q Pretty good grandma?

3 A -- go places and do things. I think I was a good
4 grandma.

5 Q That photograph was taken in 2003. In 2003, Faye,
6 that's eight years or so after your previous surgeries.

7 Did your previous surgeries cause you any kind of
8 limitation where you could not interact with your
9 grandchildren or your children or do these family
10 activities?

11 A No, sir.

12 Q Plaintiff's Exhibit No. 32 A, who is that little
13 fellow?

14 A My grandson. My oldest grandson.

15 Q Taken at Halloween?

16 A Yes, sir.

17 Q Okay. Do you do those kind of things anymore?

18 A I'm limited as to what I do with them now.

19 Q You used to spend some time in the swimming pool
20 with your grand kids, 32 C; right?

21 A Yes, sir.

22 Q Do you do that anymore?

23 A No, sir.

24 Q 32 B, you've got a redheaded grandchild?

25 A Yes, sir, I do.

Faye Atkinson - Direct Examination by Mr. Corbin

- 1 Q Cute little fellow. What's his name?
- 2 A Dustin.
- 3 Q Are you able to play and interact with Dustin the
- 4 way you used to?
- 5 A Oh, no, sir.
- 6 Q 32 E, you're bending down, lifting up a
- 7 grandchild. Who is that, please?
- 8 A That's Dustin.
- 9 Q The little pumpkin?
- 10 A Yes, sir. In fact, I made that pumpkin shirt for
- 11 him.
- 12 Q (Laughing) do you interact with grand kids that
- 13 way anymore?
- 14 A No, sir, not that way.
- 15 Q Somebody graduated, Plaintiff's Exhibit No. 32 F.
- 16 Who is in this photograph, please?
- 17 A That's my husband, me. My grandson had graduated
- 18 from kindergarten.
- 19 Q About when was that? Roughly speaking. 2003;
- 20 2004?
- 21 A Yes, sir.
- 22 Q Back in those days, did you have any kind of
- 23 physical disability that would cause you any troubles at
- 24 all to enjoy your grand kids like you do here?
- 25 A Oh, no, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q After those 1995 surgeries, 12 years before Dr.
2 Williams, did you have normal scarring?

3 A No, sir.

4 Q Did you have some scars?

5 A Yes, sir.

6 Q Describe how the scars were back from 1995?

7 A It was an incision from around by naval area down
8 to my pubic area.

9 Q Did that scar cause you any difficulties?

10 A No, sir.

11 Q Did that scar cause you to want to stay in your
12 house and not go anywhere?

13 A No, sir.

14 Q Faye, if you may -- if you will, I need to ask
15 you, do you have scarring after Dr. Williams' surgical
16 procedures on you?

17 A Yes, sir.

18 Q Exhibit No. 32 A --

19 A Yes, sir.

20 Q Tell the jury -- how long did it take you to look
21 at your stomach?

22 THE COURT: 32?

23 MR. CORBIN: I'm sorry, Your Honor, 33 A.

24 THE COURT: 33 A?

25 MR. CORBIN: 33 A, yes, sir.

Faye Atkinson - Direct Examination by Mr. Corbin

1 THE COURT: Okay. Thank you.

2 BY MR. CORBIN:

3 Q How long did it take you when you got home from
4 the hospital for you to first look at your stomach?

5 A Almost 3 years.

6 Q 33 B, May 23, 2011, last year. Was that how you
7 looked last year?

8 A Yes, sir.

9 Q Have you gotten better?

10 A I don't understand, sir.

11 Q Have the scars improved?

12 A No, sir.

13 Q The most recent photograph, on May 23, 2011,
14 Exhibit 33 F, is that a close up of the scar?

15 A Yes, sir.

16 Q Looks like there's some separation of the wound;
17 is that correct?

18 A Yes, sir.

19 Q Is it painful?

20 A It's painful to look at.

21 Q Doris, are you a complainer?

22 A No, sir.

23 Q Whiner?

24 A No, sir.

25 Q Do you like showing people your scars?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A No, sir, no one as seen my scars except for persons
2 that have absolutely had to. My family has never seen them
3 except my husband.

4 Q Bucky would take care of your scars?

5 A Yes, sir.

6 Q Did he do a good job?

7 A After home health was with me for almost a year, he
8 had to continue with the dressings. Yes, sir, he did a
9 good job.

10 Q Is that all Bucky did for you?

11 A No, sir.

12 Q Did he ever pick you up off the floor?

13 A Yes, sir.

14 Q Tell the jury about that incident where Bucky had
15 to pick you up off the floor. What was going on?

16 A The first incident after I came home, I was
17 lightheaded and I fell into the floor and I couldn't get up
18 and I had vomited and my bowels had emptied all over the
19 floor. And he found me and he picked me up and he cleaned
20 me and he cleaned up the mess. He took care of me. That
21 happened again and he took me to the emergency room.

22 Q Could you always depend on Bucky?

23 A Yes, sir.

24 Q What in the world are you going to do when Bucky
25 is no longer to care for you if you fall in the floor in

Faye Atkinson - Direct Examination by Mr. Corbin

1 your feces?

2 A I'm going to have to have somebody else to help me.

3 Q Faye, September 20th, 2012, the most recent
4 photograph, Plaintiff's Exhibit 31 A., can you just tell
5 the jury this is an accurate depiction?

6 A Yes, sir.

7 THE COURT: 31 A, Mr. Corbin?

8 MR. CORBIN: Yes, sir, 31 A.

9 THE COURT: All right.

10 BY MR. CORBIN:

11 Q After -- after you were discharged from the
12 hospital, 62 days, tell the jury how you got home.

13 A My son has an RV -- had an RV and he brought it
14 over and took me home in his RV. In it I had access to a
15 bed and the bathroom.

16 Q Tell the jury why it's important for you to have
17 access to a bathroom?

18 A When I eat a meal and I eat a regular meal -- which
19 I don't always consume all of it -- I sometimes have to get
20 up from the table and go to the bathroom. I generally go
21 about five times after eating a meal, or if I drink and eat
22 and do eat and drink often because I don't get the
23 nourishment that my body needs; -- but when I eat and drink
24 within just a short time, I have to go empty.

25 Q One time a day?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A No, sir.

2 Q The records we read yesterday to the jury
3 indicated as much as sixty some times a day. Tell the jury
4 about that.

5 A After I came home from the hospital, I think it was
6 in September that this started; I went an awful lot one day
7 and I knew it was in excess of the amount that I had been
8 going, so I started counting how many times I went to the
9 bathroom. And for almost a week, it was 60 to 68 times
10 every day. I would drink water, it would go straight
11 through. I wasn't keeping any nourishment in my body. I
12 lost all my electrolytes. I had to go to the hospital and
13 have all my electrolytes replaced.

14 Dr. Parker thought that I may have had a virus, but
15 this continued and then I kept going down to about 40
16 something, 45 times a day.

17 (WHEREUPON there was a pause in the proceedings.)

18 BY MR. CORBIN:

19 Q Are you okay, Faye? What do you think of Dr.
20 Williamson?

21 A Dr. Williamson has been a very good help to me.

22 Q Dr. Williamson told the jury the other day that
23 your persistent diarrhea makes your anus raw. Tell us
24 about it?

25 A Every day, approximately 4, 5 o'clock on an average

Faye Atkinson - Direct Examination by Mr. Corbin

1 day, I start bleeding because I have hemorrhoids -- raw
2 is -- it gets to the point where I don't want to drink
3 because I know I've got to go and I am raw from -- in that
4 area.

5 Q Do you have surgical wound hernias on top of your
6 belly?

7 A Yes, sir, I have a hernia.

8 Q Do you know of any way to surgically treat your --
9 well, are hernias painful?

10 A Yes, sir.

11 Q Do your hernias hurt you?

12 A Yes, sir.

13 Q Do you know of any way to fix your surgical wound
14 hernias? Do you know of any way?

15 A Not now because surgery would be a lot of risk and
16 surgery is not an option for me.

17 Q You indicated you had been hospitalized for
18 electrolyte imbalances. Before you saw Dr. Williams in
19 2007, did you know anything about electrolyte imbalances?

20 A I didn't have that problem.

21 Q Did you know anything about short bowel syndrome
22 before you met Dr. Williams?

23 A No, sir.

24 Q Do you know about it now?

25 A Yes, sir. I know more now?

Faye Atkinson - Direct Examination by Mr. Corbin

1 Q Kidney stones -- Dr. Williams testified that
2 because of short bowel syndrome, you have kidney stones
3 tell the jury about that.

4 A The first kidney stone that I had after his
5 surgery, we had no idea it was a kidney stone. I
6 complained for 18 months. I went to various doctors trying
7 find what the problem was that I was hurting so bad. I
8 finally passed it and when I passed the stone, I saved it
9 and took it to my primary care doctor. It was large. It
10 had gotten lodged somewhere near the point where it should
11 have emptied and it caused me a lot of pain for almost 18
12 months. And since then I have continued to have kidney
13 stones.

14 Q Faye, we had read Dr. Allen's psychological
15 report. You were not here, but we read the psychological
16 report to the jury. There was a time in 2008, 18 months
17 after your treatment by Dr. Williams, you went to social
18 security to apply for disability. Do you recall that?

19 A Yes, sir, I recall.

20 Q Dr. Allen interviewed you --

21 A Yes, sir.

22 Q -- examined you. There was a reference in Dr.
23 Allen's report -- you were 61 years old, not 62 yet?

24 A Yes.

25 Q There is a reference in Dr. Allen's report that

Faye Atkinson - Direct Examination by Mr. Corbin

1 you would like to request early retirement. Did you like
2 to request early retirement?

3 A No, sir.

4 Q After you completed your surgical treatment with
5 Dr. Williams, were you physically capable of working?

6 A Yes, sir.

7 Q Did you work?

8 A I worked --

9 Q After the surgeries?

10 A No, sir.

11 Q After the surgeries with Dr. Williams, were you
12 physically capable of going back to work?

13 A No, sir.

14 Q The early retirement that you requested of social
15 security involved what?

16 A Social security disability benefits.

17 Q Were you disabled before you saw Dr. Williams.

18 A No, sir.

19 Q Faye, Lord knows many people don't have small
20 bowel syndrome and cannot discuss it like you can. Go
21 back, think, tell this jury how bad short bowel syndrome
22 can be?

23 A Mr. Corbin, are you asking to describe maybe an
24 incident that I've had.

25 Q Yes, ma'am. What incidents have bothered you the

Faye Atkinson - Direct Examination by Mr. Corbin

1 most?

2 A It's very private.

3 Q We --

4 A It's embarrassing.

5 Q Yes, ma'am.

6 A With short bowel syndrome that I have, you do not
7 control your bowels. In other words, they really control
8 what I do, where I go, what I eat, when I eat, et cetera.
9 I have been standing, just standing, in my house and feces
10 would run down my legs and puddle on the floor time after
11 time after time and I have to clean it all up, clean
12 myself. And at those times, I thank God that there's no
13 one there. And there have been time after time after time
14 that during the night my husband and I would have to get up
15 and he would take me in the shower because I would have
16 bowel movements all in the bed, all over the carpet, all
17 into the bathroom; 2 and 3 o'clock in the morning, he would
18 get up and clean up, clean me up, put me back in the bed.

19 I've had incidents where I would leave my house and
20 attempt to go somewhere and I wouldn't be a mile down the
21 road because I had soiled my clothes. But every time that
22 I want to go somewhere, I have to be careful about timing.
23 I've had times that I've gone to the -- I've gone shopping
24 and I've had accidents in stores that just soiled my
25 clothing. But the odor was so offensive to me and I know

Faye Atkinson - Direct Examination by Mr. Corbin

1 it was by the way that the other persons were acting in the
2 store and I've never been back in those stores again.

3 I've had numerous incidents where I would just be
4 walking in my yard and my bowels would loose. And even in
5 the grass, I'd be standing in a puddle of poop. And I have
6 to find a way to get back into the house without making
7 such a mess and for the neighbors to see. I've worn pull
8 ups that don't help and I've lost so much weight that I had
9 to go in the baby department and by the buy Good Nights
10 that babies, or children wear. They didn't have them. You
11 have to eat and you have to drink and with every time I eat
12 or drink, I need to be near a bathroom.

13 Q Faye, please tell the jury how difficult it has
14 been for you just to come to the courtroom and sit here.
15 If someone were to say you've been sitting here for a
16 couple of hours, what would you say?

17 A I'd say, no, sir, I'm not fine. My whole life is
18 built around time. No matter where I go, I have to make
19 sure that I have nothing in me. I eat or drink at least
20 two and a half hours before I go out because I know it's
21 going to take that long for me to complete -- completely
22 check up before I go out and even then I have accidents
23 occasionally. It's been very difficult the last three days
24 to be here.

25 Q How difficult, please?

Faye Atkinson - Direct Examination by Mr. Corbin

1 A I am so thirsty right now, Mr. Corbin, I really
2 would love to have something to drink, but I'm not. I have
3 to get up, make sure I get my medications and wait until I
4 eat and then come. I do not eat or drink anything until I
5 get back home or either I have a safe place to use the
6 bathroom for at least two hours.

7 This morning I got on the scale at 5:30. I had
8 lost three pounds since yesterday because I did not eat or
9 drink the way I normally do. It was 107 pounds this
10 morning. At 5:30 this morning I had a half a cup of yogurt
11 with my medications. I had three swallows of water in
12 order to get here. And I will not have anything to eat or
13 drink until I get back home. I can tell you right now that
14 I am lightheaded and I am dizzy. I have two hernias and
15 they are pulling. I am so thirsty.

16 In a typical day, I usually eat and drink my meals
17 and about every hour or so -- at least every hour,
18 sometimes even between then, I'm eating crackers. During
19 the day, I smack on crackers, peanut butter crackers
20 saltine crackers -- animal crackers, I've learned to love.

21 Q Thank you, Faye.

22 A Mr. Corbin, I need to go to the restroom.

23 THE COURT: All right. You can step down, ma'am,
24 thank you.

25 All right. Ladies and gentlemen, you can go to

Faye Atkinson - Direct Examination by Mr. Corbin

1 your jury room. Please do not discuss the case. Thank
2 you.

3 (WHEREUPON the jury left the courtroom at 10:15
4 a.m.)

5 THE COURT: All right. Let's just use this,
6 gentlemen, as a morning recess.

7 MR. CORBIN: Yes, sir. And Your Honor?

8 THE COURT: Yes, sir?

9 MR. CORBIN: The daughter, Angie has been
10 instructed not to talk to her mother about the testimony.

11 THE COURT: I didn't mention that to her.

12 MR. CORBIN: I instructed her.

13 THE COURT: All right. Thank you.

14 (WHEREUPON a recess was observed.)

15 THE COURT: I apologize for the delay, I was
16 reading with the lawyers about a case that I have to try at
17 the end of the month, so.

18 Mr. McDow, are you ready?

19 MR. MCDOW: I'm ready.

20 THE COURT: Mr. Corbin?

21 MR. CORBIN: Yes, sir.

22 MR. MCDOW: Can we ask the witness to go ahead and
23 take the witness stand before the jury comes in?

24 THE COURT: Yeah. If you can have a seat, please,
25 ma'am.

Faye Atkinson - Direct Examination by Mr. Corbin

1 Mr. Corbin, how much longer will you have on
2 direct?

3 MR. CORBIN: I'm done.

4 THE COURT: You are? I just didn't hear you -- I
5 assumed that, but I didn't hear you say no further
6 questions.

7 MR. CORBIN: Yes, sir. No further questions.

8 THE COURT: All right. I'll allow you -- I'll ask
9 you to -- I'll tell you you can continue and you can say
10 whatever you want to say and we'll move on.

11 Mr. McDow, you ready?

12 MR. MCDOW: Yes, sir, I'm are.

13 THE COURT: Okay. Do you have your designations
14 that you can hand up to me for that deposition you're going
15 the read?

16 MR. CORBIN: Dr. Reynolds.

17 (WHEREUPON there was discussion off the record.)

18 (WHEREUPON the jury entered the courtroom at 10:37
19 a.m.)

20 THE BAILIFF: Jurors are seated, Your Honor.

21 THE COURT: Thank you.

22 Mr. Corbin, are you concluded?

23 MR. CORBIN: No further questions, Your Honor,
24 thank you, sir.

25 THE COURT: Mr. McDow?

Faye Atkinson - Cross-Examination by Mr. McDow

1 MR. MCDOW: Thank you, Judge, may it please the
2 Court?

3 THE COURT: Yes, sir.

4 **CROSS-EXAMINATION**

5 BY MR. MCDOW:

6 Q Ms. Atkinson, good morning. My name is Bill
7 McDow. We met when I took your deposition back on May
8 24th, 2011; do you recall that?

9 A Yes, sir.

10 Q I don't think I bit you then and I promise you I'm
11 not going to bite you now. Is that okay?

12 A Yes, sir.

13 Q All right. I have some questions and I'm just
14 going to kind of go through my notes from your deposition
15 and ask a few questions of you and then we'll go from
16 there.

17 You are obviously not happy with the end result
18 that occurred as a result of hospitalization in 2007;
19 correct?

20 A That's correct.

21 Q I think that's a fair statement. Okay. Back to
22 your 1995 surgeries, you had this abdominal exploratory
23 surgery in Hartsville, right?

24 A That's correct.

25 Q And I think that that was at what was called the

Faye Atkinson - Cross-Examination by Mr. McDow

1 old Byerly Hospital?

2 A Yes, sir.

3 Q And that hospital has closed down and there's a
4 new one over there now known as Carolina Pines; is that
5 right?

6 A That's correct.

7 Q I think Mr. Corbin had said that it was at
8 Carolina Pines and I just wanted to make sure that that was
9 the old Byerly Hospital. And as I understood you were
10 hospitalized on that occasion for 18 days; correct.

11 A That's correct.

12 Q And it was your understanding back then -- we
13 don't have the records today that you had 10 inches of your
14 bowel removed at that time; is that right?

15 A I was told 8 to 10 inches.

16 Q Eight to ten, okay, yes, ma'am. Okay. And you
17 went in for that hospitalization due to a bowel
18 obstruction; is that right?

19 A I was in pain and they found an obstruction.

20 Q Okay. And it was the pain that prompted that
21 surgery; is that right?

22 A The pain prompted me to go to the emergency room
23 and they admitted me and they did exploratory.

24 Q And in that first exploratory surgery, they found
25 adhesions had wrapped around the track and blocked it,

Faye Atkinson - Cross-Examination by Mr. McDow

1 correct?

2 A I don't know.

3 Q Well, were you told that?

4 A I think I was told that.

5 Q All right.

6 MR. MCDOW: Your Honor, may I open the original
7 deposition?

8 THE COURT: Yes, sir, you can and just -- ladies
9 and gentlemen of the jury, I explained to you yesterday
10 what a deposition is. It's a discovery tool where the
11 attorneys provide notice to certain witness to appear. In
12 this case, the plaintiff and the lawyers are permitted to
13 answer or, excuse me, ask questions of the witnesses under
14 oath at the time of the deposition. All right.

15 MR. MCDOW: This is the deposition of Doris
16 Atkinson taken on May 24th, 2011.

17 BY MR. MCDOW:

18 Q And I will turn to page 38, Ms. Atkinson. I'm
19 going to show you page 38 right on this side. And I just
20 want to refresh your memory. I know it's not fair to ask
21 you these questions I haven't had in front of you. On page
22 38, line 3, I asked you a question saying, Okay, so the --
23 the reason for the surgery was for the pain. What did they
24 find when they opened you up. And what was your answer?

25 A Adhesions had wrapped around the track and blocked

Faye Atkinson - Cross-Examination by Mr. McDow

1 it.

2 Q Okay. Does that refresh your memory now with your
3 deposition?

4 A Yes, sir.

5 Q Thank you. Okay. You can set that aside and keep
6 it up there in case we get back to that point.

7 And you understood that adhesions means scar
8 tissues; is that correct?

9 A Correct.

10 Q And adhesions had wrapped around a section of the
11 small intestine and your intestines were blocked as a
12 result of that; isn't that right?

13 A Correct.

14 Q Okay. And when the surgeon went back in and
15 removed -- well, actually, you had that surgery and then
16 while you were there, you had to have a second surgery?

17 A Correct.

18 Q Okay. When the surgeon went back in, he removed
19 the area that was blocked; is that right?

20 A Correct.

21 Q And I think I heard yesterday some -- was there
22 gangrene found at that time?

23 A No, sir.

24 Q No?

25 A That was the first --

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q The first -- oh, the very first 1995. The first
2 surgery that caused the pain that got you there to start
3 with.

4 A In 1995, yes, sir.

5 Q Okay. And that's what you're saying, before going
6 back in -- they had to go back in and take another small
7 section out; right?

8 A Correct.

9 Q Do you know the amount of the second section that
10 they took out?

11 A I don't recall the precise amount.

12 Q And the reason they had to go back in that second
13 time is because an adhesion had wrapped around quickly,
14 correct?

15 A Correct.

16 Q And did you have any nausea and vomiting when you
17 were in the hospital on that occasion?

18 A In 1995?

19 Q Yes, ma'am.

20 A Yes, sir.

21 Q And did -- then you had a hysterectomy that was an
22 open procedure back in, I think either in 1972 or 1973,
23 correct?

24 A Correct.

25 Q Well, by open procedure, did they cut your stomach

Faye Atkinson - Cross-Examination by Mr. McDow

1 at that time as well?

2 A Yes, sir.

3 Q Okay. Or after I guess it is. And to be fair,
4 you had no issues with adhesions after the hysterectomy?

5 A No, sir.

6 Q Okay. When I took your deposition back on May
7 24th, of 2011, you were on some medications for heartbeat,
8 high blood pressure, the flat ula I think Dr. Williams had
9 talked about and some other supplements. Are you taking
10 anything different today than you were back then?

11 A No, sir.

12 Q Are you taking anything less or are you still on
13 the same meds?

14 A I think I'm on the same meds including my sinuses.

15 Q Okay. And when I took your deposition, you had
16 not had any hospitalizations in the last 3 months before
17 then. Have you had any since May 24th of 2011?

18 A No, sir.

19 Q And you were a substitute school teaching being
20 paid \$70 a day; is that right?

21 A That's correct, and a long time teacher I was paid
22 \$10 more per day than you were as a regular sub.

23 Q Were you actually -- how does that work? Were you
24 considered an employee of the school district?

25 A Yes, sir.

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q Okay. Your -- you showed me back at the time, I
2 think your driver's license you had renewed and been issued
3 an October 15th, 2011, your height was 5 feet 2. You
4 weighed 106 pounds on your driver's license. Do you recall
5 that?

6 A Yes, sir, I do.

7 Q I'm not going to insult you or my grandmother by
8 asking you anything else about that today. You had no
9 blockage present when I took your deposition; is that
10 right?

11 A Could you repeat that, please?

12 Q You had no blockage, no intestinal blockage when I
13 took your deposition?

14 A No, sir.

15 Q And you haven't had any since then?

16 A I've had two scares.

17 Q Okay. When you were referred over to Dr.
18 Williams, it was Dr. Cray that referred you over here?

19 A Yes, sir, that was Dr. Michelle Cray.

20 Q Dr. Michelle Cray; and she was the OB GYN over in
21 Hartsville; is that right?

22 A Yes, sir, she is.

23 Q Okay. And you got sent over here as a result of
24 being admitted to the hospital over in Hartsville?

25 A Correct.

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q Okay. And the admission in the hospital in
2 Hartsville, you went to the emergency room due to pain; is
3 that right?

4 A That's correct.

5 Q And, of course, we know they did CT scans and
6 stuff that showed the 13 by 9 centimeter mass, correct?

7 A Correct.

8 Q And it was in Hartsville when you discovered that
9 the mass needed to be removed; is that right?

10 A Yes, sir.

11 Q Some of this stuff is out of the of order as I
12 took your deposition -- sometimes you will pass a kidney
13 stone and won't know it these days?

14 A Right.

15 Q But you still have pain with it, to be fair,
16 correct?

17 A Yes, sir, I think so.

18 Q Okay. Do you know -- but you don't know how often
19 you get a kidney stone? They come every other week, once a
20 month, you just don't know?

21 A No, sir. There's no -- no cycle on that.

22 Q When you went to the hospital for the pain, that
23 pain had been going on for about 3 to 4 days; is that
24 right?

25 A In March of '07?

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q Yes, ma'am.

2 A Yes, sir.

3 Q And I recall that Dr. -- you testified that Dr.
4 Cray told you that it was probably cancer then?

5 A Yes, sir.

6 Q Dr. Cray said that it needed to be removed?

7 A I think she did, sir. And they -- she said that
8 they would not -- I don't know if they had -- if she wanted
9 to remove that there --

10 Q Yeah, she --

11 A -- she said that I needed to see someone who had
12 more experience in that.

13 Q Right. She had worked with Dr. Smith and Dr.
14 Williams before in referrals and that's how you ended up
15 coming over here; is that right?

16 A Yes, sir, and she said she had also worked
17 personally with Dr. Smith.

18 Q And when you were over in Hartsville, no one ever
19 heard the term neoplasm or carcinoma; they used the word
20 cancer?

21 A Yes, sir.

22 Q And you were concerned about cancer as well?

23 A Sure. Everybody should be.

24 Q Appropriately so. I recognize that. And you
25 talked about coming over for an office visit. Your husband

Faye Atkinson - Cross-Examination by Mr. McDow

1 and daughter were with you, correct?

2 A Yes, sir.

3 Q Dr. Williams examined you with the nurse present,
4 correct?

5 A Yes, sir.

6 Q Okay. He said you have a large mass and it needs
7 to come out and you agreed, correct?

8 A Yes, sir.

9 Q You were in a lot of pain and discomfort at that
10 time?

11 A No, sir, the pain was more controlled with the
12 medication that Dr. Cray had prescribed for me.

13 Q So you were on pain meds at that time?

14 A Yes, sir.

15 Q What kind of pain meds had Dr. Cray prescribed for
16 you?

17 A She prescribed one medication that was called
18 Ditropan. It kept the spasms in my right back area from
19 being so bad. I was still very uncomfortable, but it was
20 better --

21 Q Okay.

22 A -- with pain.

23 Q All right. And you thought that the mass needed
24 to come out as soon as possible, correct?

25 A I agreed with Dr. Williams.

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q And you were ready for it to come out?

2 A I was ready for the pain to stop.

3 Q Yes, ma'am. Would you turn to page 45 of your
4 deposition. Are you there?

5 A Yes, sir.

6 Q Line 4, I ask you the question, But you were ready
7 for it to come out as well. What was your answer?

8 A Yes, sir.

9 MR. CORBIN: Could you please read lines 25 and
10 lines 1 and 2 on the next page?

11 MR. MCDOW: I believe up can do that on redirect.

12 THE COURT: You can do that on redirect
13 examination, Mr. Corbin.

14 BY MR. MCDOW:

15 Q Dr. Williams told you that the mass was large and
16 needed to come out, correct?

17 A Correct.

18 Q And he said it was possible cancer; do you recall
19 that?

20 A No, sir. There's also a chance that a mass is
21 cancer even with all the tests is what I was told.

22 Q Okay. One of your experts testified yesterday if
23 I understood -- it may have been the day before or
24 yesterday, that there was a 1.4 or 1.5 chance of it being
25 ovarian cancer. Would you have been willing to take that

Faye Atkinson - Cross-Examination by Mr. McDow

1 1.4 or 1.5 chance?

2 A That chance of what, sir.

3 Q Of it being cancer, but following it with serial
4 ultrasounds?

5 A You're going to have to go back and slow down and
6 talk me through this one again. I don't understand what
7 you're asking me.

8 Q Okay. You are complaining that Dr. Williams did
9 not give you the option of not operating on you, correct?

10 A That's correct.

11 Q Okay. You are complaining that he did not tell
12 you about the possibility of following the mass with
13 ultrasounds to see whether or not it would grow, correct?

14 A Correct.

15 Q If he had told you that we can watch it, but right
16 now there is a 1.4 to 1.5 percent chance of it degree
17 cancer, would you have been willing to wait another 3
18 months for the surgery.

19 A Yes, sir, I would have.

20 Q Okay. And Dr. Williams said to take out the tubes
21 and ovaries and you agreed to that?

22 A Yes, sir, I did.

23 Q He had not discussed any risk if you of an
24 esthetic complications; is that correct?

25 A Nothing specific.

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q Well, did he say anything in general?

2 A The normal risk of surgery and he said that was a
3 possibility of blood loss and that I might need some blood;
4 would that be all right with me taking someone else's blood
5 and I said yes.

6 Q Okay. Yeah, and your idea of normal risk are that
7 your blood pressure could go up and down or that you could
8 have some bleeding and a transfusion, right?

9 A Correct.

10 Q He did not discuss with you any potential
11 anesthesia complications?

12 A I don't recall that if he did.

13 Q Okay. Do you recall if he discussed any risk of
14 infection?

15 A He may have, Mr. McDow, but I don't recall that
16 specifically.

17 Q Do you recall whether or not he discussed
18 potential risk of bowel injury?

19 A No, sir, he did not. He didn't say that.

20 Q Did he discuss -- do you recall if he discussed
21 the risk of injury to the bladder?

22 A No, sir, he did not.

23 Q Or any other organs?

24 A No, sir.

25 Q And did he discuss the risk to you for potential

Faye Atkinson - Cross-Examination by Mr. McDow

1 of death from this surgery?

2 A I don't know that he did, but I am aware that
3 there's risk of death any time you do surgery.

4 Q Okay. And you agree that you needed the surgery
5 at that time?

6 A Yes, sir.

7 Q And you thought that the mass was going to
8 continue to grow?

9 A They usually do, so I assumed I did.

10 Q All right. So you came over to the hospital on
11 April the 25th, but you did not see Dr. Williams before
12 surgery that morning?

13 A No, sir, I did not.

14 Q Your first recall of seeing Dr. Williams was 3
15 days later; is that right?

16 A No, sir.

17 Q When did you see him?

18 A If I recall was after the surgery 3 or four days
19 after the surgery, but I can't say specifically that it was
20 3 days.

21 Q Okay. 3 or four days after the surgery is your
22 first memory of seeing Dr. Williams after the first
23 surgery?

24 A Yes, sir.

25 Q Okay.

Faye Atkinson - Cross-Examination by Mr. McDow

1 A I was in pain.

2 Q All right. When did you learn that the mass was
3 not cancer?

4 A I asked him.

5 Q So that was on that fourth day, do you think? Or
6 do you know when it was?

7 A No, sir, it was not at that time, it was the next
8 week. I asked him was it cancer and his response was -- we
9 sliced it, diced it and chopped it and it was not cancer.
10 And I said, are you sure. And he said, yes, I am. And I
11 said thank God.

12 Q Do you know whether or not Dr. Williams told your
13 family immediately after the surgery -- did he come out to
14 the waiting room or somewhere and tell them how the surgery
15 had gone and that it was not cancer at this time?

16 A I know that he came by to talk with my family after
17 the first surgery, but I do not know what he told them.

18 Q On the fourth day, do you recall being able to get
19 up and take a shower?

20 A No, sir.

21 Q If the records show that, would you dispute that?

22 A No, sir.

23 Q Now, you have not kept any notes as a result of
24 this lawsuit -- I think you testified in your deposition,
25 you told me you kept some mental notes; is that right?

Faye Atkinson - Cross-Examination by Mr. McDow

1 A Yes.

2 Q Okay. And I just ask you to kind of describe your
3 post-operative care and you described that as being
4 terrible and that you did not have a bowel movement, but
5 they gave you things to help you have a bowel movement;
6 correct?

7 A That was when, sir?

8 Q At some point in time during your hospitalization?

9 A Between the first and second surgeries?

10 Q Yes, ma'am.

11 A Yes, sir, they did.

12 Q Okay. But you ended up having some bowel
13 movements, correct?

14 A Yes, sir, I did.

15 Q During the times that you would vomit, where --
16 was there a bowl? Was there a bag? Where would it go?

17 A Mr. McDow, before I came to have this surgery, I
18 had my family to agree with me that as long as I was in
19 this hospital away from my home that someone would stay
20 with me. And generally when I had to vomit, someone was
21 there and I would sit up and I would make a motion or they
22 would -- it would indicate to them that I had to vomit and
23 they would grab a pan.

24 Q Okay.

25 A All right. We had the little hospital pans and we

Faye Atkinson - Cross-Examination by Mr. McDow

1 had the little curvature pan that did no good because it
2 wasn't large enough. And sometimes, I didn't get into that
3 pan. It would go onto the bed.

4 Q There were different times where you would vomit
5 more as opposed to less?

6 A Yes, sir.

7 Q Okay. All right. Do you recall any discussions
8 with Dr. Williams in between the first surgery and the
9 second surgery about you being well enough to go home?

10 A I do not recall that. I remember I wanted to go
11 home.

12 Q At one point in time between the two surgeries,
13 they started what has been referred to as TPN; do you
14 recall that?

15 A Yes, sir, I do.

16 Q Okay. And I think TPN was what they call Total
17 Parental or Parental Nutrition --

18 A Correct.

19 Q You've heard that. How is that given to you?

20 A It was given to me through a PICC line that they
21 inserted into my arm that went into the chest cavity.

22 Q So where did -- it's called a PICC line. Where
23 did that PICC line go?

24 A It went into my right arm.

25 Q Okay. And that's where the food and stuff would

Faye Atkinson - Cross-Examination by Mr. McDow

1 go through, that TPN, that liquid stuff?

2 A Yes, sir, it went through that PICC line.

3 Q Have you ever had the PICC line since being
4 dismissed from the hospital?

5 A Not from -- no, sir.

6 Q But you had a bad reaction to the TPN the first
7 time, right?

8 A Yes, sir, I did.

9 Q All right. And I think they changed the formula
10 of some type and then continued to give it to you; is that
11 right?

12 A Yes, sir, they did.

13 Q Okay. And you were on the TPN between the --
14 sometime between the first and second surgery; correct?

15 A Yes, sir.

16 Q And then after the second surgery, you got TPN
17 again; is that right?

18 A Yes, sir.

19 Q Dr. Williams made rounds every morning that he was
20 working, as you recall; is that right?

21 A Yes, sir, I do.

22 Q Okay. And he kept saying let's just wait another
23 day; right?

24 A To what question?

25 Q Well, to what was going on. He'd say wait another

Faye Atkinson - Cross-Examination by Mr. McDow

1 day?

2 A I would ask him if I could have an ice cube. He'd
3 say no, sir -- no, let's give it another day.

4 Q And you asked if you could have something to drink
5 and he said no, let's give it another day?

6 A Not even an ice cube.

7 Q And you asked him, you know, was there something
8 wrong, can you help me, but you don't recall what he said?

9 A He didn't say anything right then. I asked several
10 days.

11 Q He never gave you an explanation as to why you
12 were still in the hospital or what was wrong?

13 A No, sir.

14 Q He never told you anything?

15 A They kept doing tests and I was hoping for a reason
16 behind the tests to determine what was going on so I could
17 get better.

18 Q He never explained to you that the bowels were not
19 waking up?

20 A I heard that, but I don't recall who said it.

21 Q And he never explained that it might be this
22 partial small bowel obstruction?

23 A No, sir, he didn't.

24 Q And he never explained to you the results of
25 drinking the barium?

Faye Atkinson - Cross-Examination by Mr. McDow

1 A What do you mean by the results?

2 Q Well, the radiology -- the test results. You said
3 they kept doing tests and you kept hoping for a reason, but
4 it was never explained to you the result of that test?

5 A No, sir, I don't recall that.

6 Q Dr. Williams never said why you were sick?

7 A What do you mean by sick, sir?

8 Q Well, you described that as being sick as having
9 nausea and vomiting. He never explained why that was?

10 A No, sir.

11 Q He never gave you an explanation why you were
12 still in the hospital after five days?

13 A After five days?

14 Q Yes, ma'am. You were expecting to go home after
15 five days and he never gave you an explanation as to why
16 you were still there?

17 A I was sick, Mr. McDow, I couldn't go home. And I
18 continued to get worse.

19 Q Do you recall Dr. Williams having a discussion
20 with you and your daughter on May 18th, 2007?

21 A I don't remember the specific day. He came in the
22 room numerous times while my daughter was there; and yes,
23 sir, he spoke with both of us.

24 Q Do you recall him discussing with you the
25 potential for going back to the operating room the next

Faye Atkinson - Cross-Examination by Mr. McDow

1 week?

2 A Not -- not the next week, no.

3 Q Did he discuss with you at this time about the
4 potential for going back to the operating room at some
5 point in time?

6 A At some point in time he did, but it was a few days
7 prior to the second surgery.

8 Q All right. The second surgery, as I recall you
9 testifying, was on Memorial Day Monday?

10 A Yes, sir, it was.

11 Q And I think that was May 28th, 2011, correct?

12 A I believe.

13 Q Okay. And do you believe that Dr. Parker wasn't
14 consulted until after the second surgery, right?

15 A I do not remember seeing Dr. Parker until the day
16 before his first surgery. If he came in, I do not
17 remember.

18 Q Okay. All right. Could you turn to page 60 of
19 your deposition?

20 A Yes, sir.

21 Q And the question on the previous page, line 25 and
22 into page 60, I asked you, All right. Okay. All right.
23 Is there anything in particular you recall that you want to
24 tell me about Dr. Williams or anything that he said or
25 didn't say between the operation of April the 25th and by

Faye Atkinson - Cross-Examination by Mr. McDow

1 the time Dr. Parker was consulted on May 21st to 2007. And
2 what was your answer?

3 A Dr. Parker wasn't consulted at on May 21st, because
4 I had the second surgery on Memorial Day, 2007, in May and
5 Dr. Parker didn't come in until -- that was on a Monday and
6 Dr. Parker didn't come in until on Saturday.

7 Q Okay. And then on page 62, line 25, I asked you
8 the question again, And you believe that Dr. Parker was not
9 consulted until after that second surgery. And what was
10 your answer? Page 60, line 2.

11 A All right. What line do you want me to read, Mr.
12 McDow.

13 Q Line 2.

14 A I think it was the following day. He saw me on
15 Saturday afternoon and I think the first surgery was on
16 Sunday.

17 Q We're on a different page.

18 A All right.

19 Q Page 61?

20 A All right.

21 Q Line 25. And I ask you a question, And you
22 believe that Dr. Parker was not consulted until after that
23 second surgery, and then it goes over to page 62. And your
24 answer on line 2 was what?

25 A Yes, sir.

Faye Atkinson - Cross-Examination by Mr. McDow

1 Q Okay.

2 A And then -- consulted could have meant that I
3 didn't see him because I don't recall seeing him until the
4 day before the second surgery. Before his first surgery.

5 Q Right. And you believe that Dr. Parker was
6 consulted because you got worse after the second surgery,
7 correct?

8 A Yes, sir, my family asked for him.

9 Q And that was going to be my next thing is that
10 they had asked for a second opinion, correct?

11 A That's correct.

12 Q Okay.

13 (WHEREUPON Defendant's Exhibit 2 was marked for
14 identification.)

15 MR. MCDOW: Your Honor, may I approach the witness?

16 THE COURT: Yes, sir.

17 BY MR. MCDOW:

18 Q Ms. Atkinson, I will show you what's marked
19 Plaintiff's Exhibit 23. I believe that's the operative
20 note for the first surgery, April 25th, 2007. Can you see
21 and confirm that for me, please?

22 A Date of operation, operative report day of surgery,
23 yes, sir.

24 Q Okay. And then I want to show you Plaintiff's
25 Exhibit 25, and that should be the operative note for May

Faye Atkinson - Cross-Examination by Mr. McDow

1 28th?

2 A I believe it was, yes, sir.

3 Q And I'll show you Plaintiff's Exhibit 27 and
4 that's Dr. Parker's operative note for June 3rd. Can you
5 confirm that for me?

6 A Yes, sir.

7 Q Okay. Now, I'm going to show you what's been
8 marked as Defendant's Exhibit 2, and actually I'll even
9 highlight it for you, and can you confirm for me that that
10 is Dr. Parker's consult and second opinion from May 21st
11 2007?

12 A Consultation does not mean that he spoke with me,
13 sir.

14 Q Okay. You don't recall him coming in and
15 examining you at this time?

16 A No, sir. The only time I remember seeing Dr. --
17 the first time I remember seeing Dr. Parker was the day
18 before Dr. Parker performed his first surgery. He may have
19 come in. I was asleep, but I do not remember seeing him
20 until that Saturday afternoon before his first surgery.

21 Q Do you recall having a long conversation with Dr.
22 Parker and your husband being there about what your options
23 were on May the 21st?

24 A No, sir, not on May 21st.

25 Q Do you not recall him discussing with you what he

Faye Atkinson - Cross-Examination by Mr. McDow

1 describes as maximum medical management?

2 A No, sir.

3 Q Do you recall Dr. Smith offering you an NG tube
4 and you declined?

5 A No, sir, I do not.

6 Q Were there any times that Dr. Williams offered you
7 an NG tube and you declined?

8 A No, sir. If he had offered me an NG tube, I would
9 have taken it. I asked for an NG tube.

10 Q You had an NG tube back in 1995?

11 A Yes, I did.

12 Q Did you like it back then?

13 A You don't like it, but it helps.

14 Q So --

15 A So you take it and it helps.

16 Q Is it uncomfortable?

17 A It's not uncomfortable except for the initial
18 insertion.

19 Q Okay. Are you able to get up and walk around when
20 that's in?

21 A I didn't because I was not comfortable and -- but
22 they disconnected it if they needed to walk you in the
23 hallways, they can take it off.

24 Q Do you recall having a conversation with Dr.
25 Parker before his first surgery that he did on June the

Faye Atkinson - Cross-Examination by Mr. McDow

1 3rd, where he explained the potential for short bowel
2 syndrome or short bowel?

3 A No, sir, the initial consult -- when I talked to
4 Dr. Parker on that day before his first surgery -- could I
5 describe that conversation?

6 Q Absolutely.

7 A I woke up and Dr. Parker was sitting in my room
8 with clipboards in his hand. And he said, Hello, I'm Dr.
9 Parker, Ms. Atkinson, how are you feeling. And I told him
10 I was in pain and I was hurting and I said I was sick.

11 Dr. Parker said, I want to help you. He said, but
12 I need to take you to surgery. I looked around that room
13 and I didn't see my family at that time. They had stepped
14 out. And I told Dr. Parker, I said, you can't do anything
15 without my family. And he said, I'll find them. He said I
16 will take good care of you.

17 Q Was that on the 2nd or was that on the 3rd before
18 going back to surgery? If you recall.

19 A I recall it was on a Saturday afternoon before he
20 did that first surgery. And I am told he did the first
21 surgery on June the 3rd, which was a Sunday.

22 Q That's right. And you had gotten worse after Dr.
23 Williams' second surgery up until June the 2nd, there was a
24 change?

25 A That's correct..

Faye Atkinson - Redirect Examination by Mr. Corbin

1 Q Right. Which actually after the second surgery,
2 within the first few days you felt pretty good. Or did
3 you?

4 A The first day or two, I probably did, but I got
5 progressively worse during that week.

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

7 THE COURT: All right.

8 BY MR. MCDOW:

9 Q Ms. Atkinson, no one has -- in this case has said
10 that you're faking anything, have they?

11 A No, sir.

12 Q Please tell your husband I said hello.

13 A Thank you.

14 Q Thank you.

15 THE COURT: Mr. Corbin, redirect?

16 REDIRECT EXAMINATION

17 BY MR. CORBIN:

18 Q Faye, when you went to the hospital in 1995, at
19 Carolina Pines, little tiny hospital, with a bowel
20 obstruction, did they wait 32 or 33 days --

21 MR. MCDOW: Objection improper redirect.

22 THE COURT: Mr. Corbin?

23 MR. CORBIN: I think it is -- I think it is
24 relevant.

25 MR. MCDOW: Objection.

Faye Atkinson - Redirect Examination by Mr. Corbin

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

2 **MR. MCDOW:** She testified she was in there 18 days.
3 I think it's improper redirect.

4 **THE COURT:** All right. Objection is sustained.

5 **BY MR. CORBIN:**

6 **Q** How quickly did they do the second operation at
7 Carolina Pines? Was it 32 days?

8 **A** No, sir, it was not.

9 **Q** Okay. They did a CT at Carolina Pines --

10 **MR. MCDOW:** Again, I'm going to object. It's
11 improper redirect.

12 **THE COURT:** And did you not go through the Carolina
13 Pines to some extent?

14 **MR. MCDOW:** To some extent. But she's already
15 testified to that.

16 **MR. CORBIN:** That's all I have, Faye?

17 **THE COURT:** Anything else?

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

19 **THE COURT:** Okay. Anything else, Mr. McDow.

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

21 **THE COURT:** You can step down. Thank you, ma'am.
22 Okay. Mr. Corbin?

23 **MR. CORBIN:** We'd call Ms. Angie Kennedy to the
24 witness stand, please.

25 **THE COURT:** Okay.

Angela Kennedy - Direct Examination by Mr. Corbin

1 ANGIE KENNEDY,

2 having been duly sworn, testified as follows:

3 THE CLERK: Have a seat in the witness box and
4 state your full name for the record, please.

5 THE WITNESS: Angela Atkinson Kennedy.

6 **DIRECT EXAMINATION**

7 **BY MR. CORBIN:**

8 Q Angie, we're going to be quick. You're Faye's
9 daughter?

10 A Yes, sir.

11 Q Between '95 and the first moment she stepped foot
12 in Dr. Williams office, did she have chronic nausea and
13 vomiting, diarrhea, all these complications she's had after
14 Dr. Williams' couple of surgeries.

15 A No, sir.

16 Q Your mother is a private person?

17 A Very private.

18 Q Tell this jury when you've seen her scars?

19 A I have never seen my mother's scars.

20 Q Is she a complainer?

21 A She is not.

22 Q Whiner?

23 A She is not.

24 Q Private?

25 A Very private.

Bucky Atkinson - Portions of Deposition

1 MR. CORBIN: Okay.

2 THE WITNESS: I --

3 MR. CORBIN: Did you --

4 THE WITNESS: I mean we could have liked to, but I
5 didn't.

6 MR. CORBIN: Please reread that one.

7 THE WITNESS: I mean -- I would have liked to, but
8 I didn't.

9 MR. CORBIN: Page 41, continue.

10 THE WITNESS: But I never verbally had anything to
11 say to him, not -- not out of line.

12 MR. CORBIN: That would be it, Your Honor.

13 THE COURT: Okay. All right. You can step down.
14 Thank you, ma'am.

15 All right. Mr. Corbin?

16 MR. CORBIN: Yes, sir?

17 THE COURT: Any other witnesses?

18 MR. CORBIN: Your Honor, at this time, the
19 plaintiffs would rest their case.

20 THE COURT: Okay. All right. Everybody on the
21 jury okay? Anybody need to take a break?

22 THE JURORS: (The jurors shook their heads.)

23 THE COURT: All right. I'll note that all of the
24 necessary, appropriate motions have been made at this time
25 and we'll move forward to you, Mr. McDowell.

James Williams - Direct Examination by Mr. McDow

1 Anything you'd like to present today?

2 **MR. MCDOW:** Yes, Your Honor. We would begin by
3 calling Dr. Jimmy Williams to the stand, please.

4 **THE COURT:** Come on up, please.

5 JAMES WILLIAMS,

6 having been duly sworn, testified as follows:

7 **THE CLERK:** Have a seat in the witness box. State
8 your full name for the record, please.

9 **THE WITNESS:** James A. Williams, Jr.

10 **DIRECT EXAMINATION**

11 BY MR. MCDOW:

12 Q All right. Dr. Williams, I'm going to ask that
13 you make sure that you speak loud enough for me to be able
14 to hear you because if I hear you then hopefully this last
15 juror over here will be able to hear you as well.

16 Dr. Williams, take a few minutes and introduce
17 yourself to the jury, starting with where you grew up and
18 where you went to high school.

19 A I was born in Tuscaloosa, Alabama, but was raised
20 in the Greenville area and graduated from Travelers Rest
21 High School in 1978.

22 Q After high school, where did you go to college?

23 A I went to Furman University, graduating in 1982.

24 Q And did you have any graduate degrees after that?

25 A I have a masters degree from the University of

James Williams - Direct Examination by Mr. McDow

1 South Carolina in biology and physiology in 1994.

2 Q In 1994?

3 A I'm sorry, 1984.

4 Q Right. And then after you obtained a graduate
5 degree, did you go onto medical school?

6 A Yes, I went to medical school at the University of
7 South Carolina School of Medicine, graduating in 1988.

8 Q After you received your medical degree, did you do
9 any type of additional training after that?

10 A Yes, sir, I did a residency, an internship of
11 residency in obstetrics and gynecology at Palmetto Richland
12 Hospital, it was Richland Memorial Hospital at the time.

13 Q How many years did that take?

14 A Just four years.

15 Q Did you obtain any initial specialized training
16 after completing your OB GYN residency?

17 A Yes, I did a fellowship in gynecologic oncology at
18 Mt. Sinai Medical Center in New York.

19 Q What year did you finish your specialized
20 training?

21 A In 1994.

22 Q All right. Doctor, are you board certified?

23 A I'm board certified in obstetrics and gynecology
24 and also in gynecological oncology.

25 Q By what boards?

James Williams - Direct Examination by Mr. McDow

1 A I'm a diplomat of the American Board of Obstetrics
2 and Gynecology.

3 Q Are you a member of any other oncology groups?

4 A I'm a member of the American College of Obstetrics
5 and Gynecology, International Gynecological Cancer Society,
6 The Society of Gynecologic Oncologies, Oncology American
7 Society, Clinical Oncology, The Mid Atlantic Obstetrics
8 Gynecology Society, South Carolina Obstetrics and
9 Gynecology Society, The Gynecologic Oncology Group where
10 I'm principal investigator. I think that's it.

11 Q All right. Doctor, when you finished your
12 training at Mt. Sinai, did you then go into practice
13 somewhere?

14 A I joined the University of South Carolina School of
15 Medicine, Department of Obstetrics and Gynecology in 1994
16 as an associate assistant professor in the division of
17 gynecologic oncology.

18 Q How long were you with the USC School of Medicine?

19 A I was with USC School of Medicine until around 2000
20 and then I joined the South Carolina Oncology Associates.

21 Q And so have you been with South Carolina Oncology
22 Associates since around 2000; is that right?

23 A Yes, we established a division of gynecologic
24 oncology in the South Carolina Oncology Associates.

25 Q You work with Dr. Terry Smith?

James Williams - Direct Examination by Mr. McDow

1 A Yes, I do. I have the whole time since 1994.

2 Q I was going to say, did you work with him at the
3 you USC School of Medicine?

4 A Yes.

5 Q All right. Doctor, let me back up for a second.
6 During -- sometime during your education and training and
7 so forth, did you get married in there somewhere?

8 A Yes, I've been married for 19 years, approaching 20
9 years.

10 Q And is your wife in the courtroom today?

11 A Yes, she is.

12 Q Okay. And can you point her out to us please?

13 A She's the lovely lady sitting back there.

14 Q All right. Very good. What's your wife's name?

15 A Beth.

16 Q And y'all have any children?

17 A Two children, 17 and 15.

18 Q And where do they go to school?

19 A A.C. Flora High School.

20 Q And do you attend a church anywhere?

21 A Yes, First Baptist Church of Columbia, South
22 Carolina.

23 Q Doctor, there was some questions yesterday of Dr.
24 Irvin being given awards for best physician and whatnot.
25 Have you been awarded anything in that regard that you'd

James Williams - Direct Examination by Mr. McDow

1 I like to share with the jury?

2 A Yes, I was -- for the past two years, I've been in
3 the U.S. News award for the Top Doctor for Columbia, South
4 Carolina. Only seven years in the past two years named
5 there. I'm very proud to say that. I'm also on the board
6 of the South Carolina Cancer Foundation Board, the advisory
7 board locally.

8 Q Have you done any public service announcements?

9 A Spoke at a recent butterfly event that they had at
10 the State House about two weeks ago. I gave a discussion
11 with local newscaster from WIS TV on the same day about
12 ovarian cancer, ovarian cancer screening and risks. I'm
13 active in the community in cancer services.

14 Q You mentioned about doing some investigational
15 work. Briefly tell the jury what the institutional review
16 board is and do you have any cancer protocols get approved
17 out there?

18 A I'm a principal investigator for the gynecologic
19 oncology group. It's a -- under the national cancer
20 institute. It's a national multi-center group that
21 sponsors clinical trials in ovarian cancer medicine
22 basically. Also, I'm the local principal investigator for
23 GYN cancer for the Cannon Survey Research Institute. We're
24 affiliated with them to do national and other kind of
25 clinical trials. And I manage those trials. We have a

James Williams - Direct Examination by Mr. McDow

1 research division, but I'm the medical advisor and the
2 principal investigator locally.

3 Q All right. Doctor, tell the jury what exactly do
4 you do? What is a gynecology oncologist?

5 A Gynecological oncologist is a specialist in women's
6 health. We've trained in OB GYN, but we branched off into
7 the specialty of surgical management of GYN cancers. I
8 coordinate radiations there: I give radiation care if
9 recommended and advised. I give chemotherapy and really
10 begin comprehensive cancer therapy training and extensive
11 experience in adhesive pelvic and abdominal surgery. I do
12 extensive pelvic operations and help recondition
13 instruction in cancer operations as well as other noncancer
14 procedures as well.

15 Q So does your practice include surgical treatment
16 of pelvic masses?

17 A Yes, it does.

18 Q Can you estimate for us how many pelvic masses you
19 do on an annual basis?

20 A We have a broad group of patients that we see. We
21 see about 1000 new patients per year for various a sundry
22 conditions. I do about upwards of about 300 operations per
23 year and what percentage of those are pelvic masses, we've
24 diagnosed close to 100 of precancerous this year and in
25 this region, we do a lot of benign pelvic masses, so it's a

James Williams - Direct Examination by Mr. McDow

1 fair number of those would-be pelvic masses.

2 Q Would that basically be true for 2007 as well?

3 A Yes.

4 Q Doctor, in April of 2007, were you qualified
5 through education, training and experience to perform
6 pelvic mass surgery on patients that included extensive
7 adhesions and involvement of bowel?

8 A Yes.

9 Q How did the plaintiff in this action, Ms. Atkinson
10 come to be a patient of yours?

11 A She was referred up from Hartsville. She'd been
12 seen in the hospital by another primary care physician and
13 a local gynecologist and they called our office and they'd
14 had a patient who they want us to see, Ms. Atkinson, and we
15 set up an appointment.

16 Q Okay. She was in Hartsville, Florence would be a
17 little bit closer to her. Then why was it she would have
18 been referred to you as opposed to sending her to
19 potentially someone in Florence?

20 A There are no GYN oncologists in Florence. The only
21 GYN oncologists in the State of South Carolina are in
22 Greenville, Columbia, and Charleston.

23 Q So I guess let's go with South Carolina Oncology
24 Associates would be the place of referral for Ms. Atkinson?

25 A Yes.

James Williams - Direct Examination by Mr. McDow

1 Q Do you have a memory of the date and events of
2 your care and treatment of Ms. Atkinson in 2007?

3 A Yes.

4 Q Okay. We've, I think, introduced most if not all
5 of the records if you need to refer to those at any time,
6 please let me know and I'll hand those to you as we go
7 along.

8 You recall what date Ms. Atkinson first came to you
9 for medical advice?

10 A April 13, 2007.

11 Q On April 13, 2007, did you take a history from
12 Ms. Atkinson?

13 A Yes.

14 Q And can you summarize that for us without looking
15 at the records?

16 A Yes, Ms. Atkinson came and described that she'd
17 been admitted to a hospital locally and after she presented
18 with excruciating pain. She'd been evaluated with a CAT
19 scan, and an ultrasound and they found a large mass, 13 by
20 9 centimeters, specifically. There was a description of
21 the x-ray. There was some suggestion that she may have
22 some backing up urine in her kidneys called hydronephrosis.
23 Really it's a sign of pressure against that tube that says
24 that the cyst is putting pressure on the kidney tube and
25 she was sent up for that indication.

James Williams - Direct Examination by Mr. McDow

1 Q All right. Doctor, I'm going get this marked --

2 MR. MCDOW: Let me get this marked for the next
3 exhibit.

4 (WHEREUPON Defendant's Exhibit No. 3 was marked for
5 identification.)

6 BY MR. MCDOW:

7 Q This is your office note of April 13th, 2007.
8 It's been marked as Defendant's Exhibit 3. I point this
9 out of the health records, pages 1265 and 1264 just for
10 your reference if you need to look at it.

11 A Thank you.

12 Q Doctor, did you do a physical exam at that time?

13 A Yes, I did.

14 Q And tell the jury, again, what your physical exam
15 revealed?

16 A The physical exam confirmed that you could palpate
17 this mass. You could feel this mass. My guess was it was
18 around 14 centimeters in size in examination to the right
19 compared to the left I guess when it -- it sort of
20 confirmed all of these x-ray findings.

21 Q Did you have radiographic studies or other records
22 to review at this time?

23 A I had a CT and ultrasound report available to
24 review, yes.

25 Q And based upon the other records that you

James Williams - Direct Examination by Mr. McDow

1 reviewed, did you note anything about acceptations in the
2 mass and if you did, what's that mean?

3 A Well, the mass was described in size and character
4 and there was some acceptance noted, which is a separation
5 within -- of the cyst. Dr. Irvin described it as a line
6 that kind of goes through the ultrasound and CT. It
7 designates some complexities, something sort of like a
8 water balloon would be. It described some calcification in
9 the walls, which means that it's something that's been
10 growing and calcium is a response to the growth. So that
11 was described on the CAT scan and ultrasound reports.

12 Q Okay. Explain to the jury what you mean
13 calcifications?

14 A They both, through growth -- grows through the
15 process of change and part of that change involves cells
16 that aren't as active and they calcify and they can be seen
17 on an x-ray. In older cancer we often see a thing called
18 Sonoma bodies, which are calcific little modules that grow
19 over the cancer and so we get a little concerned when we
20 see calcium described in an ovarian pelvic mass.

21 Q Doctor, based on the history you were given, your
22 examination of the other materials you reviewed, what was
23 your diagnosis of Ms. Atkinson's condition on that date?

24 A Ms. Atkinson had a pelvic mass as evidenced by the
25 CAT scan and ultrasound that was producing pain. She also,

James Williams - Direct Examination by Mr. McDow

1 we discussed, had prior history of surgery that we began to
2 discuss proceeding to -- resulting from it.

3 Q Were you aware of the CA-125 result?

4 A I did not have that result. The comments from the
5 hospital that she was referred from said it was pending.
6 Ms. Atkinson shared with me that it was, quote, normal. We
7 did not have a number on that day.

8 Q All right. Doctor, based on your examination that
9 day and your diagnosis, did you discuss treatment options
10 with Ms. Atkinson?

11 A Yes.

12 Q What did you discuss with her?

13 A During the course of the history, as well, we
14 discussed her prior history. Ms. Atkinson's prior history
15 had been several operations. She had a hysterectomy,
16 there'd been an ovarian cyst removed, and then the bowel
17 surgery that we discussed; and that was shared by fact of
18 sort of a separate designation in the note that says her
19 most significant past history is two previous bowel
20 operations, one of them for gangrene of the bowel.

21 Nonsurgical options were merely -- the lady was
22 already on narcotic pain medication from her brief
23 hospitalization and there really weren't many nonsurgical
24 options. Those were discussed and so we talked about doing
25 an operation to remove -- the mass in the ovary itself

James Williams - Direct Examination by Mr. McDow

1 wasn't separate from the ovary -- so we were going to do an
2 operation, remove the ovarian masses, remove the ovaries
3 and ensure us that they weren't cancer.

4 Q Doctor, did you discuss with Ms. Atkinson any
5 potential for following the mass with ultrasounds?

6 A That was not considered because, again, I have a
7 patient who's on narcotic pain relievers, you can't really
8 leave somebody on narcotic pain relievers for a mass that's
9 13 centimeters when removing it would relieve the pain and
10 it's growing. It didn't come up overnight. It had been
11 developing over some time and when she developed pain, it
12 had gotten to the point and size that pain was going to be
13 a problem and that was just going to get worse.

14 Additionally, the ureter issue, the hydronephrosis,
15 that's a sign that as it gets larger, the kidneys are going
16 to back up more and if the kidney backs up more, that can
17 then cause kidney damage. Not kidney stones, but the
18 kidney doesn't like to have that pressure and it stops
19 working as well. So there's risk for damage to the kidney
20 as well.

21 Q Does the medication Ditropan provide any relief
22 for hydronephrosis?

23 A Not at all. Ditropan is a bladder relaxer. It
24 helps -- it's for patients, women who have an overactive
25 bladder. I'm not -- the sense and mood of the reports was

James Williams - Direct Examination by Mr. McDow

1 that she was having some bladder issues from the pressure
2 from this mass on her bladder. So I didn't give that to
3 her. It seemed to provide her some relief, but I didn't
4 give that to her. It wasn't going to help her for the long
5 term.

6 Q Doctor, did you discuss the material risks and
7 benefits associated in general with surgery?

8 A Yes. After the history and physical exam,
9 Ms. Atkinson dressed, we called her family in and we have a
10 room that has -- it's like a living room, it has a sofa and
11 some chairs and we sat down and talked. We reviewed all
12 that I had discussed before. The mass is present. She'd
13 been informed of the mass and the possibility that it could
14 be cancer. I actually noted in my note that I told her I
15 don't think it likely is. I found it interesting that Dr.
16 Irvin sort of worked from the normal group of women to find
17 that one to one-and-a-half percent might be ovarian cancer.
18 But we don't usually do it that way. We usually work
19 backward with women who have the highest risk and those are
20 the ones that have the mass. So in our literature,
21 honestly a post menopausal woman, one who has passed
22 menopause, who has ovarian mass, the risk of it being
23 malignant is up regards of 20 percent.

24 And so I've got to deal with the usual, but our
25 literature really says women who are menopausal have about

James Williams - Direct Examination by Mr. McDow

1 20 percent risk that the ovarian mass could be malignant.

2 Q Did you document that discussion in your office
3 notes?

4 A Yes, sir.

5 Q Did your assessment and evaluation of Ms. Atkinson
6 comply with general accepted standards of care with
7 gynecologic oncologist surgeons?

8 A Yes.

9 Q Doctor, your opinion to a reasonable degree of
10 medical certainty and did your discussion of and disclosure
11 of risk and the material risks and benefits on April 13th,
12 2007, comply with generally accepted standards of care?

13 A Yes, I explored all of the risks that are intended
14 in an operation like this: Going to sleep is a major
15 operation. We discussed risk of infection. Infection is
16 really the most common complication of any hospitalization.
17 We talked about infection. Because we're going into the
18 abdominal cavity, we talked about internal complications to
19 the bowel, to the bladder. The ovaries are typically close
20 to the ureters or kidney tubes and that was the cause of
21 the hydronephrosis and you talk about that.

22 And there was a separate discussion about the
23 bowels. It was reviewed that Ms. Atkinson had had two
24 previous bowel operations, one for what I have in quotes in
25 my records as gangrene in the bowel. That information came

James Williams - Direct Examination by Mr. McDow

1 from her and I said that's our biggest issue. And I even
2 noted as I discussed the plan of management and the plan of
3 procedure that we would have to -- and I said in my report,
4 run the bowel. What that really meant was we have to
5 assess what's going on in the bowel as we go because you've
6 been -- somebody's been there before.

7 And so all of that was reviewed and documented in
8 the history and physical examination and then that pretty
9 much ended our visit and we proceeded to schedule the
10 procedure. I have a nurse who does that scheduling.

11 Q Doctor, I was also going to ask -- two things: As
12 a result of those discussions, did Ms. Atkinson make any
13 decision about how she wished to proceed?

14 A Yes. The decision was made -- she was with her
15 husband and her daughter and the decision was made that we
16 would proceed as outlined.

17 Q And as a result of the decision by Ms. Atkinson to
18 go forward with the surgery, the surgery was then
19 scheduled?

20 A Yes.

21 Q Okay. Doctor, I gave you the exhibit of your note
22 that I pulled out of the Palmetto Health records. Did you
23 send a copy of your dictated office visit to the hospital?

24 A Yes.

25 Q Why would that be done?

James Williams - Direct Examination by Mr. McDow

1 A When my nurse scheduled the surgery, what goes to
2 the hospital by fax is a copy of the office records,
3 particularly the history of physical examination, the
4 hospital policies require that the history and physical
5 examination be in the record. And then we have some orders
6 that we send over as far as preoperative orders,
7 preoperative labs that may be necessary to give before the
8 procedure. We give a little dose of heparin or blood
9 thinner to decrease blood clot risk; and all of that's
10 faxed over -- gathered up in anticipation of the surgery.

11 Q Doctor, on the exhibit that you have before you,
12 can you tell the jury what date your note -- your office
13 note was faxed over to the hospital?

14 A April 18, 2007, 8:21 a.m.

15 Q Now, we know that surgery was performed on April
16 25th, 2007, did you see Ms. Atkinson that morning in the
17 hospital prior to the surgery?

18 A Yes. I have been on -- we have -- in the old days
19 we had a list and there were certain doctors who saw the
20 patients before surgery and there were certain doctors who
21 may not. I was always on the list that did. In the more
22 recent years, and certainly 2007 by hospital policy and by
23 actually lots of governmental guidelines we're required to
24 see a patient before the surgery. I have to see the
25 patient. I have to update, if necessary, the history of

James Williams - Direct Examination by Mr. McDow

1 physical examination on that day; sign and date the history
2 of the physical; and I have -- at that time I had to sign
3 and date the consent form that had already been signed by
4 the patient.

5 **MR. MCDOW:** Beg the Court's indulgence.

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

7 (WHEREUPON there was a pause in the proceedings.)

8 **BY MR. MCDOW:**

9 **Q** Doctor, let me show you what's been marked as
10 Plaintiff's Exhibit No. 23. I believe that's the operative
11 note for your surgery of April 25th, 2007. Do you
12 recognize that document?

13 **A** Yes.

14 **THE COURT:** Is that a part of an exhibit? Does it
15 have a number on it?

16 **MR. MCDOW:** I think I said 23.

17 **THE COURT:** Defense 23?

18 **MR. MCDOW:** No, it's Plaintiff's Exhibit 23.

19 **THE COURT:** All right.

20 **BY MR. MCDOW:**

21 **Q** All right.. Doctor, before we get into talking
22 about your operative report of April 25th, I want to show
23 this diagram to the jury. I'm a two dimensional kind of
24 guy. Would you come down actually off of the witness
25 stand.

James Williams - Direct Examination by Mr. McDow

1 A (Witness complies).

2 THE COURT: Make sure you keep your voice up,
3 please.

4 BY MR. MCDOW:

5 Q Dr. Williams, I want you to stand right here so
6 you'll be facing the court reporter. Would this diagram in
7 your opinion help assist the jury to understand the facts
8 in this case?

9 A Yes. It's the stylize, it's not anatomic, but it
10 just looks less distinct, so it helps describe what's going
11 on.

12 Q All right. Doctor, what -- first, tell the jury
13 what was the nature of your operation on April 25th, 2007.
14 What were you trying to accomplish?

15 A The planned procedure was to do a removal of both
16 of the ovaries, particularly the larger ovary and to assess
17 it for -- if it was cancerous or remove it to alleviate her
18 stomach pain. That was our plan.

19 Q All right. Doctor, about how long did this
20 surgery take?

21 A It took upwards of four hours.

22 Q And why did it take four hours?

23 A Well, from the previous, multiple now, diagnosis
24 that she had, I encountered a great deal of adhesions just
25 upon making an incision -- making an incision of the skin

James Williams - Direct Examination by Mr. McDow

1 and you go -- it contains fat and then there's a hard
2 binding around the abdomen; and once you get through that,
3 the bowel, the intestines were essentially plaster right
4 there, just about the entire abdominal cavity.

5 Q Doctor, go back and if you could, first, explain
6 here on the diagram as to where the small bowel is and how
7 that works?

8 A So when you open the bowl, you kind of -- in a very
9 perfect situation, you see this and the bowel actually
10 there's often a layer of fat that kind of over lies the
11 bowel here, but the bowel kind of lies here completely
12 filling the abdominal cavity or the abdominal incision. If
13 you kind of break it down, it comes into these sections and
14 the bowel begins in the left upper quadrant kind of here on
15 the colon and I think the other doctor's explained it runs
16 through and then it connects into the large intestine here
17 in the right lower quadrant..

18 Q Doctor, if we look at your prior note here and
19 show this to the jury, we have -- we talked about the time
20 that it took. Were you aware of her prior -- prior history
21 of diagnosis?

22 A Yes.

23 Q And what were you expecting when you went in?

24 A I expected adhesions. Everyone's different as to
25 what kind of adhesions they make and she had a history of

James Williams - Direct Examination by Mr. McDow

1 adhesion related bowel obstruction twice and so I was
2 expecting adhesions. And while this was pretty
3 significant, it was not out of the ordinary than expected.

4 Q All right. Doctor, stay where you are for a
5 minute.

6 (WHEREUPON there was a pause in the proceedings.)

7 BY MR. MCDOW:

8 Q Dr. Williams, there's been a lot of discussion
9 about adhesions in the case to this point. I put up a
10 separate demonstrative evidence. Can you explain for the
11 jury the development of adhesions as it's pictured in these
12 four frames here.

13 A Well, as I said, this the normal and it says before
14 manipulation and so it's someone who's never had an
15 operation, never had a profound infection. Then you open
16 this -- this is the peritoneal lining, but let's consider
17 it the abdominal -- interior abdominal wall. You lift it
18 up and everything's kind of in there adhesion free and it's
19 doing its thing and it's very -- there's no adhesions to
20 speak of. And we have a sense that everyone develops
21 adhesions like this, but not everybody gets adhesions.
22 Some patients can have three or four operations and slight
23 adhesions; some people have one and have marked adhesions.
24 And so what we encounter -- what I encountered in this
25 operation is adhesions that were much like this. You look

James Williams - Direct Examination by Mr. McDow

1 inside -- you have difficulty distinguishing all of these
2 loops and I think somebody said it was like glue, like
3 spaghetti. That's an accurate description.

4 Q Now, Doctor, there are -- on the right side of
5 this exhibit are one, two, three, four depictions. The
6 first up here says, thin, filled adhesions hours to days
7 after surgery. Did this depict Ms. Atkinson when you went
8 in?

9 A No, not at all. Matter of fact, if you start here
10 and after one operation you may get to here and that may be
11 there the rest of their life. That may be how it is ten
12 years later. But in this case, we were actually here
13 (indicating).

14 Q Okay. Doctor, there was a 3-D photograph Mr.
15 Corbin showed the jury previously. You had an opportunity
16 to look at that, correct?

17 A Yes.

18 Q Did you agree with the depiction of that 3-D?

19 A Well, it was a --

20 Q As it relates to the location of the bowels and --
21 and the ovaries?

22 A Well, it sort of gives the impression that in a
23 standing woman that the small intestines are somehow
24 hovering above the pelvis. Well, ovaries are sort of
25 sitting there alone, et cetera. Well, the reality is, is

James Williams - Direct Examination by Mr. McDow

1 that women -- I mean it's well -- if women stand up and all
2 the bowels go all the way down to the bottom of the pelvis
3 and so on any given day, the bowels are in contact with the
4 uterus and the ovaries and they move. So the notion that
5 they're distinctly separate is just not true, they're there
6 interrelated.

7 Q All right. Doctor, why did you not go in and in
8 20 to 30 minutes remove the right ovary that was the right
9 mass?

10 A Well, the previous diagnosis had been -- as I began
11 the procedure, there was an incision and I'll say in the
12 lower abdomen. That's typical operation -- or the typical
13 incision that would be used for the hysterectomy. It's a
14 typical incision that might be used for the bowel surgery
15 that was described before. And so I went through this
16 previous incision and when faced with this, there really
17 isn't anywhere to begin and you have to have somewhere
18 really to begin. The bulk of the adhesive process was here
19 and the ovary cyst was here. And so in order to get there
20 you have to first find out where you are and then work your
21 way to it methodically and sometimes tediously until you
22 can remove it.

23 Q Doctor, if you had not encountered the adhesions
24 in this case, would this surgery normally take about 30
25 minutes?

James Williams - Direct Examination by Mr. McDow

1 A I can barely do a DNC in 30 minutes.

2 Q What's a DNC?

3 A A dilation and curettage, a common procedure women
4 have. They go to the hospital and they have a scraping of
5 the uterus. It's a very common outpatient -- that's hard
6 to do in 30 minutes. So the laparotomy in the best of
7 circumstances is certainly minimum of an hour. There was
8 no expectation that it was going to take 30 minutes.

9 Q Doctor, in your operative procedure note, you've
10 written down extensive adhesiolysis occupying greater than
11 two-thirds of the operative time, small bowel resection.
12 My first question to you is why did you perform extensive
13 adhesiolysis?

14 A As I said, we're in and you have to start. And the
15 description in the operative summary is that I began -- you
16 begin by just freeing up this bowel from the anterior
17 abdominal walls so that you can now begin. And then you
18 find that it kind of sits free, but like this. In order to
19 get to the pelvis, you have to begin working your way
20 through those adhesions to sort out where you are. It
21 really is a hallmark of surgical technique when you don't
22 know where you are and you find out where you are. And the
23 Ligament of Treitz or the proximal bowel, this is where
24 that begins. You either go to the end or the beginning to
25 find out where you start and then work your way through.

James Williams - Direct Examination by Mr. McDow

1 I would have preferred to just go in and remove
2 this mass. Certainly it would have been more
3 straightforward, but that was just not possible.

4 Q Doctor, were you over aggressive in your removal
5 of the adhesions?

6 A Technically you don't really remove adhesions, you
7 process through them to break the bowel apart which is --
8 the adhesions cause the bowel to stick in part so you
9 separate them like separating glue. But, no it was what
10 was necessary to get from the beginning really to the end.
11 And you have to be concerned about what you leave behind
12 and so you have to make sure that everything is in its
13 right place and everything's functional, everything is
14 continuity and so that kind of required to make it look
15 like its supposed to look.

16 Q Was it possible for you in this particular case to
17 remove the mass without going to the adhesions and running
18 the bowel as you indicated in your operative note?

19 A No, not at all. It was not possible.

20 Q Doctor. Did you free up any more adhesions than
21 were necessary to safely perform this surgery?

22 A No, not -- that was not possible.

23 Q Doctor, I believe also in your operative note,
24 there is mention -- let's see multiple enterotomies.
25 Enterotomy was encountered, a large mass adhesions adhered

James Williams - Direct Examination by Mr. McDow

1 to the interior abdominal wall. My question to you is what
2 do you mean by enterotomies?

3 A An enterotomy is just by definition a hole in the
4 bowel that I got -- created. And so the bowel is slammed
5 up against the abdominal wall and even with very meticulous
6 dissections, sometimes I use scissors, sometimes you use,
7 you know a scalpel blade to sometimes just whittle away to
8 get it free. These adhesions are dense and thick. You
9 can't help but then injure the bowel. And so in the course
10 of doing that, that was identified, noted and of course the
11 procedure would be dealt with later.

12 Q All right. Doctor, what do you mean here when we
13 talk about the adhesions were lysed between the Ligament of
14 Treitz and the terminal ilium except where an enterotomy
15 had been encountered and this was resected first by
16 defining the proximal distal margin, transecting with a GIA
17 green and osmosing, taking down the mesentery and removing
18 the bowel. What is that?

19 A So it really is a flow comparative and so I
20 encountered the abdominal wall and the mass of bowel that
21 was stuck there and the -- that was the area that was most
22 difficult -- that was the area where the bowel had been
23 injured. And so the other adhesions were kind of freed up
24 and this was left sort of as an irreparable collection.
25 You just couldn't get that back to where it needed to be.

James Williams - Direct Examination by Mr. McDow

1 And so it's kind of like plumbing. You find the part
2 that's coming in and you find the part that's coming out
3 and it looks good. You divide it with a stapling device
4 that is a surgical stapling device, removing that part and
5 putting it back together with a stapling device and get it
6 all back into continuity.

7 Q Doctor, can you see the mass in the ovary before
8 you did that?

9 A Um --

10 Q Or was that part of that --

11 A This is part of the -- yeah, this is part of the
12 dissection and sort of a separate discussion that ensued to
13 get to the mass.

14 Q Well, that's where we're going to go next. Please
15 explain to the jury what you mean by dissection of the
16 pelvis unroofed a large cyst coming from the right adnexa?

17 A So as you proceed through taking the bowel and then
18 you get to where the cyst is and you go where it is and I
19 was like finally when I got there. But you -- it's kind of
20 under a roof and you know roof the bowel and you take it
21 off of there and it --

22 Q And Doctor, again, explain to the jury why you
23 removed that portion of the bowel.

24 A Well, that was the portion that was the most
25 affected by the adhesions that was just -- really was not

James Williams - Direct Examination by Mr. McDow

1 going to be healthy enough to leave in the bowel.

2 Q Doctor, I think there's mention -- I'm not sure if
3 it's on this page or the next page -- of the use of
4 Seprafilm -- yeah, seprafilm --

5 MR. MCDOW: Seprafilm, Madame Court Reporter.

6 BY MR. MCDOW:

7 Q -- what was that?

8 A There are some -- adhesions are common in surgery
9 and there are tools used to help increase the probability
10 of adhesions you create from being worse and so there's one
11 brand called Seprafilm and it is a thin -- kind of like an
12 old picture, like an old negative. It's kind of like that.
13 And it actually is a rapidly absorbable hydraulic acid, but
14 it's in a portable -- you lay it over the bowel to
15 hopefully decrease -- you can't stop all the adhesions
16 inter looped, so the bowel is likely to get back together
17 and be stuck. But to get rid of some of the adhesions on
18 the walls, that's used commonly. It's a brand named
19 product.

20 Q All right. Again, Doctor Williams, the bowel was
21 run from the Ligament of Treitz to the terminal ileum and
22 it was complete and normal. Small bowel resection and
23 anastomosis site was clean. The upper abdomen was clean,
24 et cetera.

25 Let me take this back now and ask with this

James Williams - Direct Examination by Mr. McDow

1 particular exhibit, can you explain to the jury again why
2 you're starting at the Ligament of Treitz and where the
3 terminal ilium is and what you're doing to try and
4 accomplish the running the bowel.

5 A So the sense in the week was that is so despairing
6 an area that one to the other side of the roof to the other
7 room -- well, that's not unreasonable to say that in
8 Ms. Atkinson's case where entire intestinal content was
9 kind of confined to a space that big. And so I'd taken
10 down the adhesions and another -- really a hallmark of
11 surgical technique is that you then look at the length of
12 the bowel to make sure that it is safe, it's intact, it's
13 appropriate before you close. And so you look at these
14 little pieces and you make sure everything is okay and you
15 specifically reassess the area where the bowel has been
16 removed and the operation occurred -- looked at her colon,
17 looked at the length of everything in place. The best you
18 can do is make sure -- you look at the liver edge. It was
19 fine.

20 There was no obvious tumor or other finding and so
21 you've done a thorough inspection and you can close the
22 patient's abdomen.

23 Q Were you able to remove the mass?

24 A Yes.

25 Q Doctor, did you do what they call a frozen section

James Williams - Direct Examination by Mr. McDow

1 while you were in surgery at that time?

2 A Yes, the right ovary was removed. It was sent down
3 for frozen section evaluation. That means that a
4 pathologist gets it. He then opens it and sends down
5 things that he thinks are appropriate to test in 15 minutes
6 and test the most abnormal areas. They call back in about
7 20 minutes and they'll say, this is benign. They'll say
8 this is cancer. Or this is somewhere in between or can't
9 tell. This frozen section returned as a benign tumor liken
10 to a serous cyst ad noma, which is a benign growth of the
11 ovary. And the other ovary was fairly normal. It has a
12 tiny little cyst. It was removed and then we do the scan
13 of the bowel.

14 Q Okay. Doctor, what happened to the bowel?

15 A I -- I -- when you do the surgery, you take the
16 bowel and it gets passed off and it gets passed to the
17 tech, then it gets passed to the circulator then it gets
18 passed -- I don't know. It was passed off and in the
19 process of going to the lab, I don't know what happened.
20 I'm operating and it was not discarded, you know, leave it
21 there and throw it in the trash. Through some process, it
22 didn't make it to the lab.

23 Q Okay. And Doctor, we'll come back to it later,
24 but I'm going to get you to explain now, this down here
25 says you placed a Seprafilm. Nineteen Blake drains were

James Williams - Direct Examination by Mr. McDow

1 placed over the partial bilaterally some bleeding was
2 noted, et cetera. Explain to the jury what Blake drains
3 are and what the word 19 means and where these drains were
4 placed.

5 A Okay. Ms. Atkinson had several abdominal incisions
6 and those had become more and more scarred and in order to
7 put all that back together, you really -- you take out the
8 previous incision and make a little larger incision and it
9 doesn't always just pull back together. You always -- when
10 you put tissue back together, it should be tension free.
11 You can't leave it tight. And so her skin and even the
12 subcutaneous tissue was scarred and in order to bring all
13 that back together, you end up having to what we call
14 undermine, release the fatty tissue so that it all kind of
15 loops back together. And then you leave that void or that
16 space, you don't want to leave that space. They call it
17 potential space where fluid can accumulate, you then drain
18 that.

19 So she had two drains, there called Blake drains,
20 it's a brand name -- put in either side of her lower small
21 bowel, a little lower and laterally. They were under the
22 skin and were laid over the fascia, the interior covering
23 of the abdomen to drain that fluid off from the skin.

24 Q Was there also a third drain placed?

25 A Right. A separate brand name of a drain is

James Williams - Direct Examination by Mr. McDow

1 technically called a jackson pratt drain; it looks a little
2 different. It has little holes in it. It was put in the
3 pelvis where I had removed the ovary cyst to hopefully
4 decrease the accumulation of fluid there and run the
5 potential of a second -- what we call a peritoneal
6 inclusion cyst that can develop adhesions. So when women
7 are prone to -- when people are prone to adhesions,
8 sometimes cysts or pockets can develop and this was
9 hopefully to keep that evacuated so maybe another cyst will
10 not develop.

11 Q Maybe I forgot to ask you this. Why are you
12 identifying the ureter there? What was the purpose of
13 that?

14 A In the -- in GYN surgery, particular anatomically,
15 the ovarian cells run -- they begin up here near the aorta
16 and they run down and they cross the ureter as they enter
17 the pelvis and it is a standard surgical principal for
18 gynecologists, especially GYN oncologists that we identify
19 the ureter as we take the blood supply to the ovary before
20 removing the ovary and this is the documentation that was
21 done.

22 Q All right. Anything else about that surgery that
23 you would like to explain to the jury at this point?

24 A I think that's it.

25 Q Okay. Please take your seat.

James Williams - Direct Examination by Mr. McDow

1 A (Witness complies.)

2 THE COURT: Everybody on the jury okay?

3 (WHEREUPON all jurors nodded heads.)

4 THE COURT: All right.

5 BY MR. MCDOW:

6 Q Dr. Williams, your opinion to a reasonable degree
7 of medical certainty, did you perform the surgery as you
8 just described in accordance with generally accepted
9 standards of care?

10 A Yes.

11 Q Did you do anything during that surgery that
12 unnecessarily exposed Ms. Atkinson to any additional risk?

13 A No.

14 Q Broad question, I recognize that when you talk
15 about 32 days, the time between the first surgery and the
16 second surgery being April 25th to May the 28th, generally
17 after the surgery, how did Ms. Atkinson progress during her
18 initial recovery period?

19 A The first several days were pretty routine. In the
20 first 24 to 48 hours you have a low grade temperature,
21 which we commonly see in patients who have had an
22 operation. We believe it's a condition of the lungs from
23 the anesthesia and the breathing tube that's used during
24 the course of the operation. The response to that is the
25 patient is moving and coughing and breathing. All those

James Williams - Direct Examination by Mr. McDow

1 things are done routinely -- routinely ordered. She can't
2 walk. She began to drink some liquids. So the first three
3 days or so, she had kind of routine course.

4 Q And were there discussions about her being
5 discharged?

6 A Well, we got to five -- to seven days, we began to
7 think about that, but you know, after about three days she
8 had some nausea and nausea after surgery is very common as
9 well, especially after the surgery such as this. And so as
10 response to that, we held her fluids and stopped her from
11 drinking for a day or so and then when her bowels began to
12 work and she began to pass flatus and pass stool, we slowly
13 began to liberalize her diet. It wasn't for seven days
14 that she had progressed to where we were thinking about her
15 going home.

16 Q All right, Doctor?

17 MR. MCDOW: Judge, this is actually -- we can go on
18 for hour and a half and have the jurors sitting there okay,
19 but I need to get --

20 THE COURT: All right.

21 MR. MCDOW: This might be a good time to take a
22 quick break before we get into the daily progress notes.

23 THE COURT: All right. Ladies and gentlemen, we're
24 going to take a recess at this point. It won't be terribly
25 long, but when the bailiff comes to the door, Mr. Levick,

James Williams - Direct Examination by Mr. McDow

1 if y'all aren't ready, just let him know that you're not
2 quite ready, but please do not discuss the case. Thank
3 you.

4 (WHEREUPON the jury left the courtroom at 3:33
5 p.m.)

6 THE COURT: All right. Doctor, you can step down.
7 You may not discuss your testimony with anyone at all.
8 Okay.

9 THE WITNESS: Yes, sir.

10 THE COURT: Thank you.

11 (WHEREUPON a recess was observed.)

12 THE COURT: Everybody ready?

13 MR. CORBIN: Yes, sir.

14 THE COURT: Mr. McDow?

15 MR. MCDOW: Yes, Your Honor.

16 THE COURT: Okay. Bring in the jury.

17 THE BAILIFF: Yes, sir, Your Honor.

18 (WHEREUPON the jury entered the courtroom at 3:46).

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

20 THE COURT: Thank you.

21 Okay. Mr. McDow?

22 MR. MCDOW: Thank you, Judge.

23 BY MR. MCDOW:

24 Q Dr. Williams, if you could, I've placed before you
25 the exhibit with the Palmetto Health records in there.

James Williams - Direct Examination by Mr. McDow

1 Turn to page PHR 1013, 1013.

2 A I got it, yes.

3 Q And you see the first postoperative number one,
4 April 26, 2007. Is that your entry there?

5 A Yes. That's my signature.

6 Q All right. Would you tell the jury what you found
7 based off your -- day one, based on your review --

8 A Want me the summarize or you want me to read it?

9 Q Well, you can summarize it.

10 A Okay. 4/26/17, post-operative day number one:
11 The --- designated the procedure we had just done. Noted
12 the hemoglobins. And they were fine. They were a little
13 bit lower than preoperatively, but that would be expected.
14 Afebrile, vital signs stable, ambulating, urine output a
15 little low, but okay, normal for the post-op course; lungs
16 clear. Positive bowel sounds; plan post-operative day one,
17 clear liquids. We started her on some clear liquids.

18 Q Okay. And your next entry was on post-operative
19 day number two, April 27th. You see that?

20 A Yes.

21 Q And how was she doing on post-operative day two?

22 A So postoperative day number two, it was noted that
23 she has some vomiting that morning. She was still without
24 fever and her vital signs were otherwise documented to be
25 stable. Lungs clear, heart was normal and the abdomen was

James Williams - Direct Examination by Mr. McDow

1 quiet. I did put the assessment of the surgical procedure
2 that had been done; noted that we thought she had an ileus,
3 which is a slowing on the bowel or then a waking of the
4 bowel. Stopped the liquids that we started the day before
5 and had a little bit of Reglan, which can sometimes help
6 with the nausea. She was on preordered nausea medication
7 already. That was part of the routine post-operative
8 orders.

9 Q All right. Did you look at the drains at that
10 time, at the wounds?

11 A Yes, I look at the wounds every day. The output is
12 on -- we're provided by the computer a summary of the whole
13 hospitalization and so the vital signs are given in a big
14 table form that you look at on a computer and the outputs
15 of all -- the intakes and outputs, the fluids that one
16 gives, the oral intake that one might give and then the
17 urine for other outputs for the body are recorded and so
18 those are noted on that note sheet and the abdomen is
19 examined and the drains are examined as well.

20 Q Okay.

21 (WHEREUPON Defendant's Exhibit No. 4 was marked for
22 identification.)

23 BY MR. MCDOW:

24 Q All right. Dr. Williams, I'll show you what --
25 I'll show you what our court reporter has marked as

James Williams - Direct Examination by Mr. McDow

1 Defendant's Exhibit 4. I pulled those out of the chart.

2 Is that the I&O, intake and output?

3 A Yes.

4 Q So you would have been looking at that relative to
5 Ms. Atkinson's overall condition?

6 A Yes.

7 Q All right. And what does that tell you regarding
8 the drains during that time frame?

9 THE COURT: Is that the abbreviation INA?

10 MR. MCDOW: I and O, input and output?

11 THE COURT: I thought you said INA behind that.

12 All right.

13 BY MR. MCDOW:

14 Q It has it there?

15 A It does. It's by day, by shift, so I kind of have
16 to find the correct shift. So 4/25 to 4/25 would be the
17 first post-operative dates into the second post-operative
18 dates one jackson pratt had 35 -- there listed, 35, one had
19 20, one had 55 and then they're listed at different times
20 throughout -- there are basically two shifts and they
21 were -- two to three per 24 hours cycle when they record
22 them.

23 Q Okay. It -- when you get those numbers, what are
24 they? When you say 30, 125, et cetera, what does that
25 mean?

James Williams - Direct Examination by Mr. McDow

1 A That's cc or milliliters; and so from the first
2 post-operative day, which we expected to have a higher
3 output or higher volume than other days; and so by the
4 second day, the output from one was 80, another one was
5 100, and another one was 110. And that's not unusual in
6 the first several days post-operatively.

7 Q That would be expected?

8 A Yes, sir.

9 Q All right. That's on April 27th you were talking
10 about. There is in one of the other notebooks for which
11 Mr. Corbin has referred on page 370, under wounds,
12 dressings, and drains. This is Exhibit No. 19 for ease of
13 reference, let me show you that.

14 THE COURT: Plaintiff's Exhibit?

15 MR. MCDOW: That's a plaintiff's exhibit?

16 THE WITNESS: Yes.

17 BY MR. MCDOW:

18 Q Did you see any green, brown, smelly drainage when
19 you made rounds on either April 26th or the 27th?

20 A No, not at all. This record is really not
21 available to me. This is put in by the nurses. It's in
22 the nursing record and on the computer, this would not be
23 something that's on a medical review screen for the
24 physician. There was a singular reference on this date and
25 never would be referenced again for the next five days.

James Williams - Direct Examination by Mr. McDow

1 Nothing else was commented about the green and brown.

2 There was a comment about a drainage bag, which really the
3 patient didn't even have a drainage bag of green, brown
4 fluids. One reference I think has been stated a couple of
5 times that it was three references. Well, this one has
6 three lines, but it's really just one record. And notes on
7 my rounds that morning, looking at her abdomen, I did not
8 see any green and brown fluid and I was there probably
9 within an hour of that report.

10 Q Okay. What was the next entry on that particular
11 wound dressing and the drains document?

12 A That particular next entry was -- the one we just
13 discussed was 4/27 and the next was 5/2. Nothing between.

14 Q All right. And then in one of the other notebooks
15 on page 524, this was at 7:52 a.m., and this is in another
16 notebook, I'll be happy to show it to you.

17 All right. Doctor, that's page 534 and that is
18 from the part of the chart called Systems Review. And that
19 is the entry by the nurse at 7:52 -- performed at 7:52 a.m.
20 entered at 8:38 p.m. And what does that tell you there
21 about the drains?

22 A So this is a nursing input. This is --
23 interestingly this 7:52 a.m. examination that the nurse did
24 of the patient and it kind of goes through all of the whole
25 systems and each of the wounds and the jackson pratt and

James Williams - Direct Examination by Mr. McDow

1 the Blake drains that had been there previously were all
2 identified; and this nurse puts wound one, midline abdomen
3 incision dry, intact, drainage done; two left lower
4 quadrant Jackson -- JP drains and one right lower JP all
5 putting out serous sanguineous or therein bloody type
6 fluid.

7 Q Would you expect serous sanguine and thin bloody
8 type fluid to be coming out at that time?

9 A Yes, sir, that's exactly what is expected.

10 Q All right. Was there ever any other entries to
11 your knowledge or brought to your attention by any of the
12 nurses of any other type of green, brown drainage as may
13 have been previously described?

14 A No, not at all. I round, generally with the nurse,
15 often with the night nurse who would have put the green,
16 brown drainage in. There was no mention on that day 4/27
17 of any green, brown drainage. And I'd say, I know this
18 nurse and that's something she would call to my attention.
19 But there was no drainage bag and there really was no bag
20 from which to have green, brown drainage coming.

21 Q Hypothetically, if it would have been coming from
22 there, would you have been put on any type of notice for a
23 potential small bowel leak?

24 A Absolutely, absolutely. It wasn't there, but
25 absolutely. And the patient was appropriate for the first

James Williams - Direct Examination by Mr. McDow

1 36 hours, 40 hours after the procedure. There was no other
2 factors that seemed to be in play at this time.

3 Q All right. Doctor, that was on Friday the 27th,
4 and then it looks like Dr. Smith was on call for April
5 28th, Saturday and April 29th, Sunday. You see that on
6 page 1014?

7 A Yes.

8 Q Okay. Doctor, you did not, after this surgery
9 place an NG tube, a nasal gastric tube; is that correct.

10 A No, I did not.

11 Q Okay. Did it appear to you in the records that
12 Dr. Smith offered one to the patient on April 28th?

13 A So -- yes. On April the 28th, Doctor Smith rounded
14 and on Friday before on the 27th, the Friday before the
15 Saturday, the 28th, Ms. Atkinson had lots of nausea and
16 some vomiting and Dr. Smith was on Saturday morning. He
17 saw her. He made the comments still with nausea, vomiting
18 and he says does not -- and he underlines not twice, want
19 NG. He considered her to be overall stable in the
20 post-operative time, stable as opposed to be -- if
21 you're -- it's good that there may be issues along the way,
22 but there was nothing serious that we can see at that time
23 and he described having an ileus and continue the course.

24 Q All right. Doctor, turn the page, page 1015, now
25 on Monday, April 30th. How did you find your patient on

James Williams - Direct Examination by Mr. McDow

1 Monday April the 30th?

2 A April 30th, '07, my first line -- and generally the
3 first line is a patient report, what's happening with the
4 patient. Bowels working, no nausea or vomiting, afebrile,
5 lungs clear, positive bowel sounds, and the plan was to
6 advance her diet and her care.

7 Q And then on May 1st?

8 A On May the 1st, we did note that she had some --
9 she still was having bowel movements and I know that she
10 has a positive bowel movement on the record there. Her
11 bowel sounds were present and the plan that day was she was
12 on oral pain medication. We had taken her off of all of
13 her IV narcotics. She was on Tylox, which is a codeine
14 derivative like medication that commonly is associated with
15 nausea, it's a coated-like drug.

16 In a patient that has some nausea but also having
17 bowel movements you kind of worry about other factors that
18 can be causing nausea and so we switched her pain medicine
19 from the Tylox to the Darvocet.

20 Q And had she progressed at that point as you would
21 have expected her to progress?

22 A It was not out of the ordinary in the first three
23 to four days after a procedure to have an ileus, especially
24 after this kind of procedure, so to have some nausea was
25 not completely out of the ordinary.

James Williams - Direct Examination by Mr. McDow

1 Q And again what is an ileus?

2 A An ileus is where the bowels from a surgical
3 procedure in particular, from an impact of the anesthesia,
4 impact of the local manipulation of the bowel, it is not
5 yet functional peristalsis that it would ordinarily would.
6 And plus narcotics that we give for pain, during the
7 surgery and after slows -- markedly slows down the bowel.
8 So all that has to work its way out of the system.

9 Q All right. Doctor, your next date is on May 7th
10 of 2007. How did you find the patient on that day?

11 A We did note on that day that she had some small
12 indices, 100 to 200 cc's actually afebrile, lungs clear,
13 positive bowel sounds, still with positive bowel movements.
14 I had gotten a report over in the office each day when I'm
15 not in the operating room and they had faxed a report from
16 the previous visit that she was tested for a bacterial
17 infection of her stomach. I didn't think that was really
18 her big issue, but in order to make sure that this lady now
19 having bowel movements, otherwise progressing well with
20 some nausea and some low volume vomiting, we wanted to
21 cover that and make sure because it's related to gastric
22 ulcers and gastritis; and so we treated her for the -- she
23 was noted because she had a urinary, urine sample done,
24 which is, these days sometimes a urine sample is done at
25 the time we pull the catheter that we put in sometimes in

James Williams - Direct Examination by Mr. McDow

1 surgery is removed and she was noted on a culture to have a
2 urinary tract infection, and I started her on some
3 antibiotics for the urinary tract infection.

4 On that day also because of her previous history
5 and because she's now not getting to where we thought she
6 should be. I said -- I ordered an upper GI to assess her
7 bowels to make sure now, seven days -- let's see five, six
8 days post-operatively is that she had not gotten a bowel
9 obstruction given her past history.

10 Q All right. Doctor, do you see signs and symptoms
11 from the drains at that point in time to believe that she
12 has a small bowel perforation?

13 A The drain output was recorded daily, shift wise,
14 and it was decreasing appropriately and the serous
15 sanguineous always recorded -- serous sanguineous is
16 occasionally a little bloody, but there was nothing in the
17 drains that would have suggested that.

18 Q All right. Doctor, what did you order on May 2nd,
19 as far as the barium swallow, the small bowel follow
20 through, please explain what that procedure is to the jury.

21 A It's as we discussed, you drink the dye and the
22 radiologist monitors the dye as it travels through the
23 esophagus, the stomach and the small bowel and
24 ultimately -- not so much the colon, but it does note it
25 when it gets to the colon. And so that's -- that's what we

James Williams - Direct Examination by Mr. McDow

1 ordered.

2 Q And what was the purpose of this order? Why order
3 it?

4 A As I said to -- in her history of a post-operative
5 bowel obstruction prior after a similar procedure, I wanted
6 to make sure as we got through that that was not the
7 problem.

8 Q And do you recall what the results were in that
9 particular test?

10 A I noted the results the next day. It's done late
11 in the day and the results are reviewed the next morning.

12 Q Some -- I beg your pardon --

13 A I'm sorry.

14 Q -- go to your notes on May 3rd, then.

15 A 5/3/07, upper GI yields results questionable severe
16 ileus versus small bowel obstruction and then I commented
17 and yet three large bowel movements with contrast last
18 night and no nausea or vomiting. And the plan was to
19 recheck, x-ray to monitor the course now of the barium.
20 Matter of fact, that was the recommendation of the
21 radiologist who read the report. They said, follow, you
22 know, follow the progress of the dye over the next several
23 days because it had slowed -- showed a slower transit time
24 through the bowel.

25 Q I have referred or it's been referred to as a KUB.

James Williams - Direct Examination by Mr. McDow

1 What is that KUB?

2 A A KUB for you to understand is a kidney, urinary,
3 bladder. It covers the abdominal cavity. It's an x-ray.
4 And in this case it is considered a plain film, but it is a
5 film that is the followup of a previous dye study, so it's
6 not as if you went in and had a plain film done without the
7 dye, it actually is a serial examination in followup of a
8 previous contrast dye study, a little more information than
9 just a plain film.

10 Q Doctor, there's a note on May 3rd, the progress
11 notes in between the two that you made. What is that?

12 A I just have to know this, the signature, I couldn't
13 tell you, but there was a resident who was working with us
14 at this time and that's his signature at that time.

15 Q Okay. What did he note at that time?

16 A On the afternoon of 5/3/07 at about 5:30 p.m., his
17 comment was doing great. No nausea or vomiting, wants to
18 go home. KUB consistent with partial small bowel
19 obstruction. Positive bowel movement, no nausea or
20 vomiting and his comment was discuss with Dr. Williams in
21 the a.m.

22 Q Okay. Did you make rounds again on May 4th?

23 A Yes, I did.

24 Q And what did you find in the patient on that day?

25 A May 4th, '07, eating well without nausea or

James Williams - Direct Examination by Mr. McDow

1 vomiting. KUB reveals barium in the colon. But seems to
2 have stopped through the small bowel. That's my note. No
3 nausea or vomiting, continue with repeat KUB. We were
4 going to advance her diet and then monitor how she did. So
5 I said regular a diet and I made a question mark DCC.

6 Q Doctor, do you see anything there about the drains
7 in your notes that indicate to you that there was a small
8 bowel leak?

9 A No, sir. Not at all, the KUB or the dye study is a
10 very sensitive test to determine if there's a bowel leak.
11 The dye was in the bowel and it was making its way through
12 and there was no evidence -- I'm sure we'll talk about some
13 of these x-ray reports, but there was no suggestion at that
14 time of a medical value, which means on the date that it
15 gets to the patient, nor was there any radiographic
16 evidence now on, I think three serial followup x-rays.

17 Q Why would you have advanced her to a regular diet
18 at that time?

19 A Well, she's now gone 48 hours or so without any
20 nausea, vomiting. She's reported -- self-reporting that
21 she's feeling better. Her bowels are working. We've seen
22 the dye in the colon. We know it's a little slow, but she
23 seems to be working it through and so we were hoping she
24 would feed and go home soon.

25 Q Doctor, turn the page again. Now, we're on May

James Williams - Direct Examination by Mr. McDow

1 5th, 2007. And were any of those your notes?

2 A Well, there's three notes. One of them is mine,
3 yes.

4 Q Okay. The one at the bottom, I guess it's May the
5 6th.

6 A Yes.

7 Q Okay. What did you find with her on May 6th?

8 A Well -- can I talk about May 5th?

9 Q Absolutely can. Tell us what you want.

10 A On May 5th the resident wrote that morning it says,
11 Doing well today, no nausea vomiting, bowel -- positive
12 bowel movement, afebrile, vital signs are stable. The
13 KUB's had shown that the barium was slow, which it was
14 seeming to make its way through. He wrote an order for
15 some bowel stimulant to see if he couldn't assist to push
16 the barium through her now seven days post-operative and
17 that's how it was left on 5/5/07.

18 Q What's the name of the bowel stimulant.

19 A It was called Lactulose. It's a mild, relatively
20 mild laxative.

21 Q Okay. It's a laxative. All right. Anything else
22 about May 5th that you want to note there at this time?

23 A No, sir.

24 Q All right. What about on May 6th?

25 A My note on May 6th is -- my comment is that the

James Williams - Direct Examination by Mr. McDow

1 vomiting has returned and clearly this -- that had been a
2 bad night for Ms. Atkinson. She was afebrile. She had
3 bowels -- interestingly she was still having some bowel
4 function, her lungs were clear. We noted her abdomen to be
5 somewhat distended, tympanitic, which means that it sounds
6 like a drum when you tap on it so there's air in the bowels
7 and the comment was made that it looks like she has, at
8 least this partial bowel obstruction. The recommendation
9 at that time was bowel rest and IV fluids.

10 Q Why could you give that bowel rest at that point?

11 A Well, you -- it's not making its way through -- you
12 need to stop pushing from above to allow time to rest and
13 see how it's going.

14 Q Now, this was a partial small bowel obstruction,
15 correct?

16 A The x-rays and the serial dye study x-rays followup
17 KUB's had all demonstrated that the barium contrast made it
18 through to the colon. Ms. Atkinson was reporting some
19 barium stools and so it was not complete.

20 Q All right. Doctor, what about May the 7th. It
21 looks like Dr. Smith may be back on call at that time and
22 maybe the resident made notes as well.

23 A Yes, I can usually read Dr. Smith's handwriting,
24 but not all the time.

25 Q Okay. Go to your next note then on May the 9th.

James Williams - Direct Examination by Mr. McDow

1 A Well, that's the weekend.

2 Q Okay. On the weekend when you came in, did you
3 review the chart to figure out how she'd been doing over
4 the weekend?

5 A Yeah. The reports -- the residents writes the
6 notes on the weekend that Ms. Atkinson was hungry. We
7 often TPN and the TPN was to begin -- she didn't want TPN,
8 so that progress was there. By the 8th it says doing well,
9 feels a little weak today. The bowels are working.
10 Positive BM times three and we were moving toward starting
11 the TPN; it's possible a mild obstruction is still the
12 assessment at that time. She was getting a PICC line,
13 which is the IV we described earlier today.

14 Q Okay. And who puts the PICC line in?

15 A The radiology department has a service where under
16 an ultrasound guides find a position to properly insert.

17 Q And she gets the TPN and the nutrients that go
18 through that; is that right?

19 A Right. The TPN is a high concentration of dextrose
20 solution that would be very caustic to the regular vein and
21 so you put it in a PICC line because that actually delivers
22 the potentially caustic dextrose solution to a large vein
23 near the heart, so it's diluted quickly. So she was
24 getting the PICC line.

25 Q So it goes through the veins; is that right?

James Williams - Direct Examination by Mr. McDow

1 A It goes through the veins, that's right.

2 Q So what did you find on May the 9th?

3 A So on May the 9th, overnight we started TPN. She
4 had had some allergic reaction. We talked about that and
5 we -- the TPN is the vitamins, minerals, high concentrated
6 sugar and some fat. So it's a lipid component to the TPN.
7 It would be unusual for someone to be allergic to the
8 dextrose or the sugar, not usually the vitamins. Minerals,
9 if anything, they might have some reaction to the lipids.
10 That's actually what makes the literally fat. And so we
11 reviewed that and the decision was made to resume the TPN
12 just without the lipids. She seemed to be sensitive to
13 that.

14 Q Anything on May the 9th that caused you any
15 concerns for a small bowel obstruction at that time? And I
16 mean for a small bowel perforation at that time?

17 A No, sir.

18 Q All right. Go on to the note of May the 10th, a
19 couple of pages later.

20 A Uh-huh.

21 Q Page 10 at 21. How did you find Ms. Atkinson on
22 that time when you made rounds?

23 A So this is post-operative day number 14. The
24 comment was made that she feels better than yesterday.
25 She's still having some stool. We checked her labs and

James Williams - Direct Examination by Mr. McDow

1 some of her electrolytes were needed to correct it, which
2 is not uncommon after starting the TPN. And she was
3 without fever. We corrected the electrolytes and continued
4 the TPN and the bowel rest.

5 Q All right. Doctor, keep going to your next entry
6 of how she was doing.

7 A 5/11, doing well was the comment. It's generally,
8 How are you feeling today kind of response and you know,
9 you -- so she really had no specific complaints. She
10 wasn't well, yet, but she had no new complaints on that
11 day. Afebrile, bowel signs stable, positive bowel
12 movements times two. Lungs clear. There seemed to be
13 decreased distension in her abdomen. Her abdomen had been
14 noted to be distended. We noticed that earlier. Bowel
15 sounds were present and the comment was partial SBO bowel
16 rest over the weekend.

17 This was clearly Friday and we would see how she
18 was -- we were going to leave it there. We weren't going
19 to push it because she was having bowel and was feeling
20 better and we were going to give her another 72 hours to
21 see how she did. Give it the time. At the same time
22 giving the TPN and the bowel rest.

23 Q All right. You -- you use the term afebrile.
24 What does that mean?

25 A Without fever. We look at -- the nurses take vital

James Williams - Direct Examination by Mr. McDow

1 signs every four hours and so -- at least. So you have a
2 record six times a day of a temperature, pulse, blood
3 pressure, et cetera. And we take a look at that record and
4 there is a -- you look at the trend. You look at the
5 absolute number and when you say afebrile, that doesn't
6 mean they had a 98.6, it means that the trend was generally
7 in the range that was of the normal -- normal accepted
8 range. Sometimes a little higher, sometimes a little
9 lower, much like your pulse. There are days your pulse
10 will be 80, there are days when it may be -- or average --
11 it may be 90 and there are hours where it may be 100. You
12 really look at that general trend, six -- at least six
13 vital signs every single day to see how that general trend
14 is. Really kind of looking at a line and if that line is
15 pretty flat, where it's average -- on average -- not
16 spiking or not out of the ordinary, then that would be
17 considered stable vital signs.

18 Q And then you wrote on there rechallenge on Monday.
19 What does that mean?

20 A Right. Well, the hope was that with continued
21 bowel rest, giving it time, that we had an incomplete
22 partial bowel obstruction evidenced of the dye making it
23 into the colon, that her bowel would have an opportunity to
24 regain its function without rechallenging, allowing it time
25 to rest by Monday morning. We had -- in the times when she

James Williams - Direct Examination by Mr. McDow

1 had vomiting the NG tube had been offered previously and
2 actually about -- by maybe her having bowel rest she had
3 less emesis or less vomiting any way and it actually -- the
4 NG tube was offered at other times when she was vomiting.
5 Ms. Atkinson recounted her previous experience with an NG
6 tube and said I had an NG tube for --

7 **MR. CORBIN:** May I -- excuse me, please.

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

9 **MR. CORBIN:** Objection, hearsay. Unless he had had
10 that particular conversation.

11 **THE COURT:** And the conversation was with whom?

12 **MR. MCDOW:** With the patient.

13 **THE COURT:** And would you clarify that with the
14 witness as to --

15 **BY MR. MCDOW:**

16 **Q** So had you had conversations with Ms. Atkinson
17 about an NG tube?

18 **A** Absolutely, and Dr. Smith had offered an NG tube on
19 the weekend and Ms. Atkinson said no. And then later I had
20 offered an NG tube on numerous occasions throughout the
21 course of time -- even past this time. She had repeated
22 vomiting and it's an appropriate intervention for her bowel
23 obstruction. And she would recount to me that she had an
24 experience in the previous hospital in 1995 that she didn't
25 like. And it really was left as a standing offer. It

James Williams - Direct Examination by Mr. McDow

1 wasn't worded on the chart that way, but it was ordered
2 that it was a standing offer. Ms. Atkinson, if at any time
3 you reconsider, we would be happy to put this NG tube in.

4 Q Now, Doctor, that was May the 11th. We go through
5 the weekend and then you come back on Monday, I believe,
6 May the 14th, 2007. How had the weekend gone and what did
7 you find on that Monday, May the 14th?

8 A On May the 14th and Ms. Atkinson expressed
9 frustration that she wasn't getting better. Patient
10 frustrated, had a small bowel movement, had one episode of
11 vomiting. Was otherwise afebrile; her abdomen was
12 slightly -- was distended. It actually says distended;
13 positive bowel sounds and then the assessment was really
14 the same, small bowel obstruction versus profound ileus,
15 there's still not a waking of the bowel. We were going to
16 continue her on the TPN.

17 Q All right. Doctor, what was your next note after
18 that?

19 A On 5/15/07, passed large amounts of stool with some
20 stimulation. So we gave her a little stimulation from
21 below to try to clear the barium in her colon and wake the
22 bowels up is what we do. She was afebrile on that date and
23 it was noted that there were two areas -- now, this is 18,
24 19 days post-operatively. But there were two areas of the
25 incision that had drained some serous fluid. Looked at,

James Williams - Direct Examination by Mr. McDow

1 noted was normal, the fluid from incision is now two weeks
2 old. Bowel sounds were noted; decreased distension; and we
3 continued the same plan.

4 Q What was your diagnosis? What did you write down
5 there?

6 A Partial SBO versus profound ileus.

7 Q Was she still on TPN at that time?

8 A TPN was continued and bowel rest was continued.
9 That means nothing to eat or drink. That means while the
10 NG tube may take fluid out by making someone NPO, you don't
11 put any fluid in. So we were not putting any additional
12 fluid in. We were not -- the bowels produce some fluid any
13 way, but we were not adding to that by letting her eat or
14 drink. True she did not have much in the way of liquid,
15 but that was the plan of management and that is the
16 management of the bowel obstruction.

17 Q Well, that was going to be my next question is
18 what are you trying to accomplish by waiting another day
19 and not putting anything into the bowel, even an ice chip
20 or a sip of water?

21 A It's bowel rest. It's the way to rest the bowel
22 and allow it time to open up, edema to resolve or whatever
23 is causing it to hopefully improve.

24 Q All right. Doctor, on May the 16th, 2007, how was
25 she doing then?

James Williams - Direct Examination by Mr. McDow

1 A I noted positive flatus, positive bowel movement
2 spontaneously. I really don't know what the next three
3 words are. Afebrile; lungs clean, regular rhythm, positive
4 bowel sounds; ileus versus SBO; continue bowel rest.

5 Q All right. Doctor, on May 17th, did you make
6 rounds that day?

7 A I did. Ms. Atkinson reported no nausea, vomiting
8 overnight. She was afebrile. No bowel movement that
9 day -- or that night. Lungs clear. Heart regular; abdomen
10 softer, question mark; impression plan, severe ileus versus
11 small bowel obstruction and then we were to check and x-ray
12 that day.

13 Q And the x-ray is the KUB again?

14 A The KUB, yes.

15 Q Then there was a note the next day on May the
16 18th, 2007. Do you recall having a conversation with
17 Ms. Atkinson and her daughter at that time?

18 A Yes. On May the 18th, it was noted that her
19 vomiting had -- was worse. I reviewed the -- she was
20 afebrile, but this was -- this was relatively unchanged.
21 Her abdomen was still somewhat distended. The KUB revealed
22 not much change. Consistent with the obstruction that I
23 noted previously. A notation here is I spoke with the
24 patient and the daughter. I explained the course of the
25 past now 18, 20 days and how we're doing. I explained the

James Williams - Direct Examination by Mr. McDow

1 x-ray findings and my suggestion was -- or my plan at that
2 time was -- I told them at that time was if no improvement
3 over the weekend, we'll plan to return to the OR next week.

4 Q Okay. Why would you be planning to go back to the
5 OR at that time?

6 A Well, we're now 20 days post-operative with a
7 patient with adhesive disease who has evidence of bowel
8 dysfunction on x-ray, whose bowel is not waking up and who
9 is not eating and not going home and continues to vomit and
10 it's time to do a restorative procedure, a repair.

11 Q Doctor, what is your next note on May the 19th?
12 Explain to the jury what you found when you made rounds
13 that morning?

14 A On May the 19th, overnight, large bowel movement
15 yesterday and again this a.m.; afebrile; positive bowel
16 sounds. Decreased distension. I think this may -- well,
17 check KUB in a couple of days. We were going to check
18 another x-ray on Sunday.

19 Q Then May the 20th?

20 A Reports two bowel movements but still with some
21 emesis. She was afebrile, her bowel was actually soft.
22 She had bowel sounds. The plan was to check another x-ray
23 and if without evidence of barium clearing proceed to OR
24 next week. So to assess the progress of the barium through
25 the bowel to see where it was and what it was doing. The

James Williams - Direct Examination by Mr. McDow

1 plan was to proceed next week as I discussed with the
2 patient and her daughter on the 18th.

3 Q All right. Doctor, there's a note on May the 21st
4 here. Had there been another radiology test during this
5 time frame? We'll talk about this more specifically, but
6 had there been other radiology exams done?

7 A There'd been serial x-rays to look at the progress
8 of the barium. There'd not been another -- we -- not yet
9 ordered, actually.

10 Q Okay. So what did you note on May the 21st?

11 A So, May 21st, the note says the x-rays reveal
12 little change over the past week. The patient reports
13 bowel movements, but contrast not passing. While she was
14 having bowel movements -- in spite of that she was having
15 bowel movements, the objective information by the x-ray
16 says that the barium that was in her was not making its way
17 out. The abdomen was still distended. She had vomited the
18 night before and then I put recommend or recommendation:
19 X-ray reveals no change in barium distribution, supporting
20 at least a high grade or partial versus clean obstruction.
21 Nurses report: Feculent emesis that the patient herself
22 doesn't self-report. That was in the report from the
23 nursing staff that I had gotten. Ms. Atkinson had not
24 shared that with me. And on that date, she requested a
25 second opinion about whether she needed to have an op -- we

James Williams - Direct Examination by Mr. McDow

1 were discussing another operation. She requested a second
2 opinion. And I ordered the gastrografen enema that is a
3 dye study to look at the colon and the way we were taught
4 was that if you're now going to go in and do another
5 procedure, maybe even more extensive surgery, you don't
6 want to close having done the small bowel and then find
7 that the colon is the problem. And so the gastrografen
8 enema was to make sure that the colon itself was active,
9 was not abnormal with -- obstructed itself. And that way
10 when we close at least the bowel hopefully -- we hope it's
11 going to be better.

12 Q Then the gastrografen enema, that's coming from
13 below, correct?

14 A Correct. The -- so it's an enema -- it's x-ray dye
15 that's put into the rectum and it looks at the colon. And
16 that -- that was ordered.

17 Q All right. Now, who did you ask for a second
18 opinion at that time? Who did you go to?

19 A Dr. Parker.

20 Q Okay. And did Dr. Parker render a second opinion
21 for you on May the 21st?

22 A Yes.

23 Q Okay. All right. We'll come back to that in a
24 minute, but keep going forward to May the 22nd. After his
25 consultation or after his second opinion, did you speak

James Williams - Direct Examination by Mr. McDow

1 with Dr. Parker?

2 A I did. I noted on 5/22 note I'd spoke with Dr.
3 Parker after he'd done the consult of 5/21. My note says
4 patient not interested to proceed with the surgery. This
5 is not -- and understandably Ms. Atkinson was not anxious
6 to proceed with another operation. Discussing -- I
7 discussed the realities of the x-rays, the gastrografen
8 enema, you can see the barium was just kind of throughout
9 the bowel. It was sitting there not really making its way
10 through. And so I discussed the reality of the x-rays and
11 this was not enough to convince the patient because she --
12 and I put in quotes, feels okay. And the plan at that time
13 was since a possible colectomy was in the works, a possible
14 removal of the colon, we prepared her such with an enema,
15 diagnostic/therapeutic gastrografen enema and we discussed
16 what that was for, to assess the colon, gently stimulate
17 from above to see if we could still get any of the dye to
18 move. And if all still positive, we have to go work on
19 scheduling surgery.

20 Q Now, Doctor, when Dr. Parker rendered his consult,
21 did -- what was his second opinion?

22 A Well, I have his handwritten summary. He does have
23 a dictated note. Asked to see patient, secondary to
24 questionable small bowel obstruction. Full note dictated.
25 He gives a history of multiple diagnosis, extensive

James Williams - Direct Examination by Mr. McDow

1 adhesiolysis, failure to progress with PO, eating; nausea;
2 still with reported bowel movements having been full; the
3 contrast upper GI with dye belated small bowel loops
4 consistent with small bowel obstruction. Suspect will
5 still come to reexploration had she failed nonoperative
6 management although attempt at prep from above may be
7 reasonable.

8 So he actually rendered his opinion because the
9 radiology department had encouraged us to try to clear the
10 previous barium from her system before they did the
11 gastrografenema and he rendered an opinion to say well,
12 I think it's generally stimulate from above, it may be
13 reasonable. Will discuss with Dr. Williams, updated the
14 family at 5:10.

15 Q Okay. Would the stimulation from above be with
16 the Lactulose that you mentioned earlier?

17 A Correct, there were other, but I think that's what
18 was used.

19 Q Okay. All right. So you spoke with Dr. Parker,
20 then we're up to May the 23rd, 2007. What happened after
21 the second opinion by Dr. Parker?

22 A So -- on 5/23?

23 Q Yes, sir.

24 A Okay. The gastrografenema results revealed
25 normal colon, the patient reports more chalky stool after

James Williams - Direct Examination by Mr. McDow

1 the Lactulose. Chalky stool -- barium looks chalky. It's
2 kind of like Mylanta or Maalox in a way so it kind of has
3 that appearance. So she had some passages of some chalky
4 stool. We were encouraged that maybe that was helping.
5 However, she was also having feculent emesis. It was noted
6 to be no OR time this week; recheck KUB -- patient asked me
7 to check another x-ray to make sure the barium hadn't moved
8 because she was starting to pass it. And it says recheck
9 KUB for patient comfort. I was requested to do it to
10 assure her that the barium was not moving through and the
11 comment then was OR next week.

12 Q And your next note would then be on -- that was
13 5/23, the next one is May the 24th, 2007?

14 A Correct.

15 Q And so did you try the stimulation from above with
16 the consult and opinion by Dr. Parker and did you recheck
17 the KUB at that point?

18 A Yes.

19 Q And what did you note on this particular visit?

20 A After Lactulose, the KUB was partial clearance of
21 barium, continued stools -- I can't read that on this
22 copy --

23 (WHEREUPON there was a pause in the proceedings.)

24 THE WITNESS: Bowel possibly open; observe; OR
25 Monday if no improvement.

James Williams - Direct Examination by Mr. McDow

1 BY MR. MCDOW:

2 Q And then on --

3 A I'm sorry -- will continue to stimulate gently in
4 hopes the bowel opens up. That's what it says. Will
5 continue to stimulate gently in hopes bowel opens up,
6 observe; OR Monday.

7 Q Okay. And I think I said May the 24th. That's
8 right?

9 A May 24th.

10 Q All right. And then this would now be Friday May
11 the 25th, for your next entry. How did you find the
12 patient at that time?

13 A Passing large amounts of flatus, afebrile, lungs
14 clear, abdomen distended, partial SBO, OR Monday if doesn't
15 improve, basically.

16 Q All right. And then were you on call that
17 weekend?

18 A No, I was not.

19 Q Okay. And then it looks like two entries there
20 maybe by the resident and then we're up to May the 28th for
21 your operative note on May the 28th, correct?

22 A Right.

23 Q All right. There was an NG tube placed on May
24 27th?

25 A Right.

James Williams - Direct Examination by Mr. McDow

1 Q Who ordered that, if you recall without looking at
2 the records?

3 A Well, over the weekend and we are making an effort
4 -- we're now a month -- four weeks from the procedure.
5 We're stimulating the bowel. We're seeing some marginal
6 improvement, this has been planned as we outlined with Dr.
7 Parker and we were hoping it would work better, but now
8 over the weekend, the emesis returned, she was vomiting
9 more, was more uncomfortable and on Sunday night, she
10 agreed to have a NG tube placed.

11 Q I believe Dr. Smith ordered --

12 A Dr. Smith was on call and he ordered that. That
13 was really the first time we had really been called at
14 night. She was just -- had not progressed and was not
15 doing good that day.

16 Q All right. Doctor, we've kind of gone through
17 your days, we've gotten between the first surgery to the
18 decision to make the second surgery. Let me ask you this
19 question: Was it within the standard of care not to have
20 placed the NG tube between the first surgery and May the
21 27th.

22 A An NG tube is often used. It's offered and is a
23 relatively invasive procedure, the patient really has to
24 agree to it. And Ms. Atkinson was offered -- she expressed
25 on more than one occasion that she didn't want that tube.

James Williams - Direct Examination by Mr. McDow

1 in. It was explained that -- by me, that it was to relieve
2 the vomiting. She had said to me if she vomited a couple
3 of times a day, she'd rather do that than have the tube
4 placed.

5 Q Did you violate any standards of care by not
6 placing the NG tube during that time frame?

7 A No.

8 Q Doctor, did you ever order a CT scan be performed
9 on Ms. Atkinson between the first and second surgery?

10 A No, there was no reason to do a CAT scan. She had
11 no fever, had no acute change in her care that in any way
12 was suggestive of a process that a CAT scan would be --
13 would provide some additional information.

14 Q Doctor, did you ever treat her between the first
15 surgery and the second surgery for any type of small bowel
16 perforation?

17 A No, there wasn't a bowel perforation. There was no
18 need to treat her for a bowel perforation.

19 Q What is an enterocutaneous fistula?

20 A An enterocutaneous fistula -- the classic
21 description is a small bowel that communicates skin. It
22 was described earlier this week that the small bowel opens
23 and then ultimately drains through the skin. That's not
24 exactly the same thing, but it's where the small bowel
25 content somehow drained through the skin.

James Williams - Direct Examination by Mr. McDow

1 Q Doctor, when you would make rounds during that
2 time frame, were you checking the drains?

3 A Absolutely. The drain output reduced over the
4 course of several days and ultimately the drains were
5 removed in five to six days after the surgery. Had a long
6 talk about some drainage and some yellow drainage. And the
7 space where that Blake drain was placed and the skin,
8 particularly on the left side, when the drain was removed
9 because it was no longer producing, there was more fluid
10 behind that drain that had not been accommodated by the
11 drain. And so for a few days after that drain was removed,
12 there was a yellow drainage, though in my assessment, I
13 would differ from the nurses assessment that it was ever
14 purulent drainage. It was yellow, certainly, but not all
15 yellow is purulent. And over the course of a several days,
16 it declined and it ultimately went away and by -- I think
17 5/16, there was a Band-aid on it and it was completely dry.
18 A patient who has a bowel perforation and a leak in an
19 enterocutaneous fistula, it is an unstoppable force.
20 There's no way -- that fluid is going to work its way out.
21 It doesn't clear up and dry up in three to five days or
22 five to six days.

23 Q Doctor, let me double back with you for a second
24 and show you Defendant's Exhibit No. 1. And Defendant's
25 Exhibit No. 1, that's a series of radiology reports.

James Williams - Direct Examination by Mr. McDow

1 THE COURT: Number again, please, Mr. McDow?

2 MR. MCDOW: Defendant's No. 1.

3 BY MR. MCDOW:

4 Q And again, I think those are in reverse order.

5 The first small bowel follow-through that was ordered was
6 on May the 2nd. You see that report there at the back?

7 A Yes.

8 Q Okay. First off, was barium used in that
9 particular procedure?

10 A Yes..

11 Q And who ordered the barium?

12 A Whoever ordered an upper GI with small bowel follow
13 through was not specified. The radiologist gave -- they
14 did not give water soluble contrast, it was not ordered
15 that way.

16 Q Did you have any problems based on the way your
17 patient presented with barium being used on that particular
18 procedure?

19 A No. We were days post-op and she was stable. No
20 fever. There was always a concern about other things, but
21 there was nothing suggested that we couldn't use the
22 barium.

23 Q Doctor, go through those and then I believe
24 there's another KUB in there that we've talked about May
25 the 12th of 2007. See if you can find that report.

James Williams - Direct Examination by Mr. McDow

1 A Yes.

2 Q Okay.. Is there anything in that report there to
3 indicate that Ms. Atkinson more likely than not had a small
4 bowel perforation?

5 A There's nothing here. It does note marked delayed
6 GI transit time, large amount of contrast remained in the
7 dilated portions of the small bowel as well as in some
8 non-dilated colon. There was this discussion of this
9 extraluminal focus. This was reviewed with radiologists.
10 This was him being, I guess, thorough, but on review, there
11 was nothing at that time that pointed toward a perforation,
12 otherwise stable patient.

13 Q There was testimony about there being this angular
14 description in, I believe that particular KUB or perhaps
15 another one. Do you recall the description of there being
16 this angular location of some type of --

17 A Right.

18 Q What is that?

19 A Well, in the narrative, which is one description,
20 and then they give a summary, the possibility that there is
21 an extraluminal focus of -- extraluminal focus of contrast
22 in the left lower quadrant is not excluded, but felt less
23 likely as this collection had been noted previously and up
24 here smaller than they had had previous occasions.

25 Q And followup KUB's, where does it go?

James Williams - Direct Examination by Mr. McDow

1 A It goes -- well, it -- some of it begins to work
2 its way through the bowel. In this time frame, we were
3 pushing to encourage the bowels to work. If there's been a
4 leak or a hole, there'd been barium all over there. There
5 was no suggestion about it at all.

6 Q Doctor, on this abdominal -- down here -- I'll
7 turn it back to where you are so that you can see it and
8 hopefully the jurors can too. On this segment of small
9 bowel, it says lumen down here.

10 A Uh-huh.

11 Q Explain to the jury what these descriptions are
12 and what the lumen means as it relates to the extraluminal
13 description in the KUB.

14 A Well, this is -- the bowel is a tube and it has
15 multiple layers. It has a lining and then a muscle layer
16 and then an outside covering. If the barium is on the
17 inside, it remains in continuity and extraluminal means on
18 the outside. They saw an angle that could have been
19 outside and noted it. And we followed that -- or that was
20 followed up and it went away.

21 Q Indicated it was never outside the lumen, correct?

22 A That would be correct. It doesn't come back in
23 once it's out, it doesn't come back in.

24 Q So, Doctor, that leads me -- did you have some
25 blood work done on Ms. Atkinson between these two times,

James Williams - Direct Examination by Mr. McDow

1 the first surgery and the second surgery? And if you did,
2 was the white blood cell count taken at that time?

3 A We checked the white blood count several times. In
4 the first 24 to 36 hours we check it more frequently, but
5 then less though as she begins to progress. But -- when,
6 she kind of clearly was not getting better. We checked a
7 lot of TPN labs and we check a lot of labs. Her white
8 count was never elevated above normal in that 20 -- in
9 those days after the first surgery.

10 Q All right. Doctor, what would you expect a white
11 blood cell count to be or if she had a perforation or some
12 type of free bleeder?

13 A That -- you'd expect it to go up. It's
14 leukocytosis or increase in the white blood count is a
15 common finding in someone who has a dramatic event that a
16 bowel leak would be and the white count never went up.

17 Q All right. Doctor, we went through each of your
18 notes about nausea and vomiting. Did that raise your
19 suspicion in any way for a perforation?

20 A No. There was nothing that pointed to a bowel
21 perforation in the setting. It looked like a bowel
22 obstruction and that's clearly what it was on all of our
23 objective data, objective x-rays it was a bowel
24 obstruction.

25 Q All right. Doctor, she had 3 drains in place as

James Williams - Direct Examination by Mr. McDow

1 you've described for the first surgery. There was
2 testimony regarding criticisms for you not culturing those
3 wounds. Why did you not culture those wounds?

4 A Well, the drains were in there to drain the fluid
5 and when they were taken out, the fluid remained
6 appropriate for where the drains were. There was no --
7 purulent really isn't yellow, it's white. I mean pus looks
8 white and I can have yellowish pus, this never looked like
9 a thick pus-like fluid. It was yellow draining and it was
10 decreasing over time, getting better. She was having no
11 fevers. It was draining, therefore the drainage is the
12 first thing you would do any way. So -- even if a patient
13 has to be drained, it was already draining, there was no
14 reason to culture that.

15 Q Do you recall when the drains were removed? What
16 date?

17 A I think it was around post-op day 6 or 7.

18 Q Okay. And why were -- and those -- were all three
19 drains removed?

20 A Yes, the output had dropped to the point that
21 the -- you don't leave them in indefinitely, they are taken
22 out when the output dropped today a level, usually below 30
23 cc's per day and that's -- she got to that level. It was a
24 clear yellow, appropriate for post-op state. They were
25 pulled. And one did drain a little while longer, but after

James Williams - Direct Examination by Mr. McDow

1 several days it's gone.

2 Q Doctor, there's descriptions in the Palmetto
3 records in two separate places, the wounds dressings and
4 drains and also in the systems review. Was there anything
5 in the systems review or in the wounds dressings and
6 drainage part of the records that led you to believe at any
7 time that Ms. Atkinson had a small bowel perforation?

8 A No, nothing at all.

9 Q Okay. Was there anything in there to lead you
10 against a small bowel perforation? As related to the
11 description of the fluid?

12 A All of those drains and drain sites were
13 appropriate for the procedure done and the place they were
14 put and what they should be draining. The subcutaneous
15 tissue is fat and it kind of drains a yellowish fluid and
16 that's what was coming out. There was never any suggestion
17 that it was processed bowel content. As I said earlier
18 that has a fairly classic appearance and this was normal
19 for the place the drains were placed.

20 Q All right. Doctor, that gets us to May 28th,
21 2007. You took Ms. Atkinson back to surgery at that time.
22 Did you again inform her of the material risks associated
23 with this surgery?

24 A The procedure was scheduled and planned for days
25 and we discussed it daily; and the decision, while made --

James Williams - Direct Examination by Mr. McDow

1 was planned -- could have been changed, this was not a
2 concrete decision, it was -- we had plans that if things
3 were better we would not do the procedure. But in
4 anticipation of the procedure, I once again discussed,
5 you've been here before. You've been here before in 1995,
6 you've been here before in 2007, all these things could
7 happen again. However, I do not see a remedy for this,
8 especially in your current situation, that would be
9 reasonable. Her vomiting was -- it was a concern. You
10 can't go home with an NG tube. The notion of sort of
11 watching this for 3 months -- you really can't go home with
12 an NG tube.

13 Now, there are ways to bypass that if you can do it
14 and that's certainly done, but in a patient who is this
15 way, the bowel distension, the vomiting, was not going to
16 be remedied -- in this case -- this was a bowel adhesive
17 process that wasn't going to resolve itself in my opinion
18 over the next 3 months.

19 Q And what were the material risks that you had
20 discussed over this time frame and leading up to this
21 surgery with Ms. Atkinson?

22 A Well, we reviewed all those risks that had been
23 reviewed before. It's a similar, same procedure and more.
24 It's the anesthetic complications, the infectious
25 complications, we -- and then the bowel resection had been

James Williams - Direct Examination by Mr. McDow

1 discussed on numerous occasions because I had discussed
2 with her the possibility that more bowel certainly and even
3 part of the colon needed to be removed and that was the
4 emphasis on or the reason for the gastrografen enema for
5 the clear answer of the -- to make sure that if we had to
6 do a further bowel resection that it would be cleaned out
7 and safe, appropriate.

8 Q Okay. Dr. Williams, did you comply with the
9 generally accepted standards of care in informing
10 Ms. Atkinson of these risks?

11 A Yes.

12 Q Let me show you what's been marked as Plaintiff's
13 Exhibit 25.

14 MR. MCDOW: Plaintiffs Exhibit 25, Your Honor.

15 BY MR. MCDOW:

16 Q This is your operative note for May the 28th of
17 2007.

18 THE COURT: 25, you said? Or 24.

19 MR. MCDOW: 25, I believe.

20 THE WITNESS: 25.

21 THE COURT: All right.

22 BY MR. MCDOW:

23 Q Doctor, I'm going to put up your first page here.
24 You can stay where you are and follow along on the exhibit.
25 What was your preoperative diagnosis leading into

James Williams - Direct Examination by Mr. McDow

1 this operation?

2 A Post-operative small bowel obstruction.

3 Q And what was your post-operative diagnosis after
4 you took her back to surgery at this time?

5 A Post-operative small bowel obstruction.

6 Q Doctor, you have five things here listed for your
7 operative procedure. Please tell the jury what those five
8 things are.

9 A A laparotomy, which is reopening the abdomen.
10 Extensive adhesiolysis, occupying four out of five hours of
11 surgical time; small bowel resection with reanastomosis;
12 incidental cystotomy, which is an incidental entry into the
13 bladder which was repaired. The bladder is now adhered to
14 the bowel because the bowel is all the way down to the
15 pelvis; and then an incidental enterotomy repair which was
16 an enterotomy that was not necessarily part of the
17 resection.

18 Q All right. What was the purpose of this surgery?

19 A The preoperative assessment was that Ms. Atkinson
20 had not a kink in her bowel but an adhered mass of bowel
21 that was dysfunctional and not progressing through, not
22 with the dye or anything was progressing through. And it
23 was to relieve that mass of bowel.

24 Q And did you perform this surgery?

25 A Yes.

James Williams - Direct Examination by Mr. McDow

1 Q And has Dr. Towle, T-o-w-l-e, M.D., Resident, did
2 he participate in the operation?

3 A Well, Dr. Towle is a resident who is assigned to us
4 and we teach residents, we teach medical students and Dr.
5 Towle just happened to be on our service at the time. They
6 rotate through. And he was with us that day and he
7 operated with me that day. He wasn't brought in as an
8 assistant, he was my companion for the month. He was
9 rotating with me every day. He would operate with me
10 regularly and he assisted, held things, retraction, that
11 sort of thing.

12 Q All right. Doctor, why did you not have Dr.
13 Parker or another surgeon, at least, assist you in this
14 surgery?

15 A Well, this is surgery I do regularly. This is what
16 I do. This is -- what we did the first time, it's complex
17 abdominal pelvic surgery. Dr. Parker and I had reviewed
18 it. The indication was reasonable and appropriate and it
19 could -- it was just what I do.

20 Q Doctor, was it a violation of the standard of care
21 for you not to have Dr. Parker or someone else there with
22 you?

23 A No.

24 Q Doctor, you've been criticized for your delay in
25 returning to the operating room. Why did you not take

James Williams - Direct Examination by Mr. McDow

1 Ms. Atkinson back to surgery within 10 to 14 days after the
2 initial surgery of April the 25th?

3 A It was barely -- hardly clear exactly what her
4 condition was at that time. And we also were hopeful that
5 the partialness of the obstruction and the fact that it
6 wasn't complete, would resolve itself with time. Even her
7 testimony to that effect that they resolve over time. And
8 so the signs of when it was time to go were not so clear.
9 The bowels were working some days more than others. We'd
10 see less vomiting some days than others. It seemed as if
11 she would progress and then she would regress and then over
12 time you just really put all the x-rays up and you see the
13 course of the time and you say we have reached that time
14 when delay -- more delay is not going to make it any
15 better.

16 And no one would have been anxious to return. Not
17 Ms. Atkinson, not me. I knew there was going to be
18 difficulty and it would have been overall better for her
19 not to have that operation, but it was not possible. It
20 wasn't going to get better. Her adhesions that were there
21 from 1995, they were already difficult the first time, were
22 back and they weren't going to get softer by waiting 30
23 days or 90 days or 6 months. We waited 12 years and they
24 were still hard when I did her last operation. So the
25 sense that everything's going to be so much better in 90

James Williams - Direct Examination by Mr. McDow

1 days truly wasn't the case. Her adhesions were back.

2 Adhesions caused the obstruction. It was necessary.

3 Q All right. Doctor, we talked earlier about using
4 barium. There was mention of gastrografen and water
5 soluble contrast. Did you see any signs of barium
6 peritonitis?

7 A No, not at all. Up in her abdomen, we found
8 adhesions. I went through the bowel. There was no
9 evidence of any free green drainage, no evidence of --
10 barium deposits itself, as has been described, and you see
11 little pockets of it. It's like a chalky area and there
12 was no barium free within her abdomen. There was -- the
13 greenness of it comes and it goes away. There was no green
14 staining. We looked at every surface. I -- of course,
15 during the dissection -- and you can read the operative
16 note. There was an area as I dissected the bowel from an
17 area in the right lower quadrant kind of here, I came to a
18 spot where the bowel was stuck to the back wall of the
19 abdomen. In the course of inroofing that, green barium
20 stain fluid came out. It had not been free before. I
21 encountered it exactly -- it was coming out of the bowel at
22 this point. I lifted up that area of bowel. That really
23 was kind of one of the areas where the bowel was stuck and
24 obstructing. It was part of the ultimate resection.

25 Q Doctor, did you find any evidence of barium

James Williams - Direct Examination by Mr. McDow

1 floating around in the abdomen?

2 A No, as I said, no.

3 Q Did you find any loose stool?

4 A No.

5 Q Did you find any evidence of a free leak or a
6 perforation?

7 A No, not at all.

8 Q Doctor, take a look at your operative note. This
9 first line here says massive inflammatory change in the
10 abdomen under findings. What did you mean by massive
11 inflammatory changes? And in your opinion, what most
12 probably caused this?

13 A Well, it's the picture that I showed at the
14 beginning with the adhesions. It's that scar tissue
15 covering --

16 Q Which one of these?

17 A The right lower quadrant. And it's inflammation.
18 There was no evidence of obvious infection, not equated
19 with tendonitis or bursitis versus other itis, tendonitis
20 was inflammation and certainly was inflammation for various
21 reasons. Her bowel had been challenged now and it was
22 operated on several days prior and all in the process of
23 being in the hospital, it was inflamed, but there was not
24 obvious infected bowel or infection.

25 Q Did she have an abscess?

James Williams - Direct Examination by Mr. McDow

1 A Not at all.

2 Q Doctor, in your opinion to a reasonable degree of
3 medical certainty, did Ms. Atkinson have a free leak?

4 A No.

5 Q Doctor, you've got language in here under findings
6 that says pocket of probable extravasated dye along the
7 posterior peritoneum in a pocket at the base of the
8 mesentery. Inflammatory change in most of the abdomen.
9 Multiple enterotomies were encountered. Small bowel
10 resection were approximately at the terminal jejunum,
11 removing most of the ileum, salvaging approximately ten
12 centimeters of terminal ileum, ascending transverse,
13 descending colon were intact. Do you see that?

14 A Yes.

15 Q Okay. Now, on page 2, as we go through there, you
16 have a sentence that reads, During the course of dissection
17 in the posterior peritoneum along the base of the
18 mesentery, there was a pocket of perhaps some old dye, gold
19 barium, but difficult to say. First off, where was this
20 pocket of perhaps some old dye, gold barium that was
21 difficult to say located?

22 A It was in the root of the mesentery or up in the
23 right quadrant.

24 Q Was there anything in the left lower quadrant?

25 A Not at all.

James Williams - Direct Examination by Mr. McDow

1 Q Anything down in the pelvis?

2 A Adhesions, but no abscess, no barium, no green
3 fluid, nothing in the pelvis.

4 Q Okay. Doctor, you used -- please explain to the
5 jury again, as you were inspecting the bowel what you mean
6 by pocket of probable extravasated dye versus perhaps some
7 old dye, gold barium and difficult to say, are those the
8 same areas or the same description, first?

9 A Yes, sir, it's a lengthier description of the same
10 thing. It's one spot and it's up here and -- if this is
11 the back wall and the bowel is stuck here and you work your
12 way across and you lift it up, there was where I found this
13 pocket. The probable possible that I opened it up as I
14 went -- I didn't know. I found it, noted it, recorded it,
15 it was not free. It was not anything that had been flowing
16 around in there all 32 days. Noted non essential is what I
17 reported.

18 Q Doctor, did you find any evidence of leaking bowel
19 or stool contents floating around in the belly?

20 A As I said, no.

21 Q All right. When you say multiple enterotomies
22 encountered, what do you mean?

23 A They weren't found as I -- when I did the surgery,
24 they were created much like in the first procedure as the
25 surgery was done. There was some question that I went in

James Williams - Direct Examination by Mr. McDow

1 there and I found these multiple enterotomies. These are
2 things that developed as -- the first operation just trying
3 to get the abdomen cleaned up if the area of abnormality
4 demarcated or removal repairs.

5 Q Doctor, there was testimony -- and I think we see
6 jejunum and ilium were the two different chains on this
7 particular document or this particular demonstrative
8 exhibit. Why did you not do either a jejunostomy or an
9 ileostomy and then stop?

10 A Well, an ileostomy was not possible because that
11 was the disease found. That was the area that was
12 abnormal. That -- that -- an ileostomy means you take a
13 supple or abnormal looking bowel and then you bring it to
14 the skin and then you open it up and you have the
15 colostomy, or basically stool coming out in a bag in a
16 controlled fashion. An ilium itself is not capable of
17 being used in that regard.

18 A jejunostomy would not have been practical. It's
19 very proximal, very difficult to get the jejunum up to the
20 skin. It -- it was -- this needed to be just repaired and
21 fixed, at least in my opinion at that time.

22 Q Okay. Doctor, your opinion did you perform the
23 second surgery as you've just described in accordance with
24 generally accepted standards of care?

25 A Yes.

James Williams - Direct Examination by Mr. McDow

1 Q Doctor, let's get back and talk briefly, I think
2 you did, about tachycardia, the nausea and vomiting and so
3 forth. Did any of those signs and symptoms lead you to
4 believe that she had a small bowel perforation or a leak in
5 between the first and second surgery?

6 A No. The tachycardia was 100 to 104, but it was in
7 the context of other normal 80, 85, so the trend was just
8 stable, 90, 85 to 100. It never really waivered much --
9 the 104 was, it didn't waiver much beyond that. I can
10 find, I'd say hundreds, but the general trend was very
11 stable.

12 Q All right. Doctor, why would you -- explain about
13 the ileostomy and jejunostomy, why would you not send
14 Ms. Atkinson home on TPN and operate at a later date.

15 A Well, we discussed that and -- in ovary cancer for
16 example, bowel obstruction can be a terminal event. It is
17 the thing that most women who have ovarian cancer die from.
18 And we will sometimes palliate or make them feel better by
19 putting a tube in feed them on TPN and send them home.
20 That's an identifiable reason why a woman has that at the
21 end of the ovarian cancer course. In this case, this was a
22 post-operative adhesive problem. The adhesions were not
23 going to get better in 90 days or however long and
24 Ms. Atkinson was really in no condition to go home that
25 way.

James Williams - Direct Examination by Mr. McDow

1 Q All right. Doctor, let's get back to the progress
2 notes. And we should be on page 1032. And that would be
3 on May the 29th, which is now the first day post-op from
4 your second surgery. How is Ms. Atkinson doing now?

5 A She was reported as stable, hemodynamically, she
6 was afebrile. Her urine output had been a little low, but
7 was appropriate, a little low but not dramatically. Lungs
8 clear, regulated with the heart post-operative day number
9 one small bowel resection, stable.

10 Q Did you see her next on May the 30th?

11 A Yes.

12 Q And how was she doing now?

13 A Stable, post-operative day number two afebrile,
14 urine output improving, positive bowel sounds, labs stable,
15 hemoglobin, 10, begin elemental two tube feeds, slowly,
16 VCNG.

17 Q So you put an NG tube after --

18 A It was put in in surgery.

19 Q Why this time and not the first time?

20 A Well, she had it in the night before at this
21 surgery. We assumed -- we left in it at this time.

22 Q And then you didn't see her on May the 31st?

23 A Yes.

24 Q And how is she doing now, three days post-op from
25 the second surgery?

James Williams - Direct Examination by Mr. McDow

1 A No complaints. Afebrile and vital signs stable,
2 urine output greater than or equal to 30 cc's per hour.
3 That's a parameter that we like to see. Lungs clear, heart
4 tachycardia put out gallop. Abdomen not distended, jp had
5 had some output, which we put a jp in the area where the
6 bowel was stuck previously.

7 Q And --

8 A Post-op day 3, hold tube feeds for now, ambulate,
9 recheck labs in the a.m.

10 Q All right. Now, did the resident make note on May
11 the 31st as well?

12 A Yes.

13 Q Okay. And what did he find?

14 A Doing well ambulated times two. Positive flatus,
15 pain controlled, vital signs stable, afebrile, related
16 rhythms, -- lungs clear to alter state, clear bilaterally,
17 abdomen mildly distended. I'm not sure what that says.

18 Q All right. And what about the jp drain that he
19 found there?

20 A There was a jp that had some green brown output.
21 That was in the area where we had put the drain and where
22 we'd noticed green brown output before and he noted it and
23 we were watching that.

24 Q All right. And then did you see the patient again
25 on June the 1st?

James Williams - Direct Examination by Mr. McDow

- 1 A Yes, had complaints of abdominal cramps. She was
2 afebrile, jp output had dropped to 10 cc's over 8 hours,
3 lungs clear, hold tube feeds, await bowel function return.
- 4 Q All right. And then did you -- that gets us into
5 Saturday, June 2nd. Did you then leave to go on vacation?
- 6 A That was my last day, yes.
- 7 Q Now, we've been through Saturday June the 9th.
- 8 A Sunday June 10th, I guess.
- 9 Q Yeah, Sunday June 10th and then you'd be back in
10 on Monday, June the 11th?
- 11 A Yes.
- 12 Q So when you returned from vacation, did you find
13 out the course that Ms. Atkinson had gone through?
- 14 A Yes, Ms. Atkinson indeed had -- did indeed have a
15 bowel leak this time from an un -- from -- she had a bowel
16 leak that was detected about the 4th, 5th day post-op. Dr.
17 Parker, as we heard, did that first operation and what
18 ensued after that.
- 19 Q Did you get back and look at those records between
20 June the 3rd and when you came back in on June 11th?
- 21 A Yes.
- 22 Q Okay. Did you know that Dr. -- well, first off,
23 had she had a change in condition?
- 24 A Absolutely, absolutely. She'd grown from
25 progressing okay post-op to now clearly having problems.

James Williams - Direct Examination by Mr. McDow

1 Q And Dr. Parker noted in his surgery of June 3rd,
2 that there was a .51 centimeter hole. Did you recall
3 seeing that?

4 A I saw that in his operative report. Yes.

5 Q Did you miss sewing up any type of enterotomy at
6 your second surgery?

7 A No. The bowel was examined beginning to end. It
8 was intact. It was noted -- I examined it multiple times
9 and checked the anastomosis, checked for any leaks. There
10 were no leaks at the end of that operation.

11 Q All right. What happened in your opinion.

12 A The bowel was damaged with disease, it was swollen,
13 there was an area of thin bowel that as a pressure from the
14 bowel contents began to work it's way through, popped
15 through that area and she clearly at that point did,
16 indeed, have a bowel perforation. It was identified and
17 was handled with -- and was managed by Dr. Parker.

18 Q Did you continue to see Ms. Atkinson and make
19 notes in two progress notes?

20 A Yes, sir, I saw her most every day after I
21 returned.

22 Q She'd been turned over predominantly to Dr. Parker
23 at that time?

24 A Yes.

25 MR. MCDOW: If I may have one minute, Judge.

James Williams - Direct Examination by Mr. McDow

1 THE COURT: Yes, sir.

2 BY MR. MCDOW:

3 Q Dr. Williams, in reviewing the records back at the
4 time and reviewing the records in preparation for your
5 testimony today, do you see anything in there that leads
6 you to believe that you missed some type of small bowel
7 leak between the first and second surgeries?

8 A No. I was back there. I was there again, there
9 had been no bowel leak between surgery one and two.

10 Q Doctor, was this the type of result that you
11 wanted or expected with Ms. Atkinson?

12 A No, not at all.

13 Q Doctor, with that said, at all times that
14 Ms. Atkinson was your patient and under your care, did the
15 medical care and treatment which you rendered to her comply
16 with generally accepted standards of care for gynecology
17 oncology surgery that treat patients with similar
18 conditions under similar circumstances?

19 A Yes.

20 Q Is that your opinion to a reasonable degree of
21 medical certainty?

22 A Yes.

23 MR. MCDOW: Your Honor, I have no further
24 questions.

25 THE COURT: All right. If y'all come up for just a

James Williams - Direct Examination by Mr. McDow

1 moment, please.

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

4 THE COURT: All right. Ladies and gentlemen of the
5 jury, we're going to stop for today. We'll conclude
6 tomorrow -- or excuse me conclude the testimony of this
7 particular witness tomorrow morning. I'm going to -- we'll
8 start at 9:45 instead of 9:30. Again, when we start late
9 it's typically my fault because I'm the one trying to ask
10 the lawyers certain things to make sure I know exactly what
11 trail we're going down that particular day. So we're going
12 to start at 9:45. You may not discuss this case at all and
13 we'll see you tomorrow morning.

14 Again, don't do any research or undertake -- don't
15 undertake to do any fact finding on your own. Just go to
16 the fair. (Laughter).

17 Enjoy your evening and I'll see you tomorrow.
18 Thank you.

19 (WHEREUPON the jury left the courtroom at 5:05
20 p.m.)

21 THE COURT: All right. Dr. Williams, you can step
22 down. I'll give you a little bit more elaborate
23 instruction. You may have noticed that I've told witnesses
24 before that when we take a break you can't discuss your
25 testimony with anyone.

James Williams - Direct Examination by Mr. McDow

1 THE WITNESS: Yes, sir.

2 THE COURT: I don't think we've broken overnight.
3 The construction is still the same. You can't even talk to
4 your lawyer. I guess the best way to put it is you cannot
5 talk to anyone on this planet about your testimony.

6 Any objection to that.

7 MR. CORBIN: No, sir.

8 THE COURT: Okay. Mr. McDow?

9 MR. MCDOW: No, sir.

10 THE COURT: Okay. Thank you, sir, you can step
11 down.

12 All right. One -- I know that -- what the future
13 holds, Mr. McDow is you're going to be perhaps calling Dr.
14 Smith?

15 MR. MCDOW: Yes, sir, Your Honor.

16 THE COURT: All right. What I would like for you
17 gentlemen to do is the case that we briefly discussed off
18 the record is Yoho against Thompson. It's 2001 Supreme
19 Court decision on the issue of introduction of evidence of
20 insurance coverage to show the bias of a witness. There's
21 a case cited in that case called Bonser, B-o-n-s-e-r versus
22 Shane Holtz (phonetic). You can find it, it's in the
23 opinion. It's a case from Colorado that talks about a more
24 specific inquiry and there are cases cited in that case
25 that talk about an expert witness who sits on the board of

James Williams - Direct Examination by Mr. McDow

1 the insurance trust, the insurance carrier for a particular
2 defendant. I'm not going to get into all that now, but if
3 you would please be educated tomorrow on what your
4 positions will be when we get to that point.

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

6 **THE COURT:** I realize the 403 issue that the
7 defendant's going to raise and we'll just have to be
8 prepared to address that at the appropriate time.

9 Mr. McDow, if you would like to make your directed
10 verdict motion tomorrow morning at 9:30 when you might be
11 fresh, that's fine with me. If you would like to do it
12 now, that's fine with me. I was going to give you the
13 option. You might want to review your notes and discuss
14 some things -- that's one of the reasons I wanted to start
15 late so you wouldn't be scrambling after your direct
16 examination of your client. I thought you might want to
17 have some time, but I'll leave that up to you. Either way,
18 I assume it won't take any longer than 5 or 10 minutes.

19 **MR. MCDOW:** Am to infer anything by your ruling.

20 **THE COURT:** No, no, just experience and if you --
21 if you make a motion it's not going to be fairly involved.
22 We know what the plaintiffs say and we know what the
23 evidence is in the light most favorable to them, but I'll
24 let you do which ever you'd like to do.

25 **MR. MCDOW:** Actually, I'll make it now.

1 THE COURT: All right.

2 MR. MCDOW: Because I am prepared for that.

3 THE COURT: Okay. And off the record a while ago,
4 Mr. Corbin, you agreed not to raise the issue of an
5 untimely motion for a directed verdict when he noted --
6 when I noted that all motions had been made for the record.

7 MR. CORBIN: Absolutely, no objection.

8 THE COURT: Okay. Thank you.

9 MID-TRIAL MOTIONS

10 MR. MCDOW: Your Honor, at this time, the
11 defendants move for a directed verdict for the following
12 reasons. Number one, the only reasonable inference from
13 all competent evidence is that the defendants were not
14 negligent. Two, the only reasonable inference from all the
15 competent evidence is that no act or omission on the part
16 of the defendants was the proximate cause of the plaintiffs
17 injury. Three, the only reasonable inference from all the
18 competent evidence is that no act or omission on the part
19 of any employee or agent of defendants was the proximate
20 cause of the plaintiff's injury. Plaintiff has failed to
21 prove by a preponderance of the evidence that Dr. Williams
22 violated standards of care which were proximate cause of
23 alleged injuries or damages. Four, the only reasonable
24 inference from all the competent evidence is that plaintiff
25 was fully informed of the risk of surgery and the defense

1 moves for directed verdict as to any informed consent cause
2 of action.

3 On the additional grounds, the plaintiff testified
4 she wanted the surgery. Plaintiff failed to show a
5 reasonable person having been properly informed would have
6 elected not to have the procedure. Plaintiff also failed
7 to prove proximate cause on this issue.

8 THE COURT: On the informed consent issue?

9 MR. MCDOW: That's correct.

10 THE COURT: Okay.

11 MR. MCDOW: Five that the only reasonable inference
12 from all the competent evidence is that these defendants
13 did not act in a reckless, willful or wanton fashion or in
14 conscious disregard for the plaintiff's rights or safety.
15 Plaintiff has failed to prove clear and convincing evidence
16 that the defendants acted recklessly, willfully, and
17 wantonly and plaintiff is not entitled to punitive damages
18 against these defendants.

19 THE COURT: And you are asking for punitive
20 damages, Mr. Corbin?

21 MR. CORBIN: Yes, sir.

22 THE COURT: All right. And we all agree that this
23 case is before the punitive damage statute that was
24 effective January 1 of this year.

25 MR. CORBIN: Yes, sir.

1 **THE COURT:** Okay.

2 **MR. MCDOW:** That the awarding of punitive damages
3 is in violation of the constitution and these defendants
4 move for a directed verdict on punitive damages as pled in
5 their answer to the plaintiffs complaint.

6 Now, specifically, three things Dr. Bailey never
7 used the term proximate cause. He was never asked a
8 question if he had an opinion to a reasonable degree of
9 medical certainty as to whether or not a violation of the
10 standard of care or proximate cause the alleged injuries or
11 damages to Ms. Atkinson. So I move for a directed verdict
12 based on all of his testimony.

13 **THE COURT:** Okay. How about Dr. Irvin?

14 **MR. MCDOW:** Dr. Irvin never used the term -- on the
15 same grounds. Dr. Irvin never used the term proximate
16 cause. He was never asked specifically did he have an
17 opinion to a reasonable degree of medical certainty as to
18 whether or not any violations of the standard of care were
19 the proximate cause of the alleged injuries or damages of
20 Ms. Atkinson. Quite frankly, Judge, whether something is
21 safer, whether something would be better is not the
22 standard of care. And although I appreciate Mr. Corbin's
23 efforts in that regard, there was no testimony that linked
24 any of that together.

25 In addition to that, I would move for a directed

1 verdict on the NG tube at least as it relates to informed
2 consent between the two -- the two time frames. The
3 experts did not testify that the failure to place or the
4 failure to offer the NG tube was a violation of the
5 standard of care.

6 THE COURT: They had to offer it?

7 MR. MCDOW: That's correct.

8 THE COURT: Okay. And I recall Dr. Irvin's more
9 than Dr. Baileys. I've got to review my notes on that,
10 so -- all right. Anything further?

11 MR. MCDOW: Let me check my margins. I would move
12 for a directed verdict relative to any testimony for not
13 having the bowel and the pathology report. In other words
14 what may have become of it. There was absolutely no
15 testimony that failure to have to bowel specimen was a
16 proximate cause of the alleged injuries.

17 THE COURT: Wouldn't that be more right for a
18 motion to strike that testimony as opposed to a directed
19 verdict?

20 MR. MCDOW: Well, I would move to strike in the
21 alternative, but I don't think that he's entitled to use
22 that information or seek a recovery based upon that.

23 THE COURT: Well, that came more to light, arguably
24 with your client's testimony on direct as opposed to you
25 dropped the door down at the end of the plaintiff's case.

1 I understand what you're saying. I understand what you're
2 saying. The only thing that I see from that testimony or
3 evidence is that we don't know what happened to it and the
4 losing it, you're saying, is not negligent by your client's
5 evidence.

6 MR. MCDOW: Forget what my client said, I'm talking
7 about at the end of the plaintiff's case for a directed
8 verdict, there was absolutely no testimony whatsoever to
9 indicate where the missing bowel may be caused her any
10 harm.

11 THE COURT: Maybe I misspoke. With regard to your
12 clients there is no evidence of negligence arising from the
13 fact that nobody knows where it is. That's what you're
14 saying?

15 MR. MCDOW: That's what I'm saying.

16 THE COURT: All right.

17 MR. MCDOW: In addition to even if they then try to
18 get relief by proximate cause.

19 THE COURT: Okay. I guess -- I got you.

20 MR. MCDOW: Yeah, also, either move to strike or in
21 the alternative for a directed verdict relative to the
22 testimony of taking down or being over aggressive with
23 adhesions in the first surgery. Dr. Bailey said that he
24 was not there so he can't comment on where the adhesions
25 were. He said there's an option if possible to always

1 leave the adhesions.

2 THE COURT: The first surgery?

3 MR. MCDOW: The first surgery. And only Dr.
4 Williams knows what he found. I don't believe there was
5 any testimony relative to the fact that he violated the
6 standards of care of being over aggressive or taking down
7 too many adhesions.

8 THE COURT: All right. And Dr. Irvin, didn't he
9 say about the same thing?

10 MR. MCDOW: That was Dr. Irvin.

11 THE COURT: I thought you said Dr. Bailey.

12 MR. MCDOW: Well, if I did, I misspoke. It was Dr.
13 Irvin.

14 THE COURT: That's what I thought too. Now, Dr.
15 Irvin said two to three times that he wasn't there, so he
16 didn't quite know the lay of the land as far as the
17 adhesions were concerned, talking about the going up to the
18 Ligament of Treitz to work his way back around. Okay.

19 MR. MCDOW: And that's all I'm going to have.

20 THE COURT: Okay. Mr. Corbin would you like to
21 address those points today.

22 MR. CORBIN: I can quickly, Your Honor.

23 THE COURT: I'm leaving it up to you.

24 MR. CORBIN: Yes, sir.

25 THE COURT: Okay.

1 **MR. CORBIN:** In general, my position would be both
2 of my experts testified as to the standard of care. Both
3 testified to the numerous, repeated violations of the
4 standard of care and both testified that if Dr. Williams
5 would have abided by the standard of care, these
6 complications would have been avoided. It even got as
7 precise to say that if he would not have violated the
8 standard of care, the four surgeries by Dr. Parker could
9 have been avoided. The testimony is filled with references
10 to violations of the standard of care. I mean that --
11 that's why we did the charts we did. I think we have
12 numerous violations of the standard of care. With respect
13 to the punitive damage aspect, we don't contend that Dr.
14 Williams did it on purpose. We wouldn't be in the Court if
15 he did it on purpose.

16 It's our contention that he had numerous
17 opportunities to do basic things that doctors are supposed
18 to do to treat patients like Faye. And we're talking about
19 100 or 200 red flags or warnings that should have prompted
20 him to do a CT scan, NG tube decompression therapy and to
21 avoid that second surgery. Even his medical partner is
22 saying it in direct contradiction to what he just said on
23 the witness stand. He just said there was no option in
24 this world except surgery. Dr. Smith said, I wouldn't have
25 done it. Dr. Colner (phonetic), another expert that they

1 hired will say I wouldn't have done it. TPN, NG tube, and
2 await surgery to see if she resolves.

3 I think the record is clear. We have hundreds of
4 violations of the standard of care and sufficient testimony
5 at this stage of the proceeding for the Court to conclude
6 that causation has been testified to by the experts as
7 well.

8 THE COURT: So you believe that Dr. Bailey and Dr.
9 Irvin did provide expert -- or testimony as to a causal
10 link between the breach of the standard of care and her
11 damages.

12 MR. CORBIN: Absolutely. Several times.

13 THE COURT: Mr. McDow, is there any room for -- in
14 the law that the standard of care caused this, this and
15 this to be done or that he didn't do such and such in
16 violation of that standard and that she ends up with 20
17 inches of small intestine and the accompanying problems she
18 has because of that, would that not be a logical deduction
19 by the jury.

20 MR. MCDOW: I don't think they linked it up.

21 MR. CORBIN: Well, I do --

22 THE COURT: Wait. Wait. Mr. Corbin, how about the
23 issue about informed consent and the NG tube. Mr. McDow
24 says there's no testimony for failure to offer that was a
25 violation of the standard of care.

1 **MR. CORBIN:** Both experts --

2 **THE COURT:** I've got pretty good notes on that and
3 I will say that the experts from time to time did say,
4 well, it would have been better to do so and so and they
5 didn't immediately couch their testimony in terms of a
6 violation of the standard. But I've got pretty detailed
7 notes on that. And your contention is that they covered
8 all of that.

9 **MR. CORBIN:** Yes, sir, Dr. Bailey specifically did,
10 when you review even Dr. Smith's exception, publication
11 part, he said that it is the standard of care for the NG
12 tube.

13 **THE COURT:** All right. How about the testimony --
14 what does it add to this equation as far as the doctor is
15 concerned and the practice that the hospital lost the bowel
16 between the operating room and the lab? What's that got to
17 do with what the doctor did or didn't do.

18 **MR. CORBIN:** He has a right to explain what's
19 missing. I think that everyone agrees that feet of
20 bowel --

21 **THE COURT:** Well, you got to go more than you've
22 got a right to explain it. You've got to prove that it's
23 something that he did.

24 **MR. CORBIN:** Yes, sir. If I may continue, he has a
25 right to explain why the bowel is missing. Under -- first

1 of all our request for punitive damages, concealment of
2 evidence is -- sustains a punitive damage ruling. The --
3 it is our position that Dr. Williams -- and he explained
4 it, but there's -- he explained it, he doesn't know what
5 happens to it -- what happened to it. He said he sent it
6 to pathology. There's no record pathology got it and the
7 jury might believe that. But also, the jury could believe
8 that the bowel which he cut out, which our experts
9 testified if he would have sent feet of bowel to pathology
10 they could have told us how many perforations he put into
11 it, how big those perforations were, and what caused those
12 issues, and how long it was.

13 THE COURT: Was it after -- wait a minute, Mr.
14 McDow. I know you disagree with everything he says.

15 When was it, after the first surgery or the second
16 surgery that it was lost?

17 MR. CORBIN: After the first. It was the first
18 time.

19 THE COURT: That's what I thought. And has anybody
20 testified how many feet it was.

21 MR. CORBIN: There was testimony of feet.

22 THE COURT: But no number of feet?

23 MR. CORBIN: No.

24 THE COURT: All we know is she should have between
25 14 to 16, or 16 to 18, or 18 to 20 as an adult. I heard

1 those numbers float around.

2 MR. CORBIN: Yes, sir. Yes, sir.

3 THE COURT: And she's got 20 inches now.

4 MR. CORBIN: Yes, sir.

5 THE COURT: Okay.

6 MR. CORBIN: Your Honor, if I may too --

7 THE COURT: Yes, sir.

8 MR. CORBIN: At the appropriate time I would ask
9 the Court to issue an spoliation charge.

10 THE COURT: But you've got to prove that he did it.
11 You can't just say that it's lost and it must have been
12 him. If -- it --

13 MR. CORBIN: Your Honor, it's my understanding
14 under the spoliation case law that if a piece of evidence
15 that is material to this case --

16 THE COURT: Uh-huh.

17 MR. CORBIN: Which in fact, the missing bowel is,
18 that if it's missing, it was in his charge, he has an
19 absolute right to explain to the jury why it's missing and
20 the jury might believe him. But the jury might also
21 believe that, in fact, he never sent it to pathology.

22 THE COURT: Okay. But the jury -- the jury has to
23 base a belief on something other than speculation. So
24 we'll -- that's a jury charge issue. Anything else on the
25 directed verdict?

1 **MR. CORBIN:** I think I covered everything, Your
2 Honor, Mr. McDow raised lots of points. I think I covered
3 everything.

4 **THE COURT:** All right. Anything else Mr. McDow?

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

6 **THE COURT:** I don't want to talk about a spoliation
7 charge.

8 **MR. MCDOW:** No, I won't talk about that. I want to
9 go back and make sure I'm clear because Mr. Corbin sited my
10 client's testimony and I'm making my directed verdict
11 motion based on --

12 **THE COURT:** Well, that's why I talked about to not
13 talk about spoliation because I don't want to hear about it
14 right now.

15 **MR. MCDOW:** Right. Which gets me back to the
16 testimony of their experts never saying anything that any
17 loss of bowel from the first surgery that can't be found
18 has caused her any harm.

19 **THE COURT:** Well, you're a hundred percent correct
20 about proximate cause. He's talking about the specter of
21 lost bowel, not for any causation, but from the cast a
22 cloud over everything to the extent that that establishes
23 proximate cause. I tend to agree with you that there is no
24 evidence that the loss of an excised body part, the loss of
25 it, physically, between the lip and the -- whatever that

1 saying is.

2 MR. CORBIN: Yes, sir.

3 THE COURT: That isn't cause for damages, the fact
4 that it was lost. It might hurt you in proving your case
5 and that's what he's talking about. So it's really not a
6 directed verdict issue, except what you're asking me to
7 consider. Spoliation is not a directed verdict issue.
8 Yours is a narrower question that I completely understand
9 and I'll just have to review it.

10 All right. How about motion to strike or in the
11 alternative for a directed verdict as to being overly
12 aggressive as to removing the adhesions in the first
13 surgery. None of the doctors really wanted to use that
14 term, aggressive, even Dr. Irvin.

15 MR. CORBIN: Oh, I think Dr. Bailey came down here
16 and he talked about there'd be no reason to go -- if you're
17 getting -- that's why we had the anatomical model there
18 showing the ovaries down here and he said there was no
19 reason -- there's no reason -- you take out the minimal
20 amount of adhesions as possible especially given her
21 situation and to start at the very top, at the Ligament of
22 Treitz and come down and run the entire bowel, run the
23 entire bowel. I mean he said that was --

24 THE COURT: And running the bowel, what -- nobody's
25 ever explained to me except at the very beginning.

1 **MR. CORBIN:** Yes, sir. It's my understanding it
2 means that the doctor starts at the top and he starts
3 removing adhesions freeing the bowel --

4 **THE COURT:** Okay. Freeing up the bowel as far as
5 the adhesions are concerned.

6 **MR. CORBIN:** All the way down, yes, sir.

7 **THE COURT:** All right. Okay. Well, I -- here's
8 what I want you to do. 9:15, if you have any clean up
9 arguments you want to make on this, I'll be glad to hear
10 it. I know we've had a long day.

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

12 **THE COURT:** I guess the frightening thing for me is
13 I understand all this, I think. But we'll get together on
14 that. There are a couple of points that Mr. McDow has
15 raised that I think are pertinent and I'll examine all of
16 my notes real closely.

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

18 **THE COURT:** Okay. 9:15 and if you would read those
19 cases and we'll go -- after we finish with Dr. Williams
20 we'll go -- we'll take a break and you can make your
21 arguments on the Yoho issue.

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

23 **THE COURT:** And Mr. McDow, you may want to read
24 those bias cases when the witness is on the board of
25 directors of the carrier, overly bias.

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

2 **THE COURT:** It's Yoho and a lot of cases are sited
3 in that.

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

5 **THE COURT:** All right. Thank you.

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

7 (WHEREUPON court was in recess until Thursday,
8 October 11, 2012.)

9 * * * * * **END OF VOLUME III** * * * * *

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1 State of South Carolina)

In the Court
Of Common Pleas

2 County of Richland)

3 Docket No. 2010-CP-40-5705

4
5
6 Doris F. Atkinson and)
William E. Atkinson, Jr.,)
7 Plaintiffs,)

Transcript of
Record

8 vs.)

Volume IV

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

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

14
15 B E F O R E:

16 The Honorable George C. James, Jr., Judge and a jury.

17
18 A P P E A R A N C E S:

19 Daryl J. Corbin, Esquire
Attorney for the Plaintiffs

20 William C. McDow, Esquire
Attorney for the Defendants

21
22
23
24 Brenda J. Sigwald, Circuit Court Reporter
For the Honorable R. Knox McMahon
25 P.O. Box 206, Jackson, South Carolina 29831

I N D E XPageVOLUME IVTHURSDAY, OCTOBER 11, 2012

Dr. James Williams

Cross-Examination by Mr. Corbin..... 743

Glen Strickland

Direct Examination by Mr. McDow..... 823

Cross-Examination by Mr. Corbin..... 858

Dr. Harris Parker

Direct Examination by Mr. McDow..... 889

Cross-Examination by Mr. Corbin..... 914

Dr. Matthew Kohler

Direct Examination by Mr. McDow..... 920

Cross-Examination by Mr. Corbin..... 957

Redirect Examination by Mr. McDow..... 998

E X H I B I T S

<u>NO.</u>	<u>DESCRIPTION</u>
P-1	Dr. Bailey Curriculum Vitae
P-2	Doris Faye Atkinson Fever Temperatures
P-3	Doris Faye Atkinson Tachycardia - Heart Rate
P-4	Doris Faye Atkinson Nausea and Vomiting
P-5	Doris Faye Atkinson Abdominal Distention
P-6	Doris Faye Atkinson Wound Drainage
P-7	Small Bowel x-ray
P-8	Small Bowel x-ray
P-9	Adult Mental Status Examination
P-10	Peter O'Kelly, M.D. Records
P-11	Columbia Gastroenterology Associates Records
P-12	South Carolina Oncology Associates Records
P-13	T. Bright Williamson, M.D. Records
P-14	McLeod Home Health Records
P-15	Susan Reynolds, M.D. Records 1 of 3
P-16	Susan Reynolds, M.D. Records 2 of 3
P-17	Susan Reynolds, M.D. Records 3 of 3
P-18	Four Binders of Medical Records, One Box
P-19	Green Drainage and Emesis Report
P-20	Room Visits and Radiology Reports
	4/27/07 through 6/3/03
P-21	Findings Report 5/2/07
P-22	Findings Report 5/17/07

1	P-23	Findings Report 5/2/07
2	P-24	Findings Report 6/25/07
3	P-25	Findings Report 5/29/07
4	P-26	Findings Report
5	P-27	Findings Report
6	P-28	Medical Expenses of Doris Atkinson
7	P-29	Bowel Removed during 4/25/07 Stay
8	P-30	Curriculum Vitae William Irvin
9	P-31A	Photograph
10	P-31B	Photograph
11	P-31C	Photograph
12	P-31D	Photograph
13	P-31F	Photograph
14	P-31G	Photograph
15	P-32A	Photograph
16	P-32B	Photograph
17	P-32C	Photograph
18	P-32D	Photograph
19	P-32E	Photograph
20	P-32F	Photograph
21	P-33A	Photograph
22	P-33B	Photograph
23	P-33C	Photograph
24	P-33D	Photograph
25	P-33E	Photograph

1	P-33F	Photograph
2	P-34	Surgical Associates of South Carolina
3		Records
4	P-35	Chart before Trial Loss
5	P-36	CT Scan DVD
6	P-37	DVD
7	P-38	DVD
8	P-39	DVD
9	P-40	DVD
10	P-41	DVD
11	P-42	DVD
12	D-1	Richland Hospital Radiology Report
13	D-2	Consultation Notes 5/21/07
14	D-3	Consultation Notes 4/13/07
15	D-4	Palmetto Health Chart
16	D-5	Progress Note 5/21/07
17	D-6	Operation Note 6/3/07
18	D-7	Operation Note 6/15/07
19	D-8	Operation Note 6/17/07
20	D-9	Operation Note 6/11/07
21	D-10	Curriculum Vitae
22	C-1	Juror Note
23	C-2	Juror Note
24	C-3	Sidney Smith's Deposition
25	C-4	Defendant's Objections

1	C-5	William Atkinson, Jr.'s Deposition
2	C-6	Glen Strickland's Deposition
3	C-7	Defendant's Request to Charge #15
4	C-8	Stipulation of Fact
5		
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1 **THE COURT:** All right. Anything further on the
2 directed verdict motions, Mr. McDow?

3 **MR. MCDOW:** No, sir, Your Honor.

4 **THE COURT:** All right. Anything else, Mr. Corbin.

5 **MR. CORBIN:** Your Honor, I would just note that the
6 Court's attention to the publication part of Dr. Smith
7 where he -- in fact, he stated under oath in publication NG
8 tube and standard of care. And it's on informed consent,
9 standard of care starting on page 56, lines 1 through 8.

10 **THE COURT:** All right. As far as the first three
11 points, kind of your initial three points that there was --
12 taking all the evidence in the light most favorable to the
13 plaintiffs that the defendants weren't negligent, there was
14 no evidence of any act or omission on their part that
15 proximately caused any damage to the plaintiff. As a
16 preliminary matter, there is certainly evidence if the jury
17 chooses to believe the testimony presented by the
18 plaintiffs that there was breach of standard of care. I'll
19 get to the issue of proximate cause in just a moment.

20 I think there's a jury issue as to whether or not
21 the plaintiff was fully informed. And I'll get to that
22 proximate cause on that in just a moment too. I do
23 typically -- I do struggle, as do most people about
24 evidence of -- by clear and convincing evidence of
25 reckless, willful and wanton conduct on the punitive

1 damages issue.

2 On the issue of the NG tube, Mr. McDow claims
3 there's no testimony that the failure to offer it was a
4 violation of the standard of care. I think there is
5 evidence of that. I'll come back to the testimony about
6 the preservation of the bowel that was removed. And I'll
7 also come back to your motion to strike or in the
8 alternative for a directed verdict as to being overly
9 aggressive in removing the adhesions in the first surgery.

10 All in all, I think there's enough to go to the
11 jury on the issue of proximate cause. Obviously she has
12 put in evidence -- economic and noneconomic damage and I
13 think that the experts and the -- well, the evidence as a
14 whole at this point -- and again, I'm cutting it off at the
15 point where the plaintiff closed or rested. I think
16 there's enough evidence to go to the jury at this stage on
17 the issue of negligence, damage and a causal connection.

18 I fail to see at this point what the missing bowel
19 has to do with anything. I think that is more of a
20 question -- not a directed verdict, but actually just
21 telling the jury that they are not to give it any weight
22 whatsoever. We're not to that point yet, but that was one
23 of my primary questions all along is what did that have to
24 do with anything. The fact is not what happened to it, but
25 the fact that she doesn't have it in her body. That's the

1 question. So we'll cover that more, I think from a clean
2 up standpoint after the case is fully rested.

3 On the issue of punitive damages, as the lawyers
4 well know, the parties don't really get this connection,
5 because this is something we deal with every day, it's a
6 matter of degree and if this was a statutory standard of
7 care, we all know from Wise versus Broadway and other cases
8 saying that evidence of the violation of the statute is
9 evidence of recklessness, willfulness, and wantonness. We
10 don't have that, I don't believe in this case. There's no
11 evidence of violation of any regulation that I've heard.
12 But in any event, I think there's enough evidence at this
13 point to deny the defendant's motion for a directed verdict
14 on the issue of punitive damages.

15 The motion to strike or in the alternative for a
16 directed verdict as to being overly aggressive in removing
17 the adhesions from the first surgery, my review of my notes
18 and my recollection of the testimony is that Dr. Irvin
19 sited that as a violation of the standard of care on the
20 part of Dr. Williams. I can fully see how the jury, at
21 least at this point, would accept Dr. Williams explanation.
22 And as acknowledged by one of the doctors, I think it was
23 the doctor from Florida who said, I wasn't there. You
24 don't know what you've got. And the plaintiff's witnesses
25 argument according to Dr. Williams have tried to paint a

1 picture of a nice little pristine, almost cartoon like
2 inside that, oh, you can go straight there. But Dr.
3 Williams' testimony that -- that's not always the case,
4 especially when the bowel comes down and is over
5 everything. The jury may readily accept that.

6 I think all in all there's enough that the jury can
7 hang its hat on. As far as the close of the
8 plaintiff's case is concerned.

9 So I'm going to respectfully deny your motions.

10 All right. Anything else, Mr. McDow?

11 **MR. MCDOW:** Your Honor, make sure I understand, you
12 are finding at the present time that the plaintiff has
13 proved by clear and convincing evidence --

14 **THE COURT:** I'm not saying he's proved it, I'm
15 saying there's evidence of it.

16 **MR. MCDOW:** Clear and convincing standard to allow
17 punitives to go forward and be presented to the jury?

18 **THE COURT:** At this point. And the reason for that
19 primarily is that Dr. Irvin repeatedly said, never ordered
20 a CAT scan. And I understand your cross-examination on
21 that and I understand what your evidence is going to be
22 counter to that. But his testimony was that he repeatedly
23 said if he'd done a CAT scan, if he'd done a CAT scan, if
24 he'd done a CAT scan. If they had just noted this green
25 brownish discharge. Just his take on it was he totally

1 ignored it. Obviously, your take on it is through the
2 presentation of your witnesses is going to be different,
3 but that's what he repeatedly said. I wasn't terribly
4 swayed by much of anything that Dr. Bailey said, but I
5 think there's evidence of it at this stage.

6 Sometimes the juries think that the plaintiffs are
7 over reaching if this close question to stand on a soap box
8 and demand punitive damages. My job is not to determine
9 the weight of the evidence -- of course, I do on clear and
10 convincing have to give that some consideration because
11 while I can't be concerned with the weight of the evidence
12 on a typical negligence directed verdict, I have to be
13 somewhat concerned about weight to see whether or not as a
14 matter of law it doesn't get to the clear and convincing
15 stage. And I think at this stage that it does.

16 All right. Do you have any case law that guides
17 the trial court on how to analyze that in the context of
18 this type of case, I'll be glad to look for it. There's
19 really not anything there. It's kind of a you know it when
20 you see it type thing. And I just -- the tenor of Dr.
21 Irvin's testimony is that these things would have just,
22 boom, never would have had the problem and he didn't even
23 ever bother to consider it.

24 The jury may conclude that he's an armchair Monday
25 morning quarter back of the worst kind. And at the close

1 of all of the evidence from a factual standpoint -- of
2 course, I'd never be able to tell you, but I may agree with
3 that. But I can't substitute my view of the facts. I've
4 got any ideas like anybody whose sat through this trial.
5 I've got my own ideas about my own view of the evidence,
6 but I'm not going to share it with you. Except as far as I
7 think I can rule as a matter of law.

8 **MR. MCDOW:** I would submit that Dr. Irvin's
9 testimony in the light most favorable to the plaintiff as
10 you analyzed simply sets up that there was a decision to be
11 made one way or the other and they had this pure choice,
12 but that doesn't rise to the level of consciousness
13 disregard for the safety of others or willful wanton and
14 reckless and certainly not by clear and convincing. Not
15 that I wasn't ordering it -- you know --

16 **THE COURT:** But by the same token, you could -- if
17 that were the case, then it would be relatively routine
18 for, as a matter of law, that it didn't rise to the level
19 of tipping the scales ever so slightly. But, of course,
20 you'll have a chance to renew all of that at the end and
21 you'll go into that in a lot more detail on the issue of
22 punitive damages. Do I think this jury will award punitive
23 damages? I don't know. I don't know. But I think there's
24 enough to deny your motion at this time.

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

1 **THE COURT:** All right. Anything else before we
2 begin?

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

4 **THE COURT:** You'll be cross-examining the witness?

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

6 **MR. MCDOW:** I do have one other thing, Judge, that
7 I wanted to put on the record now. When we broke last
8 night, there was the issue of calling Dr. Smith as a
9 witness. And the issue of the insurance and his
10 substantial connection to that issue. Simple -- while Your
11 Honor was most likely eating cotton candy or something --

12 **THE COURT:** No, I didn't go. I didn't -- it took
13 me 45 minutes to get to -- to get out of town because of
14 that traffic and my daughter decided to go with somebody
15 else anyway.

16 **MR. MCDOW:** Okay.

17 **THE COURT:** Kind of made it -- no, sir, I was
18 reading cases.

19 **MR. MCDOW:** Well, I was reading cases too and as a
20 result of reading those cases and although I think -- I
21 think I can distinguish them for purposes of this case, I'm
22 not interested in creating an appealable issue for either
23 side, so I am going to withdraw Dr. Smith as a witness, he
24 will not be called.

25 **THE COURT:** Okay. Those cases were -- the one that

1 was sited in the South Carolina decision, you know, I guess
2 in layman's term kind of jaw dropped me in some respects.
3 It goes to the logic of extreme that turn these cases on
4 their ear. I know that in South Carolina doctors have
5 relative limited source of finding coverage. I don't know
6 if it might ever bar anybody from getting in state experts
7 because of -- but there're all kinds of distinctions that
8 would create some very interesting questions. I don't know
9 what the answer would be in this case. I will -- of
10 course, if you change your mind, you just let me know.

11 MR. MCDOW: No, we're not going to call him as a
12 result of all that. We are just having an educational
13 discussion.

14 THE COURT: All right.

15 MR. MCDOW: I'll give you those thoughts on the
16 record later.

17 MR. CORBIN: Your Honor, if I may too, please just
18 say something. Dr. Smith is not the only one with a
19 connection to the insurance company. Dr. Parker, his
20 partner also sits on the board.

21 THE COURT: Whose partner?

22 MR. CORBIN: He's the subsequent treating surgeon.
23 His partner sits on the board.

24 THE COURT: But he doesn't.

25 MR. CORBIN: He doesn't.

1 **THE COURT:** You've got a long row to hoe on that.

2 **MR. CORBIN:** Yes, sir. But the case law indicates
3 the fact that he's insured by the insurance company is
4 also --

5 **THE COURT:** Not -- but that's not the fact.

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

7 **THE COURT:** I read all those and I think that most
8 of the time you've got a much, much --

9 **MR. CORBIN:** Got you.

10 **THE COURT:** -- more difficult thing. You'll
11 certainly be able to proffer that outside of the jury.

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

13 **THE COURT:** But that's -- that one's going to be
14 tough.

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

16 **THE COURT:** I'll certainly respect your right to
17 put it on the record.

18 **MR. CORBIN:** Thank you sir.

19 **THE COURT:** To me there's a relatively clear
20 distinction on the issue of commonality on a witness who's
21 on the board of directors or a witness who happens to be
22 insured by the same person -- obviously if it's a trust,
23 which I assume this is, if money is paid out everybody's
24 premiums go up, but --

25 **MR. CORBIN:** And the stuff isn't paid out mutual,

1 so they all share -- but I stipulate -- for the purposes of
2 appeal, I stipulate it doesn't make any difference to Dr.
3 Parker.

4 THE COURT: All right. But if you want to pursue
5 it, just let me know.

6 MR. CORBIN: Yes, sir.

7 THE COURT: Because we'll have to do that as a
8 proffer.

9 MR. CORBIN: I understand.

10 THE COURT: All right. Everybody here?

11 THE BAILIFF: No, sir.

12 THE COURT: Do you know who's not, or how many are
13 not.

14 THE BAILIFF: Three just went in, I'll check right
15 now.

16 MR. CORBIN: Your Honor, while we have just a
17 minute, I don't know if Bill --

18 (WHEREUPON the attorneys are conferring.)

19 THE COURT: All right. We're still missing two?

20 THE BAILIFF: Yes, sir.

21 THE COURT: I don't want to fuss at the jury at
22 this stage of any trial.

23 MR. CORBIN: Yes, sir.

24 THE COURT: I'm not going to let them know we're
25 kind of at their mercy.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 We'll be at ease for a bit.

2 MR. CORBIN: Yes, sir.

3 (WHEREUPON a recess was observed.)

4 THE COURT: Okay. The last juror is here. Mr.
5 Corbin are the plaintiffs ready? Plaintiff ready?

6 MR. CORBIN: Yes, sir.

7 THE COURT: All right. Mr. McDow?

8 MR. MCDOW: Yes, sir.

9 THE COURT: All right. Doctor, you can have a seat
10 on the witness stand. Of course, you're still under oath.

11 THE WITNESS: Yes, sir.

12 THE COURT: Okay. You can bring in the jury.

13 Thank you.

14 (WHEREUPON the jury entered the courtroom at 10
15 o'clock a.m.)

16 THE BAILIFF: The jury is seated Your Honor.

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

18 All right. Ladies and gentlemen, we're ready to
19 continue. Dr. Williams is still on the witness stand and
20 obviously he is still under oath.

21 Mr. Corbin, you can cross-examine the witness.

22 MR. CORBIN: Thank you, Judge.

23 **CROSS-EXAMINATION**

24 **BY MR. CORBIN:**

25 Q Good morning Dr. Williams?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Good morning.

2 Q I hope you and I can agree on a lot of stuff today
3 with you under oath. In fact, you were under oath when you
4 gave your deposition to me a few months ago, correct?

5 A Yes.

6 Q And a few months ago when you gave your sworn
7 deposition testimony to me, that was truthful, wasn't it?

8 A Yes, sir.

9 Q So the answers that you give to this jury on the
10 witness stand ought to be the same as you gave in your
11 deposition under oath. Fair enough?

12 A Yes, sir.

13 Q No reason to change it?

14 A No, sir.

15 Q Let's see if we can agree to a few things. Number
16 one: You agree that between the first and second
17 surgeries, Faye had a 30 percent to a 50 percent chance of
18 a bowel leak, agreed?

19 A No, sir. When asked in my deposition, what is the
20 rate of bowel leak after bowel -- small bowel anastomosis,
21 I gave a partial answer and then we moved on to something
22 else. The answer is more complicated than that. In
23 studies looking at people who have had small bowel
24 resection or anastomosis in studies when they gave the dye
25 afterward and there was noted to be some incidental: That

Dr. James Williams - Cross-Examination by Mr. Corbin

1 is to say, noted bleeding of dye inside the anastomosis but
2 never -- but not clinically significant. The clinically
3 significant patients that represent with symptoms and
4 complications is actually much less than 10 percent. So
5 there's actually a second part of that answer; a bit more
6 complicated than that given answer. But the rate of
7 bowel -- small bowel anastomotic leak for small bowel is
8 less than 10 percent.

9 Q In Faye's case, complicated surgery with a major
10 portion of the bowel removed, put back together, a complete
11 lysis procedure from the top to the bottom. It's your
12 position she fell at the bottom of the risk factors or the
13 top?

14 A The risk factor is less than ten -- it ranges up to
15 less than 10 percent would be the average clinically
16 evident anastomotic leak patients become sick or
17 symptomatic later is going to be less than 10 percent.

18 Q So if it's two to ten, she's going to be at the
19 higher part of that?

20 A Yes, sir. Page 14, if I may please read you the
21 question 1 through 5 and let you read to the jury your
22 answer, lines 6 and 7. Question: --

23 MR. CORBIN: And, Your Honor, may I approach the
24 witness like this during this?

25 THE COURT: Yes, sir. All right. I have the

Dr. James Williams - Cross-Examination by Mr. Corbin

1 original here?

2 MR. CORBIN: Yes, sir.

3 THE COURT: He's got a copy, of course. You're
4 talking about his deposition --

5 MR. CORBIN: Yes, sir.

6 THE COURT: When you say page 14 --

7 MR. CORBIN: Right.

8 MR. MCDOW: Your Honor, I'd ask that the original
9 be opened and be presented to the witness so he can follow
10 along.

11 MR. CORBIN: Right.

12 MR. MCDOW: And I'll be able to hear what he says.

13 MR. CORBIN: That's right.

14 Thank you, Mr. McDow.

15 THE COURT: Just to make sure that the record is
16 clear, Mr. Corbin, this is the deposition of the witness
17 taken on May 25, 2011.

18 MR. CORBIN: Yes, sir.

19 THE COURT: All right. You can hand that to the
20 witness. And page numbers and line numbers so Mr. McDow
21 can follow as well.

22 BY MR. CORBIN:

23 Q Page 14, lines 1 through 7.

24 Question: What is the risk of having a leak? If
25 in fact you encounter the situation you did in Ms.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Atkinson's case and you had to remove part of the bowel and
2 reattach two separate parts of the bowel. Is there a risk
3 of future leakage?

4 What was the answer given?

5 A This is a front and back so I'm having trouble kind
6 of --

7 Q Yes, sir.

8 A So I'm having trouble finding the pages.

9 Q Page 14, lines 6 and 7.

10 A Could you repeat the number please? The line
11 number. Page 14. I have it.

12 Q Yes, sir. The question was. What is the risk of
13 having a leak? If in fact you encounter the situation you
14 did in Ms. Atkinson's case and you had to remove part of
15 the bowel and reattach two separate parts of the bowel. Is
16 there a risk of future leakage?

17 A You want me to respond by reading that?

18 Q Please do.

19 A The risk of leakage may be as high as 32 percent of
20 bowel anastomosis.

21 Q Did you tell Faye?

22 A We discussed the inherent risks of the surgery and
23 that included bowel --

24 **MR. CORBIN:** Your Honor, could I please --

25 Excuse me --

Dr. James Williams - Cross-Examination by Mr. Corbin

1 **THE WITNESS:** Sorry.

2 **MR. CORBIN:** Excuse me. To avoid confusion, could
3 I please ask him to answer yes or no and then fully
4 explain?

5 **THE COURT:** He can -- I will deny that request.
6 You can continue to examine him on the answers he gives,
7 but I'm not going to give that blanket instruction.

8 **BY MR. CORBIN:**

9 **Q** Did you tell Faye?

10 **A** Yes, I explained to her the inherent risks of these
11 surgeries specifically related to the bowel and the risk of
12 complications associated.

13 **Q** Did you tell her her percentage could be as high
14 as 30 to 50 percent that she could have a bowel leak?

15 **A** No. I -- we don't inherently list the relative
16 percentages for each of those individual complications.

17 **Q** Did you tell her any percentage that she could
18 have a bowel leak?

19 **A** The discussion -- no. The risk of bowel
20 complications as a general concept specifically related to
21 her previous history was explained.

22 **Q** Rule out the worst first, agree?

23 **A** Yes, sir.

24 **Q** Perforations can kill a patient, right?

25 **A** Yes.

Dr. James Williams - Cross-Examination by Mr. Corbin

- 1 Q Pretty bad, right?
- 2 A They can be, yes, sir.
- 3 Q Signs of a bowel perforation: Abdominal pain,
- 4 agreed?
- 5 A Among others, yes.
- 6 Q Yes, sir. Nausea, agreed?
- 7 A Yes, among others.
- 8 Q Vomiting, agreed?
- 9 A Among others, but it's down the list actually.
- 10 Q Yes, sir. Abdominal distention, agreed?
- 11 A Yes.
- 12 Q Okay. We've got five or six signs here. Correct?
- 13 A Yes, among others.
- 14 Q Warning signs?
- 15 A Yes, for a bowel perforation and multiple other --
- 16 Q Yes, sir?
- 17 A -- conditions.
- 18 Q Red flags?
- 19 A Yes, for bowel obstruction and multiple conditions.
- 20 Q Orange cones?
- 21 A Among other things, they are things that we look
- 22 for.
- 23 Q You look for them because your index of suspicion
- 24 was high with Faye that she might have a bowel leak that
- 25 could be very dangerous at the first surgery, correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Could you repeat the question?

2 Q Doctors, if you have a patient in complex
3 difficult surgery, taking out part of the bowel,
4 reattaching it. Your index of suspicion -- that's what
5 doctors like to say -- index of suspicion that you might
6 have a bowel perforation ought to be pretty high, agreed?

7 A There's an index of suspicion for all
8 post-operative complications. Bowel leakage is one of
9 them. There are multiple others.

10 Q Was your index of suspicion high for Faye that she
11 could develop a bowel leak after her first surgery? Yes or
12 no?

13 A My index of suspicion was -- was no higher than
14 others. She had a bowel procedure. Given all patients who
15 have conflicts with that operation, my index of suspicion
16 was the same as would have been for those patients as well.

17 Q That's assuming from day one, right?

18 A You monitor from day one, yes.

19 Q Of course it's just logical that the index of
20 suspicion -- because a perforation could kill Faye -- would
21 increase if you have 30 separate days -- 27 consecutive
22 days of abdominal distention, one of those red flags.
23 Raise the index?

24 A The concern of this symptom raises concern for
25 multiple possible issues and you have to take each of those

Dr. James Williams - Cross-Examination by Mr. Corbin

1 data points in the context of the whole day and the day
2 prior. And so as an individual or specific two or three
3 symptoms, you don't make decisions based on two or three
4 hundred data points --- per day to review for each
5 individual patient's care. So those are certainly taken
6 into -- kind of in the full context.

7 Q Did it raise your suspicion that she might be
8 suffering from a perforation? Because you indicated that's
9 a red flag.

10 A That, among other things, yes.

11 Q Okay. So the index was going up?

12 A The index was present, yes.

13 Q It's present on everybody, isn't it?

14 A Yes.

15 Q Okay. The question was, you start out, you said,
16 just like any other patient on day one. The question was,
17 if she has 30 consecutive -- 27 consecutive days that her
18 belly is distended, the index has to go up a little bit,
19 doesn't it? Kind of?

20 A The index is present. You talked about the full 30
21 days, there were other findings that ruled against a bowel
22 perforation including a dye study that revealed no dye --
23 no dye outside the bowel. No fever, no white count.

24 Q Did your index of suspicion go up one iota because
25 of her distention?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A My index of suspicion was present throughout
2 regarding all of her symptoms, the distention being one of
3 them, for multiple conditions.

4 Q Did it go up?

5 MR. MCDOW: Your Honor, I'm going to object.
6 That's been asked and answered. He's badgering the
7 witness.

8 THE COURT: Overruled.

9 BY MR. CORBIN:

10 Q Did it go up?

11 A I had ruled out the bowel obstruction -- the bowel
12 perforation with the dye study. Her diagnosis and working
13 diagnosis at that time was bowel obstruction, partial
14 persistent ileus versus other. And so I had ruled out that
15 technically and so my suspicion was not going up that she
16 had a bowel perforation.

17 Q Anything worse than a perforation that you ruled
18 out or was perforation the worst one on the potential list?
19 Worst to first -- what is worse than a perforation that you
20 suspect that she might suffer from?

21 A I don't -- the bowel perforation certainly quite
22 serious. There are other -- other things that she was --
23 no other findings led themselves to worry about
24 perforation.

25 Q You indicated that red flag warning sign that Faye

Dr. James Williams - Cross-Examination by Mr. Corbin

1 might be suffering from a perforation would be nausea and
2 vomiting. 65 episodes, on at least 25 -- 7 days despite
3 the nausea medication everyday. Faye had nausea and
4 vomiting. Did that make the index go up a tiny bit?

5 A Having -- having dye studies that demonstrated no
6 perforation, the diagnosis of a partial bowel obstruction
7 was daily reviewed and followed. No other findings led
8 themselves to that conclusion. No fever, no elevated white
9 blood cell count, so there were no other supporting
10 findings that would have changed that diagnosis.

11 Q In that subset of nausea and vomiting, we need to
12 put in there feculent vomiting too, right?

13 A Feculent vomiting is a description of vomiting.

14 Q If throwing up is a warning sign, a red flag, an
15 orange cone, if you're throwing up feces, that has to also
16 be a red flag, agreed?

17 A Yes, it's a red flag primarily for a prolonged or a
18 progressive bowel obstruction. Less so for perforation.

19 Q Consistent with perforation?

20 A Yeah. Vomiting isn't so inherently related to a
21 perforation. There may be vomiting with a perforation, but
22 it's not universal.

23 Q Did the feculent vomiting raise your index of
24 suspicion? They might be suffering from perforation a tiny
25 bit?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A No.

2 Q Tachycardia. Surgeons know post-operative
3 tachycardia needs to be paid attention to. Agreed?

4 A Yes.

5 Q Because that is a red flag. There might have been
6 some sort of surgical mishap. Agreed?

7 A I'm not going to object to that. That's one thing
8 tachycardia could be a sign of.

9 Q Faye had this symptom under your care. Had
10 tachycardia for 37 days between the first and second
11 operation. Raised the index a tiny bit?

12 A No, as I explained yesterday. As we look at these
13 data points taken, you look at the trends. Ms. Atkinson's
14 pulse was slightly over 100 on numerous occasions, but it
15 was also below 100 on other numerous occasions and that
16 line from day to day would not change. So we take an
17 average. When they take their pulse six times a day, you
18 take the average as it goes. There were no dramatic spikes
19 outside of that average during the course of any of those
20 30 days.

21 Q Nothing that dramatic in Faye's case, right?

22 A In those 30 days, there was no dramatic change,
23 that's correct.

24 Q And you agree that hypo bowel sounds, less than
25 normal, is a warning sign of a potential perforation,

Dr. James Williams - Cross-Examination by Mr. Corbin

1 agreed?

2 A Hypoactive bowel sounds may be present in multiple
3 conditions.

4 Q Including perforations. Fair enough?

5 A It could be.

6 Q And absent bowel sounds, when they're not even
7 there, could that be consistent with a hole in the bowel?

8 A Yes, amongst many other things.

9 Q Now, Faye -- I think this is Exhibit No. 29?

10 THE COURT: Could the lawyers come up here for just
11 a minute?

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

14 THE COURT: Go ahead Mr. Corbin.

15 BY MR. CORBIN:

16 Q Dr. Williams, tachycardia could be a red flag for
17 a post-surgical patient is having complications. Faye had
18 29 days of hypoactive bowels. Does that raise your index a
19 tiny bit?

20 A For lots of problems related to a surgery, yes.
21 It's not necessarily for a bowel perforation. There are
22 multiple other conditions.

23 Q Perforations on your list, right?

24 A Over the course of time, perforation had been
25 effectively ruled out by the dye study that yielded no

Dr. James Williams - Cross-Examination by Mr. Corbin

1 apparent dye outside of the bowel as we discussed
2 yesterday.

3 Q Absent bowel sounds. Is that a big deal?

4 A It's one of many clinical findings that are
5 important.

6 Q Absent bowel sounds means for whatever reason,
7 something's going on. Something's going on inside of the
8 small bowel, right?

9 A It means that your bowels are quiet. They're not
10 moving gas which is the sounds you hear from the bowels
11 when the bowel's awake. Could be related to anesthesia,
12 related to narcotic drug use which makes the bowels quiet.
13 Could be related to an ileus. Could be related to a bowel
14 obstruction. Bowel perforation inherently would not
15 produce the findings specifically of hypoactive or absent
16 bowel sounds.

17 Q The 6 days of totally absent bowel sounds, in
18 Faye, raise the index a tiny bit?

19 A Not for a bowel perforation.

20 Q We can agree peritonitis is by medical definition
21 inflammation of the abdominal cavity, is that fair?

22 A That's a really simplistic response. Peritonitis
23 is actually a clinical medical term related to a complex
24 number of symptoms. There's maybe abdominal pain and maybe
25 abdominal findings and maybe fever, tachycardia. Really

Dr. James Williams - Cross-Examination by Mr. Corbin

1 it's a constellation of things that produce the diagnosis
2 of peritonitis.

3 Q Peritonitis is serious in a post-operative
4 patient, correct?

5 A It can be, yes.

6 Q Does peritonitis get your attention in the
7 post-operative patient, like Faye?

8 A In any patient, yes. Peritonitis is a very
9 important condition.

10 Q If you have the high index of suspicion that a
11 patient might be having a bowel perforation, peritonitis
12 could be a very serious condition, couldn't it?

13 A Yes, in that circumstance.

14 Q The patient could die. Correct?

15 A Yes.

16 Q Bowel leaks can cause peritonitis. Correct?

17 A Yes.

18 Q Bowel leaks deserve the surgeon's immediate
19 attention, correct?

20 A Yes, they often do.

21 Q Dr. Williams, you would agree that you are a
22 gynecological oncologist and you are required to abide by
23 the extent of the care as a gynecological oncologist,
24 correct?

25 A Yes.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q In addition -- you indicated to us that you're a
2 surgeon. Correct?

3 A Yes.

4 Q Would you further agree that you are required to
5 abide by the standards of care that apply to surgeons.
6 Correct?

7 A Yes.

8 Q You have the same standards of care as Dr. Irvin,
9 the gynecological oncologist. Correct?

10 A Yes.

11 Q You have the same standards of care as Dr. Bailey,
12 the surgeon. Correct?

13 A Yes.

14 Q If Ms. Atkinson did have signs of peritonitis
15 between her first and second surgeries, you would agree
16 that relates back to your first surgery, correct?

17 A Yes.

18 Q You would agree that if Faye did have signs and
19 symptoms or actually had peritonitis -- let me ask you
20 that. Would you agree if Faye had peritonitis sometime
21 between the first and second surgery, the most likely cause
22 would be a bowel perforation?

23 A Well, Ms. Atkinson didn't have a bowel perforation,
24 or I'm sorry, didn't have peritonitis. Peritonitis is
25 associated with fever, tachycardia, more of a change, more

Dr. James Williams - Cross-Examination by Mr. Corbin

1 abdominal discomfort, elevated white count. We never saw
2 any of the secondary signs or symptoms.

3 Q In your deposition, would you turn to page 25.
4 And let's start at 25, line 21 and let me ask you the
5 question. Please read the answer.

6 Question: If, and we all understand that you
7 didn't see any signs of peritonitis, but let's assume Ms.
8 Atkinson had some signs of peritonitis after the first
9 surgery that you performed on her. And if you would have
10 seen these signs of peritonitis, would it be fair for you
11 to assume the cause of the peritonitis related back to your
12 surgical procedure? Your answer?

13 A Yes.

14 Q Would the most likely cause of that peritonitis
15 given what you knew about her intestinal situation, would
16 probably be some kind of leakage of the bowel?

17 A I said, that's intentionally true.

18 Q Can you think of a more likely cause if, in fact,
19 she did have peritonitis and some kind of bowel -- some
20 kind of leak in her bowel?

21 A Not in this context, no.

22 Q A normal female around Faye's size, 5 foot 2. She
23 should have about 16 to 18 feet of small bowel, correct?

24 A Yes.

25 **MR. CORBIN:** Mr. McDow, can I see the chart that

Dr. James Williams - Cross-Examination by Mr. Corbin

1 you showed yesterday with the different stages of
2 adhesions?

3 MR. MCDOW: This one?

4 MR. CORBIN: Yes, sir.

5 Your Honor, for the record, I'm just showing the
6 chart that they used yesterday for illustration purposes.

7 THE COURT: All right.

8 BY MR. CORBIN:

9 Q Dr. Williams, yesterday you were answering
10 questions about this particular chart. If I may, is it
11 your testimony that Faye Atkinson, the condition that you
12 encountered, would be the fourth photograph -- fourth
13 depiction on this chart, remain adhesions months to years
14 after surgery. Is that fair?

15 A That's what I testified to yesterday.

16 Q That is your testimony how Faye's bowel looked
17 when you opened her up the first time, correct?

18 A It's an artistic representation, but yes, that's --

19 Q Is it -- is it a fair depiction?

20 A Yes, sir.

21 Q Okay.

22 A Yes.

23 Q Is it your position that her small bowel before
24 she got to you was abnormal, like in that particular
25 depiction?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes.

2 Q Not normal, correct?

3 A That's correct, yes.

4 Q Now --

5 **MR. CORBIN:** The Court's indulgence, Your Honor?

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

7 **MR. CORBIN:** All right. Exhibit No. 29, Your
8 Honor. Plaintiff's Exhibit No. 29.

9 **BY MR. CORBIN:**

10 Q Now, according to the records, I want you to help
11 us, if you would, figure out what happened to Faye's bowel?
12 Even before you got into the care of her, assume that she
13 was a normal female, that's your assumption. Before she
14 went to Carolina Pines in 1995, is that a fair assumption?
15 Before any resection we see here -- normally, it's fair to
16 assume her bowel was 16 to 18 feet long. Is that fair?

17 A Yes.

18 Q Now, let's talk about how much bowel has been
19 removed from Faye. It started out as 16 to 18 feet in
20 1995. If we could, let's focus on you first. The first
21 surgery that you performed, the bowel never -- well we
22 don't know what happened to the bowel. Correct?

23 A Yes.

24 Q Okay. So I put a question mark here. Is it fair
25 to have a question mark next to the amount of bowel removed

Dr. James Williams - Cross-Examination by Mr. Corbin

1 in the first surgery, for discussion purposes, fair?

2 Agreed?

3 A I don't have a record of that. That's correct.

4 Q Okay. The second surgery. When you removed her
5 bowel the second time, for whatever reason, that bowel got
6 to pathology. Correct?

7 A Yes.

8 Q That's where it should have been. Correct?

9 A Yes.

10 Q Pathology looked at it, examined it, and they told
11 us you removed 51 centimeters of her small bowel. Correct?

12 A The section they measured was 51 centimeters.
13 Whether they measured the entire length, I can't speak to,
14 but they said 51 centimeters.

15 Q Minimum, you took out 51 centimeters. Fair?

16 A That's fair.

17 Q Okay. And I -- I want to be conservative on this?
18 Dr. Parker -- after your two surgical procedures, Faye had
19 complications, didn't she?

20 A Yes.

21 Q She required four additional surgeries. Correct?

22 A Yes.

23 Q It was necessary. Correct?

24 A Yes.

25 Q It related to the surgical complications from the

Dr. James Williams - Cross-Examination by Mr. Corbin

1 second operation you performed. Correct?

2 A Yes.

3 Q Dr. Parker, four surgeries, two times, he removed
4 parts of Faye Atkinson's small bowel. Correct?

5 A After eight surgeries, yes. I was not there.

6 Q The total Dr. Parker removed 15.5 centimeters the
7 first time, 4.5 centimeters the second time. Dr. Parker,
8 according to pathology, removed 20 centimeters of small
9 bowel. Agreed?

10 A I assume that's correct, I have no idea.

11 Q Okay.

12 A An estimate.

13 Q I'm going to have you follow along. If I misstate
14 something from pathology, let me know. All the records are
15 right here.

16 So the length of the bowel Faye had resected at
17 Palmetto Health Hospital by Dr. Parker and you was 71
18 centimeters. That's about 20 inches. Correct?

19 A Yeah, if the math's right.

20 Q Yes, sir. Accept the math to be true. It's about
21 28 inches, 71 centimeters. Let's be conservative. Let's
22 call it 2 feet. Is that fair?

23 A Yes. In your math, yes.

24 Q Pathology at Palmetto Health got 2 feet of her
25 bowel. Everything that Dr. Parker took out, and nothing

Dr. James Williams - Cross-Examination by Mr. Corbin

1 you took out the first time. Correct?

2 A Yes.

3 Q And that's 2 feet. Now, Carolina Pines -- is it
4 fair, 1995, don't really have records from 17 years ago.
5 Is it fair -- can we also -- in fairness to you, put a
6 question mark there?

7 A Yes.

8 Q She had some removed. She testified -- she was
9 told 10 inches, but --

10 A Twice.

11 Q How much?

12 A Twice.

13 Q Okay, so twice --

14 A So she had two procedures.

15 Q Okay. Ten inches --

16 A I don't how much was removed. She had two
17 procedures.

18 Q Yes, sir.

19 A The same --

20 Q I'm just asking, do you know --

21 A I don't know.

22 Q So I can take off this question mark. Okay. So
23 in fairness, let's not put 10 inches there, let's put a
24 question mark. Is that fair?

25 A Yes.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Now, we do know that Dr. Williamson,
2 gastroenterologist, he's examined Faye's bowels after all
3 of her hospitalizations have been held. Correct? He's her
4 doctor?

5 A Yes.

6 Q He's a gastroenterologist, an expert in
7 intestines. Correct?

8 A Yes.

9 Q He told this jury that he's been treating Faye.
10 He had an x-ray -- a CT scan -- he had a CT scan of her
11 small bowel. Testified under oath, she now has 20 inches
12 left. Can you dispute that?

13 A Well, the evidence you presented to me in this
14 court was his upper GI, it was not a CT scan, so I won't
15 dispute the point, but it was actually an upper GI picture.

16 Q Will you dispute Dr. Williamson's testimony that
17 the x-ray that he reviewed, he testified under oath, and in
18 his opinion, she had 20 inches of small bowel left?

19 A I won't dispute that.

20 Q Let's call that 2 feet to be fair. Okay? Now, if
21 we add 2 feet taken out at Carolina Pines and we know what
22 happened -- we know what happened there, it went to
23 Pathology, 2 feet. Correct? Two feet went to Pathology?

24 A Not from Carolina Pines, that was --

25 Q No, sir, from -- from your hospital.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A That's what --

2 Q Two feet?

3 A -- is demonstrated right here.

4 Q Yes, sir. So we can account for those two feet.

5 We can account for another two feet because Dr. Williamson
6 accounted for the next two feet. Correct?

7 A Yes.

8 Q So we can explain four feet. Correct?

9 A No. It's really not that easy. The pathologist
10 doesn't tease out the bowel as if it's a string and lay it
11 out in the lab and then measure it from end to end. They
12 take the bowel that was sent down that's now been preserved
13 over night and they measure the specimen that's presented.
14 So while the -- it's an exercise that's difficult to say --
15 I can't tell you that indeed, that's exactly correct.

16 Q Yes, sir?

17 A I've worked with the Pathology Department. Did
18 rotations in residency and the pathologists are not teasing
19 the bowel out and laying it out across the room and
20 measuring the entire length. They measure the specimen as
21 it's received. So to follow the logic, I would say from my
22 knowledge, I can't say that all of those things are
23 necessarily true. That's how it's reported, but that
24 report may be misleading in length.

25 Q Because it's not long enough. Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A No, sir. It's just not simply recorded as such by
2 the pathologists. So these measurements don't necessarily
3 correlate directly to the length of the bowel removed.

4 Q Yes, sir. Your second surgery, 51 centimeters,
5 you told me a minute ago you really think it's more than
6 that because that's not stretched out. And I asked you,
7 are these figures conservative, and you said yes. Is it
8 your position now that Pathology was wrong? You removed
9 more than 51 centimeters?

10 A No, sir. I'm not really changing my position, I'm
11 just saying that that's not a directly accurate
12 representation -- we're trying the length of bowel and put
13 it back together the pathologist doesn't reconstruct it
14 that way. So the information presented isn't really --
15 doesn't lend itself to that reconstruction.

16 Q Yes, sir. So we -- according to Pathology and Dr.
17 Williamson, we can account for four feet of bowel.
18 Correct?

19 A As I said, according to Dr. Williamson through the
20 measurements that he did, but otherwise, Pathology doesn't
21 measure the bowel exactly in that way.

22 Q Yes, sir. And -- would you agree that Pathology
23 -- that's the best record we have because at least
24 Pathology indicated they measured the length. Do you have
25 anything better?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A It -- no, it's a record of the specimen presented.

2 Q So we can account for four feet. Normal bowel
3 length, 16 to 18 feet for Faye, before she went to Carolina
4 Pines --

5 MR. MCDOW: It's Byerly Hospital.

6 MR. CORBIN: Which is now Byerly Hospital in
7 Hartsville.

8 THE COURT: Byerly first, right?

9 MR. CORBIN: Yes, sir. Oh, yes, sir. But the
10 hospital in Hartsville --

11 BY MR. CORBIN:

12 Q You're understanding what I'm saying. Right?

13 A Yes.

14 Q Okay. Faye went to the hospital in Hartsville.
15 We can account for -- we're doing an accounting of her
16 small bowel, four feet. So in fairness, account for the
17 four feet that we know what happened to it. She should
18 have 12 to 14 feet that is unaccounted for. Right?

19 A I can't account for what they did at Byerly
20 Hospital so I think it's -- I don't know that I can say one
21 way or the other.

22 Q So we -- we don't know how much Carolina Pines
23 took out in 1995. Correct?

24 A No, sir.

25 Q We don't know how much you took out of your first

Dr. James Williams - Cross-Examination by Mr. Corbin

1 surgery. Correct?

2 A Not specifically, no, sir.

3 Q Okay. But in an average person, Faye should have
4 had 12 to 14 feet of bowel when she stepped in your office
5 for the first time. Fair?

6 A I think -- I --

7 Q I'm sorry. Let me rephrase that. I --

8 A I didn't understand the question.

9 Q Yes, sir. She had 16 to 18 feet when she came to
10 see you. We've accounted for four feet that was removed.
11 She should still have 12 to 14 feet of bowel minus whatever
12 you took out, whatever Hartsville took out. Fair?

13 A Fair. I have no argument that Ms. Faye Atkinson
14 has less bowel now than she did before.

15 Q Yes, sir. Is it your position, Dr. Williams, that
16 when you first opened Faye's abdomen that whatever happened
17 at Carolina Pines, which has nothing to do with you at
18 Hartsville, nothing to do -- we do have two resections. In
19 fairness to you, we really don't know how much was taken
20 out. It is your position, a normal female, 12 to 14 feet
21 that is missing, that had to come during the resections in
22 Hartsville?

23 A I didn't quite understand the thought.

24 Q It had to come from Hartsville or you. Correct?
25 That's the only people taking out parts of the bowel

Dr. James Williams - Cross-Examination by Mr. Corbin

1 besides Hartsville is you. Correct?

2 A No, Dr. Parker removed additional bowel.

3 Q What I see in the operative report --

4 A In the second surgery, I described that all of the
5 disease ileum, which in my opinion was the area that had
6 been the most trouble from '95 and '07 from my surgeries,
7 that the ileum was diseased -- that portion of the
8 intestine. I described in my second operative report that
9 I had identified and spared both the jejunum, which is that
10 first part, removed that most of the diseased part of the
11 ileum where, in my opinion, most of the surgery had been
12 done in '95, of course, in '07 by me. And then reconnected
13 those two together. My opinion is that without other
14 complications that that would have not resulted in such
15 severe, if any, short-gut syndrome. So I'm not disputing
16 that she has less bowel. I don't know -- I don't dispute
17 that she has less bowel than she did before.

18 Q But you would agree how much she had before --
19 before she got to you, had to be taken out in Hartsville.
20 Correct?

21 A I'm not sure I understand that question.

22 Q I'm only trying to determine -- do you know of any
23 other places in the world besides Hartsville and Columbia
24 where her bowel was removed?

25 A I'm sorry, no.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Would you agree, Dr. Williams, that in your
2 deposition you indicated, I really don't know how much
3 small bowel I took out during the first operation, but it
4 was feet. Do you recall that?

5 A I don't recall that.

6 Q Would you agree that your operative report doesn't
7 indicate how much bowel you removed either, does it?

8 A It does not specifically say.

9 Q Okay. And would you at least agree that Faye's
10 condition when she first came to see you, for a surgeon
11 during that first operation, to remove 12 feet of bowel,
12 would clearly violate the standard care. Agree?

13 A No. It would depend on the nature of the surgical
14 indications for the procedure. There are indications where
15 12 feet of bowel might need to be removed.

16 Q I'm asking --

17 A As one said --

18 Q I'm asking in this particular situation, you were
19 in the operating room. You were the only surgeon there,
20 correct?

21 A Yes.

22 Q Okay. So I'm asking you, would you agree for a
23 surgeon in Faye's first operation, with what you saw there
24 to start with, would it be a violation of the standard of
25 care in Faye's case to remove 12 feet of the small bowel?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Well, I did not remove 12 feet of small bowel.

2 Q Assume somebody did. Would that be a violation of
3 standard of care?

4 A I did not remove -- the scenario -- can you repeat
5 the question.

6 Q My understanding of your testimony is, you did not
7 remove 12 feet of bowel. The question was educate the
8 jury. If a surgeon were standing in your shoes out there,
9 in Faye's case, operation number one, exactly the same, it
10 would be a violation of the standard of care for that
11 surgeon to remove 12 feet of her small bowel. Agreed?

12 A If in that case, a surgeon were to indiscriminately
13 remove 12 feet of otherwise normal bowel, that would be a
14 violation of the standard of care.

15 Q A bad one. Right?

16 A I -- it would be indiscriminate and it's a bad
17 thing.

18 Q Can you help us with how much bowel you removed
19 so -- or do you know, the first time?

20 A The -- I have a recollection, I do not have a
21 measure. Yes, but it was not an extensive portion of the
22 bowel that was removed in the first operation.

23 Q Yes, sir. It is important in Faye's situation --
24 the purpose of your operation was the fear of cancer.
25 Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A The -- no. The purpose was to remove her ovary for
2 the listed indication, I explained yesterday.

3 Q If Faye were not afraid of cancer, would there be
4 any reason to remove that ovary?

5 A Absolutely. She had excruciating pain that had
6 already made her to present to the hospital. She was on
7 oral narcotics at the time, between the hospital and my
8 office and that condition was not going to relieve itself
9 on its own. And it would likely -- likely worsen.

10 Q The purpose of Pathology when a surgeon removes a
11 patient's body part -- a significant body part, like the
12 small bowel, you are required under the standard of care to
13 send that to Pathology for testing for the patient's
14 safety. Are you not?

15 A Yes, sir. Amongst other things. And that -- it
16 was done. I was operating; it was passed off to other
17 hospital employees who then processed that specimen. I --
18 the surgeons do not carry that and log in or present it to
19 the Pathology Department, so...

20 Q The reason the surgeon sends it to Pathology --
21 and you want to make certain Pathology gets it, don't you?
22 Don't you want to make certain Pathology gets the specimen?

23 A Yes.

24 Q It doesn't make sense to remove it and send it to
25 Pathology and they don't get it. Right?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A No, I had no way to track that personally on that
2 given day.

3 Q So when you take out the small bowel that day, you
4 send it to Pathology. Did you ever get a report back about
5 the small bowel?

6 A The small bowel was not in the report, no.

7 Q You got a report back because, you know, Pathology
8 got the ovaries. Right?

9 A Yes.

10 Q Pathology told you what they indicated they found
11 in the ovaries. Correct?

12 A Yes.

13 Q Were you upset when they didn't tell you what they
14 found in Faye -- Faye's bowel specimen. I bet you were
15 upset, weren't you?

16 A I honestly don't remember that -- those parts of
17 the events now, five and a half years later.

18 Q It is a serious violation -- Doctor, you've been a
19 physician for several years, probably sit on several
20 committees for the hospital. Correct? Over the years?

21 A Yes.

22 Q Okay. It is a serious violation for body parts to
23 be kind of missing in the hospital. Is it not?

24 A Body parts weren't missing. There was no Pathology
25 report and I have no record that the Pathology Department

Dr. James Williams - Cross-Examination by Mr. Corbin

1 received that specimen.

2 Q Is it serious to a hospital, with you sitting on
3 these committees, you know that if the body part is
4 missing, that is serious. Isn't it?

5 A I'm not an expert to that area specifically.

6 Q Given your experience, will you at least concede a
7 body part missing is serious?

8 A Yes. It's not a desirable thing to happen.

9 Q And it hinders your ability to probably diagnose
10 and treat your patient if a body part is missing. Correct?

11 A It could, yes, sir.

12 Q Among other things, correct?

13 A It could, depending on the reason you were doing
14 it.

15 Q Tell the jury if you have any documentation at
16 all, any records, in the 2,000 pages of the hospital
17 documents where you mention missing bowel in your records?

18 A No, sir, there's not.

19 Q Pull out from your records where you notified
20 Pathology. I bet you know the director. Right?

21 A Yes.

22 Q Friends?

23 A I'm not sure that the director knew me at that
24 time, really.

25 Q You knew the director and how to get in touch with

Dr. James Williams - Cross-Examination by Mr. Corbin

1 the director. Correct?

2 A Yes.

3 Q Show the jury where you notified the director of
4 Pathology that your patient's body part was missing?

5 A I have no record.

6 Q Was it not important enough to put it in the
7 record?

8 A I have no recollection of that five years later.

9 Q Dr. Williams, let's talk a little bit about
10 informed consent, what it means to you as a physician. Do
11 you feel comfortable talking about it?

12 A Yes.

13 Q A patient has an absolute right -- in Faye's
14 situation, she's not unconscious, she's not a child, she's
15 not incompetent, so assume that in this question. You have
16 a competent patient, adult. She has an absolute right to
17 pick and choose what treatment you provide to her.
18 Correct?

19 A Amongst those offered, yes. The patient --
20 whatever would be appropriate, yes. It's not like a menu
21 and they pick things. You have to make medical judgement
22 and recommendations and in the course of that you discuss
23 the plusses and minuses and the risks and benefits and then
24 the decision is made.

25 Q The decision is made by the patient. Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes.

2 Q Not by the doctor. Right?

3 A The plan of management has to be outlined with the
4 doctors -- somebody has to make a diagnosis and a
5 recommendation and you can make the recommendation to what
6 options are available and then the patient, through those
7 options, then makes the decision.

8 Q In your relationship with Faye, you were the
9 information provider and she was the decision maker.
10 Right?

11 A Yes.

12 Q If you failed your job to give her full
13 information about her condition so she could make the right
14 choice, that's a violation of the standard of care. Is it
15 not?

16 A Yes, sir. I gave her all appropriate information.

17 Q The second surgery -- the jury has heard plenty
18 about what happened during those 32 or 33 days. Correct?

19 A Yes.

20 Q Let's focus on the second surgery. First surgery
21 didn't go too well for Faye, did it?

22 A No. She had complications afterward.

23 Q She had a tough time, didn't she?

24 A Yes.

25 Q Lots of nausea and vomiting, other troubles.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Correct?

2 A Yes.

3 Q Waiting 32 days, 33 days, she told you, I'm
4 afraid, I'm anxious, I don't want anymore surgery. And
5 that's reasonable, isn't it?

6 A Yes, to be concerned and anxious. Yes.

7 Q Doctor, if there's any way to avoid surgery,
8 that's what I want to do. Isn't that what she was telling
9 you as your patient? Avoid it. True?

10 A We talked about the options and she was not
11 anxious, as I stated yesterday, anxious to proceed with
12 certain things.

13 Q She did not want surgery, did she?

14 A She did not decline surgery. She was anxious about
15 having surgery as anyone would be.

16 Q And I saw in her hospital chart, I think the day
17 that you were going to do your surgery that she was telling
18 the nurse, gosh I'm anxious, I'm scared. Right?

19 A Yes, as most patients would do in that situation.

20 Q If you would have given Faye, anxious and scared,
21 a surgery, a reasonable option to avoid it, no doubt in
22 your mind she would have taken that option. Correct?

23 MR. MCDOW: Your Honor, that requires for
24 speculation. He can't say what her mind --

25 MR. CORBIN: I said no doubt in his mind that it's

Dr. James Williams - Cross-Examination by Mr. Corbin

1 her position given this interaction, what she would do?

2 THE COURT: Why don't you ask him first of all,
3 does he know?

4 MR. CORBIN: Yes, sir.

5 THE COURT: And then you can follow up.

6 MR. CORBIN: Yes, sir. Thank you, Judge.

7 BY MR. CORBIN:

8 Q You know she was afraid, correct? Rightfully so.
9 Correct?

10 A Yes.

11 Q You know she was scared, rightfully so. Correct?

12 A Yes.

13 Q You know it's in the records that she was scared
14 and anxious about the second surgery. Correct?

15 A Yes.

16 Q You know she told you and Dr. Parker, I do not
17 want more surgeries. Correct?

18 A Not in those words. She expressed concerns about
19 having more surgeries, but did not declare those -- that's
20 a declarative statement. She did not declarative
21 statement, no I don't want more surgeries. She said, I'm
22 very anxious about having more surgery. That is very true.

23 Q So you end up, based on your interactions with her
24 and all the stuff that happened in the first surgery
25 forward, that she would have been given the chance to avoid

Dr. James Williams - Cross-Examination by Mr. Corbin

1 that second surgery, she would have done it. Correct?

2 A I don't know.

3 Q Okay. You didn't give her that chance, did you?

4 A Well, actually, the record will show that, as I
5 testified yesterday, that that was the reason why -- at the
6 family's request and Ms. Atkinson's request, we had Dr.
7 Parker see her with a second opinion about whether it was
8 really necessary. The context was, I don't really want
9 more surgery, is it really necessary? I said, let's get
10 somebody else to say. And that's the context of the second
11 opinion.

12 Q Your medical partner is Dr. Smith. Correct?

13 A Yes.

14 Q You trust his opinion?

15 A Yes.

16 Q Well experienced, correct?

17 A Yes.

18 Q Faye really had a choice besides the surgery that
19 you performed the second time. Didn't she?

20 A In my opinion and Dr. Parker's, we felt that the
21 surgery -- the opinion was that it was the best option at
22 the time.

23 Q Was there a new -- another option that she could
24 have chosen besides surgery?

25 A There are multiple options on any given day. My

Dr. James Williams - Cross-Examination by Mr. Corbin

1 opinion was surgery and Dr. Parker's opinion on surgery was
2 an indicated procedure or indicated option at that time.

3 Q Do you take responsibility for the surgery, or do
4 you partially blame Dr. Parker?

5 A Dr. Parker wasn't there.

6 Q Yes, sir.

7 A For the surgery.

8 Q So you made the decision about the second surgery.
9 Correct?

10 A The decision to -- yes. The decision to proceed or
11 recommend surgery was my decision.

12 Q Faye really had an option besides surgery. She
13 was on TPN at that time. Correct?

14 A Yes.

15 Q You can insert an NG Tube, relieves the
16 distention, nausea, vomiting, and pain, and you can wait
17 until it's less dangerous to operate. That was an option.
18 Correct?

19 A In my opinion at the time, I did not think that was
20 the best option.

21 Q Did you ask your partner what the options were?

22 A He and I discussed it numerous times.

23 Q Did you ask your partner, does Faye have an option
24 besides surgery, for example, TPN, NG Tube, and wait until
25 the second surgery. Did you ask him that?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A No. That's a specific question. He and I
2 discussed it numerous times. We -- he never expressed a
3 differing opinion about the plan of management.

4 Q Yes, sir.

5 A As a matter of fact, I checked up to him just
6 seventy-two hours prior to the surgery -- the second
7 surgery, discussed the plan of management for the weekend.
8 He expressed no differing opinion, no alternate view points
9 were expressed.

10 Q If avoidance of surgery with NG Tube insertion,
11 TPN, and watchful waiting until it's less dangerous to
12 operate, if that were a reasonable option, Faye certainly
13 should have been told that one. Correct?

14 A We did do watchful waiting for many days. We
15 already did the watchful waiting and that had not been
16 successful.

17 Q If on the day of the operation, if you really had
18 to go with one choice: Either surgery, which you knew
19 would be dangerous. Correct?

20 A All surgeries are risky, yes, sir.

21 Q Just like any other surgery. That second one was
22 just like any other one. Right?

23 A They're all important and have risks.

24 Q If you would have told -- well, an option on that
25 day -- let's talk about that day. Surgery. Are you

Dr. James Williams - Cross-Examination by Mr. Corbin

1 telling this jury that an option of treatment available to
2 Faye, if she would have been fully informed, would have
3 been avoid surgery, NG Tube, keep the TPN in, and let's
4 delay your surgery until it's safer. Are you saying that
5 was not even an option?

6 A My opinion, as discussed, the procedure was
7 appropriate and -- appropriately recommended at that time.

8 Q Assume that Faye, in fact, did have no reasonable
9 options to avoid surgery and you did not do it to her, that
10 would be a violation of standards of care. Correct?

11 A In my opinion, the other option was not a reliable
12 option at that time.

13 Q Assume there was, in fact, another available
14 option. Put yourself in that position. That maybe you
15 were wrong. Assume there was another reliable position.
16 Perhaps you had a different partner. Instead of surgery,
17 she can do the TPN, the NG Tube, and wait until it's safer.
18 Assume that's true. You had the duty to tell Faye, didn't
19 you?

20 A I had a second opinion from Dr. Parker that
21 confirmed that the exploration was an appropriate next step
22 to management.

23 Q So the question was, if she had another option
24 besides the one you chose, another reasonable option,
25 regardless of how you felt about it, if there was another

Dr. James Williams - Cross-Examination by Mr. Corbin

1 reasonable option, you had the duty to fully inform her.

2 Correct?

3 A Yes.

4 Q Okay. Did you tell her, Faye, that going into the
5 second operation that it was going to be worse than the
6 first?

7 A I discussed it, yes, sir. I discussed that
8 potential. It could be.

9 Q You go in there, you open Faye's abdomen, and low
10 and behold, just like you expected, you were confronted
11 with what?

12 A Adhesions through the bowel.

13 Q If Faye had a perforation, that could contribute
14 to the massive adhesions you found on the second operation?
15 Correct?

16 A Yes, a perforation could. I did not see a
17 perforation.

18 Q The definition of peritonitis, you indicated, the
19 medical definition, it was massive inflammatory change.
20 Correct?

21 A That's not exactly what I said. Peritonitis is a
22 clinical syndrome of multiple values. Inflammation of the
23 abdomen would be one of them.

24 Q The only way -- and you recall when you did the
25 barium sip test. Faye sipped some barium, it went into her

Dr. James Williams - Cross-Examination by Mr. Corbin

1 small intestine. The only way it could get outside of her
2 intestine, it would have to be a hole, correct?

3 A Yes, but there was not a hole identified at the
4 time of the second surgery.

5 Q Yes, sir. The barium is a contrast dye. Correct?

6 A Yes.

7 Q Would you agree that if you missed Faye having
8 peritonitis between the first and second surgeries, that
9 would be a violation of the standards of care?

10 A She did not have peritonitis by the clinical
11 definition of it.

12 Q Let's assume that, in fact, she did. Would you at
13 least concede -- I know you don't think she had it, but if
14 she had it, you missed it. Fair?

15 A That question is very difficult to answer in the
16 context.

17 Q If she had a perforation and you missed it, that's
18 a violation of the standard of care. Correct?

19 A The evidence today did not reveal a perforation.

20 Q If she had a perforation and you missed it, that
21 would be a violation of the standard of care. Correct?

22 A A missed perforation could be a violation of
23 standard of care.

24 Q Plaintiff's Exhibit No. 25. I'm going to ask you
25 a few questions about it. The purpose of findings in a

Dr. James Williams - Cross-Examination by Mr. Corbin

1 surgical report is to accurately put in words what you
2 found. Correct?

3 A Yes.

4 Q Operative reports under the standard of care are
5 required to be truthful. Correct?

6 A Yes..

7 Q The very first finding that you had, now that you
8 completed -- how many hours of surgery was the second one?

9 A Four and a half to five.

10 Q After about four and half or five hours of
11 surgery, when you prepared your report, the very first
12 finding that you put was quote, massive inflammatory change
13 in the abdomen, quote. That's peritonitis, isn't it?

14 A No, as I explained yesterday, inflammatory change
15 is like tendonitis or bursitis is inflammation related to
16 all sorts of irritants. Peritonitis can cause
17 inflammation, but that's not the only one.

18 Q Peritonitis could be causing the bowel distention
19 for 30 days. Right?

20 A No, it's not likely. Peritonitis is what was
21 causing that for 30 days.

22 Q Peritonitis can cause tachycardia. Right?

23 A Yes. Peritonitis can cause tachycardia.

24 Q A patient with peritonitis, it's not uncommon
25 they're going to have lots of nausea and vomiting, Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes, they may. A patient with peritonitis would
2 not really have peritonitis for 30 days.

3 Q The second sentence reads, pocket of probable
4 extravasated dye along with posterior peritoneum in a
5 pocket at the base of the mesentery. That's at the base of
6 the small bowel?

7 A Well, as I described yesterday, this is not a free
8 pocket. That description is my description and I generally
9 account what I saw. This was the bowel. As I explained
10 yesterday, the bowel is sitting against the back wall and
11 as I unroofed the bowel, not a pocket separate from the
12 bowel, but the bowel itself, there was dye there. It was
13 in the bowel when I lifted it up and it was out of the
14 bowel -- when I was there, it was out of the bowel when I
15 lifted it up. The description says, possible, probable. I
16 could not tell as I lifted it up, there's no where else in
17 this pocket about this big, but it's connected to the
18 bowel.

19 Q From the inside?

20 A When I lifted that bowel, I was inside, in the
21 tube -- the pocket was inside that one. Point being that
22 whether I opened the bowel and lifted it up and encountered
23 it or whether it was an isolated pocket sitting behind the
24 bowel at the time, it was all injured related to the lumen
25 of the bowel.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q In your report you start out saying it's a
2 probable pocket of dye and about on May 12th, this is two
3 weeks before the second surgery, You got a plain, KUB film.
4 And in that film, at least there was a suggestion by the
5 radiologist that there was a possible extravasation of dye
6 outside of her intestine. Correct?

7 A Yes.

8 Q You discounted that right quick, didn't you?

9 A No, sir. The radiologist actually discounted that
10 in saying it -- seems much less likely to be that.

11 Q And the radio -- Well, does the radiologist know
12 more about -- know more about Faye's condition than you did
13 at that time?

14 A No.

15 Q You had a high index of suspicion it might be a
16 perforation, didn't you?

17 A Among other things.

18 Q Yes, sir. You didn't expect the radiologist --
19 well, in fact, when you looked at that study, you asked him
20 to check because of the nausea and vomiting, didn't you.

21 A Yes.

22 Q You didn't say, check because I don't have a high
23 index of suspicion of peritonitis or a perforation, did
24 you?

25 A No, the -- actually the plain film was not so

Dr. James Williams - Cross-Examination by Mr. Corbin

1 plain, as I explained yesterday, It was a followup film
2 from the previous dye study. And I -- there had been no
3 report of any barium outside of the bowels at that point.
4 That was a comment on one sentence, then discounted, and
5 then followed up. The recommendation was followed up when
6 he called us. Now that'd be clear. And interestingly in
7 relation to my second operative report would be -- the
8 described area was in the right upper quadrant and the
9 x-ray report was in the left lower quadrant, very
10 despairingly different locations.

11 Q Now, a CT scan would show a perforation. Correct?

12 A Yes, a CT scan can show a perforation.

13 Q Tell the jury how many CT scans you took in 33
14 days?

15 A None. I didn't see where they were indicated based
16 on all the information.

17 Q Faye didn't need one, to keep her safe?

18 A I didn't see any indication based on all the
19 findings.

20 Q If Faye had a perforation -- one way to follow up
21 when the radiologist says, doctor, you possibly have a
22 leaking intestine there with barium coming out. A good way
23 to follow up with that would be, let's do a CT scan.
24 Correct?

25 A Among others, that's one thing.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q CT scan in that situation is almost 100%
2 diagnostic, isn't it? Pretty good?

3 A Yes.

4 Q And a gynecological oncologist, I think I heard
5 someone say, they order CT scans by the wheel-barrel full.
6 Correct?

7 A I can't -- no, we order them as they're
8 appropriate.

9 Q You don't order a bunch of CT scans?

10 A Yes.

11 Q During a year, you order a lot of CT scans.
12 Correct?

13 A Yes.

14 Q And if you wanted to definitively see if Faye had
15 a hole in her bowel after that radiologist told you it was
16 a possibility, the way to do it is a CT scan, correct?

17 A That's one way to follow up a dye study if you'd
18 already done --

19 Q How did it help her not to do one at that point?
20 Save a little bit of money? Any other benefit to her by
21 not doing it?

22 A No.

23 Q Would it have hurt her to get a CT scan?

24 A No.

25 Q You seem to have some confusion about this

Dr. James Williams - Cross-Examination by Mr. Corbin

1 operative report talking about probable extravasated dye.

2 Do you think it was dye that you really encountered when
3 you went into her bowel?

4 A There was an barium stained intestinal contents.

5 Which is what we're describing --

6 Q So the --

7 A In the operative report.

8 Q The pocket was barium?

9 A It was barium stained intestinal contents in the
10 pocket of the -- in the area of the bowel that was lifted
11 up, revealing that it was not discovered when countered in
12 the abdomen at all. There were no other pockets and there
13 was nothing else. This was under and the bowel was open as
14 I brought it up. That's the probable possible discussion.
15 Was it there before? Was it there as I opened it? I could
16 not say.

17 Q Confusing. Correct?

18 A Unable to be determined at that time.

19 Q You had a confusing and complex patient and you
20 really want to see what's going on inside her abdomen, CT
21 scan is the way to go?

22 A That's one way. I went inside her abdomen and
23 that's the description. I don't believe a CT would have
24 demonstrated a finding other than -- without it
25 demonstrating that finding. There was no abscess. There

Dr. James Williams - Cross-Examination by Mr. Corbin

1 was no other finding. The CT would not likely have even
2 shown that. It's a separate area.

3 Q Let's talk a little bit about abscesses and the
4 wound drainage and the foul smelling drainage. I bet you
5 had that cultured to see what it was, didn't you?

6 A No, sir.

7 Q Swabbed it, sent it to the lab, tell me what my
8 patient has. Did you do that?

9 A No.

10 Q The pocket of barium, you sent that to Pathology.
11 You said, examine this, tell me what it is. Didn't you?

12 A There was no test for that, no.

13 Q Okay. So you didn't send the barium that you
14 found to the laboratory. Correct?

15 A No.

16 Q Okay. The second surgery, when you went inside
17 her abdomen, you found her intestines and it was -- you
18 described it as spaghetti or a ball of glue. Is it fair to
19 say that you encountered a ball of glue?

20 A Yes.

21 Q And -- let's put into perspective -- and if we're
22 talking, you know, 16 feet of bowel, it fits inside the
23 abdominal cavity, doesn't it?

24 A Yes.

25 Q Okay. And it's all wadded up. You can take an

Dr. James Williams - Cross-Examination by Mr. Corbin

1 extension cord, 16 feet, and it'd probably be about like
2 that, wouldn't it?

3 A No, sir.

4 Q How big would 16 feet be?

5 A I'm not sure I understand the question.

6 Q Yes, sir. Well it fits inside the abdominal
7 cavity. Right?

8 A All bowel fits inside the abdominal cavity.

9 Q And when you opened her up, you encountered the
10 ball of glue and --- just like the first surgery when you
11 said you had to find out where you were, you didn't know
12 where you were, so you went to a landmark, Ligament of
13 Treitz to find out where you were. Second operation, you
14 go ahead, you had troubles again, locating organs and
15 differentiating between bowel and organs, didn't you? It
16 was tough.

17 A It was a difficult operation.

18 Q It was tough and I bet you got an experienced
19 surgeon to help you. Didn't you?

20 A I did the procedure.

21 Q Faye deserved to have an experienced surgeon to
22 help you. Correct?

23 A I am an experienced surgeon and I did the
24 procedure.

25 Q Did you have an experienced surgeon help you for

Dr. James Williams - Cross-Examination by Mr. Corbin

1 this complex difficult surgery?

2 A I did not have another surgeon help me with the
3 surgery.

4 Q You selected a resident. Correct?

5 A A surgeon -- a resident surgeon was the assistant
6 during the procedure.

7 Q Was he qualified to do that surgery by himself,
8 Doctor?

9 A No.

10 Q Okay.

11 A But I was.

12 Q Yes, sir. You started the surgery. You opened it
13 up, a ball of glue, you knew this is going to be a mess;
14 this is going to be difficult. I'm probably going to
15 encounter an enterotomies. Correct?

16 A I did. So --

17 Q Okay. At that point in time, you had an option?
18 Okay. You had an option to proceed and probably cause
19 holes in her bowel or to sow her up, NG Tube, TPN. Let's
20 wait until this hostile abdomen is less. You had that
21 option, didn't you?

22 A Yes. In my opinion, it was reasonable and prudent
23 to proceed in the direction that I saw.

24 Q Okay. And so when you proceeded -- the resident's
25 not in charge of the surgery, is he?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A No, sir.

2 Q Okay. This is your surgery. Right?

3 A Yes, sir.

4 Q Okay. So you made the decision knowing, I'm
5 probably going to cause holes in Faye's body. I've got a
6 mess here; it's a ball of glue, but I'm going forward.
7 Correct?

8 A No, not quite that.

9 Q Did you proceed?

10 A It's all a process. I did the procedure.

11 Q Okay. You proceeded and you proceeded to cause
12 multiple holes in her body. Correct?

13 A Yes. In the course of the procedure, enterotomies
14 developed in the course of taking out the glue, the bowel,
15 yes.

16 Q Who caused them?

17 A In the course of the operation, I induced those as
18 I proceeded to operate on the bowel.

19 Q And did you cause multiple all at one time? Did
20 you cause multiple holes all at one time?

21 A No.

22 Q Okay. So when you go in there you know, if I
23 continue I'm going to cause enterotomies, or holes. You
24 start causing holes. At that point in time, you also had
25 the option to fix the damage that you've done and get out.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Correct?

2 MR. MCDOW: I want to object to the statement
3 qualifying the question in the testimony.

4 THE COURT: Rephrase the question, please, Mr.
5 Corbin.

6 BY MR. CORBIN:

7 Q When you started causing the holes, not all at
8 once -- let's talk about after you caused the second one.
9 At that point in time you knew, continue with this gall of
10 glue -- I'm probably going to cause more enterotomies.
11 Correct?

12 A I don't know. You have to do the procedure to
13 know. You don't necessarily know that you're going to
14 cause more. They just occur as you proceed through the
15 operation.

16 Q Were you concerned after causing two, her
17 condition was so poor in the intestines, I'm probably going
18 to cause more? Were you concerned about that?

19 A Yes.

20 Q Okay. So when you caused two holes in her bowel
21 and you had concerns, if I continue, I'm probably going to
22 cause more holes in her bowel, an option you had as a
23 surgeon was to stop the proceeding, give her TPN and let's
24 come back another day. Correct?

25 A Yes, at some point, the other options in this

Dr. James Williams - Cross-Examination by Mr. Corbin

1 procedure, things went to the way that I thought it was
2 reasonable to proceed and finish the operation as
3 described.

4 Q Do you know what Faye would have wanted you to do
5 if you would have -- let's assume that she could
6 communicate with you. And you were doing what you thought
7 she wanted, right?

8 A Yes, I was there to make her better. To help her,
9 make her better.

10 Q Yes. And your job was only to do what she wanted
11 you to do. Correct?

12 A I'm not sure I understand the question.

13 Q Can you do something on her that she instructs you
14 not to do?

15 A No.

16 Q So the only thing that you could do to her is what
17 she wants you to do. Correct?

18 A Yes.

19 Q Okay. So when you're in there, enterotomy hole
20 number one, enterotomy hole number two, and if I go forward
21 there's going to be more holes. Did you even give any
22 thought to Faye? I wonder if she'd want me to stop and
23 quit causing holes? Did you think about that?

24 A I always think of what's in the best interest of
25 patients. So yes. The procedure -- yes, we do think about

Dr. James Williams - Cross-Examination by Mr. Corbin

1 the patient that we're operating on.

2 Q But it didn't stop you. Did it? Did it stop you?

3 A No, I continued with the procedure and finished the
4 procedure.

5 Q And you continued the procedure and you caused
6 multiple holes in her bowel. Correct?

7 A Yes.

8 Q And the way you made her better, or to fix her
9 situation, you decided to take the multiple enterotomies,
10 could be as many as ten -- fair?

11 A I don't think it was that many. You asked me how
12 many there were and you said less than ten? And I said,
13 yes, less than ten.

14 Q Yes, sir. But we do know that you didn't put it
15 in your records. Correct?

16 A The specific --

17 Q It's not --

18 A --number is not listed; no it is not.

19 Q So your solution to fix Faye's problem, after
20 multiple enterotomies, was, I'm going to go to one end of
21 her bowel and the other end of her bowel and I'm going to
22 cut everything out in between it. Correct?

23 A As I described earlier, the most diseased portion
24 that had been operated on now four times was removed, her
25 main portion left, and put back together.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Did you fix her?

2 A At the end of the procedure, I would say that yes,
3 it was fixed.

4 Q Did you tell Ms. Faye, after she came to, oh by
5 the way -- just what you told the jury, did you tell her,
6 your patient?

7 A Yes, absolutely.

8 Q Was she pleased with you?

9 A She didn't express emotion such as that.

10 Q When you told her, I had the option to stop when I
11 caused one or two holes but I made the decision to go
12 forward and removed a large portion of your bowel, was she
13 happy about that? Or did you tell her?

14 A I told her, yes, that she had -- what the procedure
15 was, exactly as it was described.

16 Q Is it your testimony you told her how much bowel
17 you removed?

18 A Yes.

19 Q How much did you tell her?

20 A Well, I didn't list the number, no.

21 Q Okay.

22 A No.

23 Q But how in the world can you tell her how much
24 bowel you removed if you don't tell her the number? How do
25 you do that?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Well, you describe the procedure the way that she
2 understands it. A portion of the bowel was removed, so
3 it's described in layman's terms.

4 Q Did you tell her, I caused so many holes I didn't
5 count them?

6 A No.

7 Q She didn't have a right to know about this?

8 A I didn't tell her.

9 Q Okay. You didn't tell her because she didn't have
10 a right to know that, did she?

11 A No, sir, that's not the reason.

12 Q If she had the right to know it, you would tell?

13 A Yes, I told her that -- the difficulty of the
14 procedure and what was necessary to correct her problem.

15 Q So if you tell someone, Gosh I had a difficult
16 procedure but I did what to correct your problem, did you
17 tell her you caused multiple holes?

18 A I don't remember whether I said specifically those
19 words.

20 Q Did you tell her -- Well, you took out a large
21 portion of the bowel, would you disagree?

22 A I took out, as described, the ileum which is about
23 twenty inches, as described.

24 Q Almost two feet. Did you tell her, I took out
25 almost two feet of your bowel?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A I don't recall that I specifically said those
2 numbers.

3 Q Well, she had a right to know that, didn't she?
4 That was her body part that you removed. She had a right
5 to know that?

6 A Yes. I didn't say she didn't. I just don't recall
7 I specifically said two feet.

8 Q Now after the second surgery, your progress
9 notes -- and you went through some yesterday and I think
10 you skipped a few. But you went through some yesterday --

11 **MR. CORBIN:** Let's hand him the notes.

12 **BY MR. CORBIN:**

13 Q Let's focus on how Faye did after you fixed her
14 problem with the second surgery. You would agree, and
15 yesterday you kind of explained, the green, brown,
16 foul-smelling wound drainage, really wasn't a red flag to
17 you, was it, on post-operative day two?

18 A I never saw it, it was never brought to my
19 attention. I don't believe it was there.

20 Q If you don't see it, it's not there, correct?

21 A If I don't know it, I don't know it. I can't speak
22 about what I did not know.

23 Q Well, you read the records, didn't you? To treat
24 your patient?

25 A The --

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q How can you properly treat your patient if you
2 say, Unless I see it, I don't know it, unless you read the
3 records when you're treating your patient. How can you do
4 that?

5 A I admit, I did not see the brown-green drainage and
6 was not aware of it and I have no response; I don't know
7 what to say.

8 Q If it was there and you missed it, that's a
9 violation of the standard of care, correct?

10 A It was not there.

11 Q Doctor, assume. Let's assume some other doctor
12 was there. Let's take you out of the picture. Assume
13 another surgeon was there and your patient, post-operative
14 day two, when you believe she was a high risk of a
15 perforation, had brown and green foul-smelling pus coming
16 out of her wound, he needs to check on that, doesn't he?

17 A Given that situation, yes.

18 Q If he misses it, it's a violation of the standard
19 of care; is it not?

20 A It could be.

21 Q It is a huge red flag to surgeons, correct?

22 A It could be.

23 Q Would you at least agree after the second surgery,
24 if you would have seen green or brown drainage following
25 Faye's wounds, that would certainly prompt your attention,

Dr. James Williams - Cross-Examination by Mr. Corbin

1 wouldn't it?

2 A Yes.

3 Q Because a nurse didn't write that down, right?

4 A Right.

5 Q A doctor did, right?

6 A Yes.

7 Q And sometimes you have a question about whether or
8 not the nurses know what, for example, purulent drainage
9 really is? They're not doctors, right?

10 A Yes.

11 Q And in Faye's records, between the first and
12 second operation, there were numerous references by the
13 nurses about foul-smelling, purulent drainage, right?

14 A There were several references about purulent, yes.

15 Q And you were aware of that, weren't you?

16 A I saw yellow drainage from the incisions that I
17 described yesterday. From the old jp site, as described.

18 Q If the nurses knew what they were talking about
19 and the drainage -- can't put my hands on it. But assume
20 the nurses for four or five days in a row, they saw what
21 they thought was large amounts of purulent, foul-smelling
22 drainage coming from the wound. Would that get your
23 attention?

24 A Yes.

25 Q Would you believe it to be true?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A I saw it myself and recognized it was yellowish,
2 but not purulent.

3 Q We're going to look at some of your progress notes
4 after Faye's second surgery.

5 A Okay.

6 Q Yes, sir. Yes, sir. And I'm going to ask you a
7 few questions before we get into that.

8 Now, before the second surgery, the day before, now
9 Faye gets an NG Tube, correct?

10 A Yes.

11 Q But the foul-smelling, brown, black stuff and gunk
12 came out of her abdomen, correct?

13 A Yes.

14 Q Two plastic bottles full, correct?

15 A I don't remember.

16 Q Don't have the number, but did the number make any
17 difference to you?

18 A I don't know the number today.

19 Q Would it make any difference to you that it made
20 Faye feel better?

21 A Yes.

22 Q Because the purpose of the NG Tube was to treat
23 what she was complaining about for 32 days: Distention --
24 it treats that, correct?

25 A Yes.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Nausea and vomiting; it treats that, correct?

2 A Yes.

3 Q Abdominal pain; it treats that, correct?

4 A Yes.

5 Q Those were her complaints, weren't they?

6 A Yes, and an NG Tube had been offered on numerous
7 occasions.

8 Q We're going into get into that in a minute.

9 A Okay.

10 Q But the way Board certified surgeons and
11 gynecological oncologists treat distention; nausea --
12 persistent nausea and vomiting, sometimes fecular; and
13 abdominal pain, the simplest way is NG Tube, correct?

14 A Yes.

15 Q Especially if a patient is taking medication for
16 nausea and vomiting and she's throwing it right back up,
17 correct?

18 A Yes.

19 Q She's a candidate for NG Tube, correct?

20 A Yes.

21 Q If you allow that distention and somebody, it
22 might have been you, talking about a garden hose. If you
23 cut the portion out of the garden hose and you sew it back
24 together, if you allow water pressure to build and build
25 and build, and her intestines were three or four times the

Dr. James Williams - Cross-Examination by Mr. Corbin

1 normal size? Six, seven centimeters? Right?

2 A No, no, not at the time of the surgery.

3 Q During the time of her distention, is it your
4 testimony that her small intestine was not dilated to six
5 centimeters or more?

6 A There was one reference on her upper GI, but who --

7 Q So we got the water hose cut, sewn back together,
8 water coming through it, pressure building, and you
9 testified that the pressure building certainly puts
10 pressure on the repair spot, correct?

11 A Yes.

12 Q If you allow that pressure to continue, the index
13 of suspicion goes even higher that there might be a bowel
14 leak. Correct? That water hose has got a leak. Right?

15 A Could you repeat the question?

16 Q If you allow that water to continue to build
17 pressure and put pressure on the repair spot, eventually
18 it's going to leak, correct?

19 A No, not in all cases. Eventually it heals.

20 Q In Faye's situation, do you have -- how many
21 times -- well, you say that you -- while you know that
22 proper treatment for the condition you diagnosed Faye as
23 having was small bowel obstruction, or ileus, correct?

24 A Yes.

25 Q Certainly not the perforation, correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes.

2 Q Certainly not a fistula. Correct?

3 A Yes.

4 Q Certainly not peritonitis. Correct?

5 A Yes.

6 Q Small bowel obstruction or ileus. The proper way
7 to treat that is you put the patient on IV new -- what do
8 you call it? What nutrition?

9 A TPN.

10 Q Well TPN and you do the IV's?

11 A Yes.

12 Q Correct?

13 A Yes.

14 Q TPN and IV's, bowel rest, nothing by mouth, and NG
15 tube; that's the standard way to do it?

16 A Yes.

17 Q That's the basic way to do it?

18 A Yes.

19 Q That's the standard of care or way to do it?

20 A Yes.

21 Q Faye did not have an NG tube until the day before
22 her surgery, correct?

23 A Yes.

24 Q Your testimony is, under the standard of care, she
25 should have at least been offered and should have had the

Dr. James Williams - Cross-Examination by Mr. Corbin

1 chance to have it, correct?

2 A Yes.

3 Q Your testimony is that -- you didn't put anything
4 in the record about that, in fact, did you?

5 A No, I did not. It's put in at one point, but I did
6 not.

7 Q Let's focus on what you did. Never, during those
8 32 or 33 days, did you write anything in your records, I am
9 offering Faye NG tube? Nothing like that, is there?

10 A No.

11 Q No documentation. Correct?

12 A No.

13 Q And under the standard of care, progress notes are
14 supposed to be accurate and correct. Fair?

15 A Yes.

16 Q If a patient declines or refuses to accept your
17 advice in a situation that could cause her danger; you're
18 required to document that, are you not?

19 A Yes. I did not document that.

20 Q And doctors, if you have a patient refusing a
21 treatment, that if she refuses it, it's going to cause her
22 some harm, you document that all over the record, don't
23 you?

24 A Yes.

25 Q And you failed to document one time. Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes.

2 Q And you tell this jury numerous times, numerous
3 times, I told her you need it. She rejected it. But you
4 didn't take the time to put that in her records even a
5 single time, didn't you?

6 A I didn't write it down. Dr. Smith had written it
7 earlier, I did not write it down.

8 Q And the reason why you said she refused it is
9 because, Doc, this fecular vomiting isn't too bad? Let me
10 do it. I'd rather do that than have an NG tube and get rid
11 of it. Is that your testimony?

12 A No, sir.

13 Q Is it your testimony that when you told Faye, you
14 need an NG tube, did you tell her, Faye, that's how we
15 treat nausea and vomiting? It'll go away. That's how we
16 treat your distention. It'll go away. That's how we treat
17 your abdominal pain. It'll go away. Did you tell her?

18 A Yes.

19 Q She refused and told you, I would rather vomit. I
20 would rather have my distention. I'd rather have my pain
21 instead of this tube. Correct?

22 A Yes, as I said yesterday. She said that she only
23 put -- the time that was discussed, she only vomited a
24 couple of times and she'd rather have that than the NG
25 tube.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Well, you had discussed it all through the
2 hospitalization, didn't you?

3 A Yes, it was discussed at different times.

4 Q Well, it better be discussed early on. Right?

5 A Yes.

6 Q When she first needs it, that's when you first
7 need to offer it to her. Correct?

8 A Yes.

9 Q When the persistent nausea and vomiting comes, you
10 better be offering the NG tube to her. Correct?

11 A Yes.

12 Q And it's your testimony that after you offered it
13 to her by post-op day two, three, something like that?

14 A Dr. Smith offered it to her that day and that's the
15 day --

16 Q Okay.

17 A -- that she refused it.

18 Q Well let's talk about when you offered. You said
19 you offered it early on. How far into this 32 day period
20 did you start your persistent offering of the NG tube?

21 A After about day seven.

22 Q Okay. After day seven. And she didn't have
23 nausea and vomiting after that?

24 A She did.

25 Q In fact, you know the jury will have this to -- it

Dr. James Williams - Cross-Examination by Mr. Corbin

1 looks like every day -- post-operative day 17 for example.
2 She had five episodes of nausea and vomiting. Vomiting was
3 persistent. Vomiting was large, thick, foul-smelling.
4 Vomiting was yellow. She said, Do not give me that NG tube
5 that day, didn't she?

6 A I don't recall that specific day.

7 Q So no CT scan. No proof you offered NG tube. No
8 culture of the wounds. Let's look at what you did after
9 the second operation. Could you come down here, Doctor,
10 please?

11 **MR. CORBIN:** May I show him on the screen, Your
12 Honor, it might be easier.

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

14 **THE COURT:** Everybody on the jury okay? Anybody
15 need to take a break?

16 (Whereupon, there was no response from the jury.)

17 **THE COURT:** Okay. Go ahead and step down, please.
18 Keep your voice up, if you don't mind.

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

20 **BY MR. CORBIN:**

21 Q Now, you felt like you'd fixed Faye's problem, in
22 that May 28 surgery. Correct?

23 A Yes.

24 Q And if there just were green or brown drainage,
25 that red flag would fly in your face, correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A It creates concern.

2 Q Did you have any concern before you went on
3 vacation? From the time you did the second operation until
4 you went on vacation, my patient's in trouble. Did you?

5 A I had concern about this one.

6 Q You see what's on the screen?

7 A Yes.

8 Q May 31, post-op day three. Is that your
9 signature?

10 A No.

11 Q That your resident?

12 A Yes.

13 Q Do you have a duty to read -- when you're not
14 there and the resident covers for you, you've got to read
15 what he put. Correct?

16 A Yes.

17 Q And if he just would have said there's green-brown
18 output from the drains, that would be a red flag, wouldn't
19 it?

20 A Yes.

21 Q When you read here, jp green-brown output, that
22 got you concerned, didn't it?

23 A This jp was in the area of the surgical-bowel that
24 was stuck and where we did have, really, the only soiling
25 at the time of the operation. That was good that it

Dr. James Williams - Cross-Examination by Mr. Corbin

1 drained that potential; that was observed, watched -- we
2 were going to watch that at that time.

3 Q Was it --

4 A She otherwise was -- was doing okay, was
5 controlling herself. We did note that and I did note that
6 at that time.

7 Q Worried about a surgical mishap?

8 A Could be. She did have a complicated surgery at
9 that time.

10 Q And most of the time, green-brown output right
11 after surgery does indicate surgical mishap?

12 A Well, it was in the area where green-brown fluid
13 was found in the first place, so it was one of the known.

14 Q And you didn't know which one it was?

15 A Not at that time.

16 Q Did you do a CT scan?

17 A I didn't do a CT of that.

18 Q Okay. Let's see what's going on the next day.

19 How long does a CT scan take?

20 A Up to an hour. Up and back, maybe.

21 Q Doctor, please return to your seat.

22 On 06/01 -- we know you didn't do a CT scan on May
23 28. You knew it was a red flag of a surgical mishap, but
24 you decided not to do a CT scan; you're going to watch it.
25 Correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes.

2 Q And then on 06/01 -- let's go down to 06/02 -- did
3 you see more brown-green drainage before your vacation?

4 A Can I look at the board?

5 Q Yes, sir. We're going to put it on the screen in
6 just a second. But do you recall -- I mean, that's
7 something that you would remember?

8 A Well, I noted that.

9 Q Yes, sir.

10 A And watching her trying to decrease that.

11 Q Yes, sir. And it was there on June 1st, too?

12 A I have to look at that specifically.

13 Q And that your records indicate that your resident,
14 again, found brown and green drainage. Did it change her
15 course of treatment in anyway?

16 A No, there was no difference at that time. We were
17 continuing to watch.

18 MR. MCDOW: Page 1035 if you need to refer to the
19 hard copy in front of the 06/01 notes.

20 MR. CORBIN: You see the note on 06/01.

21 MR. MCDOW: Page 1035.

22 MR. CORBIN: Thank you. Can you look up there?

23 THE WITNESS: Page 1035.

24 BY MR. CORBIN:

25 Q And the first records on 06/01 is where you

Dr. James Williams - Cross-Examination by Mr. Corbin

1 examined the patient?

2 A Yes.

3 Q And you said that she's doing well?

4 A I said, complaints of some abdominal cramps.

5 Q And then --

6 A Afebrile.

7 Q And then, I guess, your resident -- what -- the
8 resident saw her at 4:30 in the afternoon -- Said she's
9 doing okay and it says jp, at least now the output of the
10 green-brown color, the drainage is going down. Correct?

11 A Correct.

12 Q Did you check for perforation?

13 A At that time, I did not do any -- the CAT scan or
14 other --

15 Q Yes, sir. 06/01, we notified Dr. Parker; he went
16 in 06/03, correct?

17 A Yes.

18 Q And he found perforation?

19 A Yes, she did have a perforation.

20 Q Would you agree that on 05/28, when you have a red
21 flag of green-brown drainage, potential surgery mishap.
22 And 06/01, you're again notified green-brown drainage, red
23 flag, surgical mishap? That's an indication that she had a
24 perforation that Dr. Parker later found, isn't it?

25 MR. MCDOW: I'm going to object to the testimony --

Dr. James Williams - Cross-Examination by Mr. Corbin

1 THE COURT: Sustained.

2 MR. MCDOW: -- statement.

3 THE COURT: Sustained.

4 MR. MCDOW: Thank you. The facts aren't in
5 evidence.

6 BY MR. CORBIN:

7 Q Green-brown drainage is consistent with a
8 perforation. Correct?

9 A It can be.

10 Q Yes, sir. Green-brown drainage May 28 is
11 consistent with a surgical mishap. Correct?

12 A That was the day of her surgery. I'm a little
13 confused.

14 Q Okay. The previous reference, 5/30, the reference
15 there about the green-brown drainage by your intern -- or
16 resident. We just talked about that.

17 A 5/31.

18 Q Yes, sir, 5/31. That's a red flag of a potential
19 mishap. Correct? Perforation. Correct?

20 A It was a red flag and it was -- it was jp in that
21 into an area. That was the area that we were continuing to
22 watch. We had a marker there with the jp --

23 Q Yes, sir. And then --

24 A -- below the drains.

25 Q Yes, sir. And then 6/01, again you have an

Dr. James Williams - Cross-Examination by Mr. Corbin

1 indication, green-brown drainage, consistent with a
2 perforation. Correct?

3 A Well, it's going down. In the area where the
4 green-brown was being evacuated because of the jp in there.
5 Because the previous surgery, the green-brown is where it
6 was -- the drain was placed where the surgical finding was
7 noted on 5/28.

8 Q It was --

9 A There was green-brown, watch it now, but there was
10 still little information there. That was left to prevent
11 infection or any other issue. As it went down, we
12 continued to watch. So some output from there may have
13 been expected to be this color.

14 Q When you saw the green-brown drainage on these two
15 occasions, your assumption was, it's not perforation,
16 right?

17 MR. MCDOW: I'm going to object to that. It's not
18 a fact in evidence ---

19 THE COURT: Sustained.

20 MR. CORBIN: The two references to brown-green
21 drainage --

22 MR. MCDOW: I don't know if he's referencing the
23 first surgery or if he's saying there's two after the
24 second surgery.

25 THE COURT: Clarify that. I think he's talking

Dr. James Williams - Cross-Examination by Mr. Corbin

1 about post-second surgery.

2 MR. CORBIN: Yes, sir.

3 THE COURT: Is that right, Mr. Corbin?

4 MR. CORBIN: Yes, sir. Absolutely.

5 BY MR. CORBIN:

6 Q Dr. Williams, we're only talking about what
7 happened after the second surgery.

8 A Yes, sir.

9 Q Between then and when you went on vacation.

10 A Yes, sir.

11 Q Okay. And during that three or four day period,
12 on at least two days, according to these records, you saw
13 green-brown drainage. Correct?

14 MR. MCDOW: Same objection.

15 BY MR. CORBIN:

16 Q Correct.

17 A Yes.

18 Q And you indicated that could be a sign of a
19 perforation, correct?

20 A Yes.

21 Q You went on vacation, correct?

22 A Yes.

23 Q Dr. Parker comes in June 3rd, opens her abdomen
24 and finds the perforation, correct?

25 A Yes.

Dr. James Williams - Cross-Examination by Mr. Corbin

1 Q Are you telling this jury that the references
2 after the second surgery, May 30th and June 1, we assume
3 she did have a perforation, that really was a perforation,
4 wasn't it?

5 A It turned out to be, yes.

6 Q And you were wrong?

7 A I had not made an assessment at that time. We were
8 continuing to watch that area and it evolved over those
9 next 24 to 48 hours; it was a perforation, yes.

10 Q Your diagnosis that she was not suffering from a
11 perforation was wrong, correct?

12 A Yes.

13 Q A CT scan taken on 5/30 would show the
14 perforation, correct?

15 A Possibly. She didn't really present with dramatic
16 changes until the other day -- two days. There was no
17 indication on 5/30.

18 Q The two --

19 A There was no green-brown drainage on 5/30.

20 Q 5/31?

21 A 5/31, she had green-brown drainage, yes, sir.

22 Q You completed the second operation; you sewed Faye
23 back up. She was doing well before you went on vacation.
24 Dr. Parker comes in, he's required to do four corrective
25 surgeries, correct?

Dr. James Williams - Cross-Examination by Mr. Corbin

1 A Yes, sir.

2 Q Okay. And that all relates back to your second
3 surgery, correct?

4 A It was following the second surgery, yes.

5 Q Faye spends 60-some days in the hospital, correct?

6 A Yes.

7 Q Her medical bills are \$570,000, correct?

8 A Yes.

9 Q Did you get paid?

10 A I don't know. I don't keep up with her -- whether
11 she paid me or not.

12 Q Well, you certainly gave her a bill?

13 A I assume my office submitted her bill.

14 Q And if you send a bill to a patient and you don't
15 get paid, you're going to follow up on that one, aren't
16 you?

17 A I don't do the billing.

18 Q Yes, sir.

19 **MR. CORBIN:** Your Honor, may we approach.

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

21 Go ahead, Mr. Corbin.

22 **MR. CORBIN:** Dr. Williams, I don't have anymore
23 questions at this time. Thank you.

24 **THE COURT:** Mr. McDow, any redirect?

25 **MR. MCDOW:** I beg the Court's indulgence. I ask

1 for just one minute, Your Honor.

2 THE COURT: All right.

3 MR. MCDOW: I have no follow-up questions for this
4 witness.

5 THE COURT: All right. Thank you, sir. You can
6 step down.

7 All right. Ladies and gentlemen, we'll take the
8 morning recess at this point. Obviously, you may not
9 discuss this case, but we'll have you back out in just a
10 few minutes and we'll continue with the presentation of
11 evidence.

12 All right. Thank you.

13 (Whereupon, the jury left the courtroom.)

14 THE COURT: All right. Your next witness, Mr.
15 McDow, will be Dr. Glen Strickland. I'm not going to ask
16 anymore how long y'all think it will take, but what's your
17 plan for before lunch?

18 MR. MCDOW: To get him off, at least.

19 THE COURT: The Direct part?

20 MR. MCDOW: Yeah, the Direct at a minimum.

21 THE COURT: Dr. Strickland?

22 MR. MCDOW: Strickland.

23 THE COURT: Okay. And he is going to -- he is the
24 expert witness or ---

25 MR. MCDOW: He's an expert surgeon.

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

2 (Whereupon, a recess was observed.)

3 **THE COURT:** All right. You can bring in the jury.
4 You've got Dr. Kohler on the way today?

5 **MR. MCDOW:** He will be here at two o'clock. I've
6 got Dr. Parker scheduled to be at the courthouse at 1:15.
7 I wasn't sure what time we'd be finished --

8 **THE COURT:** We're going to press on.

9 **MR. MCDOW:** We're pressing on. Yes, sir. I'm not
10 slowing down.

11 **MR. CORBIN:** And if I may, for the record, just
12 hand out the original deposition transcript of Dr.
13 Strickland. Just in case we need it.

14 **THE COURT:** All right. Thank you.

15 (Whereupon, the jury entered the courtroom.)

16 **THE BAILIFF:** The jury is seated, Your Honor.

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

18 All right. Mr. McDow?

19 **MR. MCDOW:** Thank you, Your Honor. The Defense
20 would call Dr. Glen Strickland to the stand, please.

21 **THE COURT:** If you would come around and be sworn.

22 **DR. GLEN STRICKLAND,**

23 having been duly sworn, testified as follows:

24 **THE CLERK:** Have a seat in the witness box and
25 state your full name for the record, please. Spell you

Glen Strickland - Direct Examination by Mr. McDow

1 first, please.

2 THE COURT: Your first name is spelled with one N?

3 THE WITNESS: Yes, sir. Yes, sir. My name is Glen
4 Strickland. My first name is spelled G-L-E-N.

5 THE COURT: All right.

6 **DIRECT EXAMINATION**

7 **BY MR. MCDOW:**

8 Q All right, Dr. Strickland, if you could, please
9 tell the jury where you practice medicine and what do you
10 do and what the name of your practice is?

11 A I'm a general surgeon at Lexington Hospital. I
12 have privileges in all hospitals in town. I'm with
13 Riverside Surgical Group.

14 Q Okay. Doctor, let's go back and start with your
15 education. Where did you go to undergraduate school?

16 A I went to Vanderbilt.

17 Q Okay. I have your curriculum vitae in front of
18 me. Did you graduated with honors from Vanderbilt?

19 A Magna cum Laude.

20 Q And what year did you finish Vanderbilt?

21 A 1980.

22 Q And then did you go on to medical school after
23 that?

24 A Yes, sir. I was born in Columbia, raised in Little
25 Rock. Went back to my home town in Little Rock, University

Glen Strickland - Direct Examination by Mr. McDow

1 of Arkansas Medical School.

2 Q And what year did you finish medical school?

3 A Medical school was 1980 to 1984.

4 Q And after you finished medical school, what did
5 you do?

6 A I started my general surgeon residency. It's a
7 six-year program here at the University of South Carolina
8 in Columbia.

9 Q Okay. Let me back up. You also said that you're
10 from Columbia originally, but it says you went to Park View
11 High School. Where is that?

12 A That's in Little Rock.

13 Q Okay. And you were valedictorian in your high
14 school as well?

15 A Yes, sir.

16 Q Now, when you finished medical school and you came
17 to USC -- you went to USC School of Medicine; is that
18 right?

19 A No, sir. I went to --

20 Q I'm sorry. You did your residency?

21 A Yeah. I did my residency here. It was a six-year
22 surgical program here.

23 Q Okay. Tell us about what the surgical program
24 consists of.

25 A Well, it's a general surgical program which

Glen Strickland - Direct Examination by Mr. McDow

1 basically deals with all the bread and butter of -- general
2 surgery covers a lot: Trauma, gut surgery, GI surgery.
3 Our program here was very diverse. We did a lot of
4 vascular surgery, wound surgery, urologic surgery. Not
5 having the benefit of a lot of fellows, we wound up doing
6 the duties without them. So we did -- we did a broad range
7 of general surgery.

8 Q You said something about not having the benefit of
9 fellows, but I see on your curriculum vitae that you did a
10 fellowship. What is a Fellowship?

11 A A fellowship is additional training beyond your
12 residency and I did a one year additional training in
13 plastic surgery at the University of Texas at Dallas.

14 Q Okay. What hospital were you at in Dallas?

15 A We were at seven hospitals, but the main hospital
16 was Parkland Memorial.

17 Q And what year, Doctor, do you recall, that you
18 finished your Fellowship?

19 A 1991.

20 Q All right. After you completed your Fellowship,
21 what did you do?

22 A Went into private practice in Texas for three
23 years -- two years in Texas.

24 Q And then where did you go after that?

25 A Came back to Columbia. Practiced at Lexington

Glen Strickland - Direct Examination by Mr. McDow

1 Hospital. Been there ever since.

2 Q All right. And again, what is the name of your
3 current practice?

4 A Riverside Surgical.

5 Q All right. Dr. Strickland, does your surgical
6 practice include bowel surgery?

7 A Yes, sir.

8 Q Does it include post-op ileus?

9 A Yes, sir.

10 Q Does it include full or partial small bowel
11 obstruction?

12 A Yes, sir.

13 Q Does it include anastomosis and re-anastomosis of
14 the bowel?

15 A It does.

16 Q Does it include the diagnosis -- diagnosis of
17 perforation and leaking of the bowel?

18 A Yes, sir.

19 Q Dr. Strickland, does your general surgery
20 practice, is it similar to what was done in this case that
21 we have here today?

22 A Yes, sir.

23 Q Can you estimate for me how many surgeries you
24 have done in your career?

25 A I'm very fortunate that I do 500 to 700 cases a

Glen Strickland - Direct Examination by Mr. McDow

1 year. I have since I've been in practice. So twelve,
2 fourteen thousand cases.

3 Q All right, sir. Are you Board certified?

4 A Yes, sir.

5 Q And by what groups?

6 A The American College of Surgeons.

7 Q What is involved in becoming Boards certified?

8 A Well, when you finish your residency, you take a
9 written exam; and if you pass that, you take an oral exam;
10 and if you pass that, you are entered into the group of
11 fellows; and then ultimately they approve and you pass.
12 And once you become Board certified in general surgery, you
13 have to repeat your Board exams every 10 years.

14 MR. MCDOW: Your Honor, at this time, we would
15 present Dr. Strickland as an expert in the field of general
16 surgery for the issues relayed in this case.

17 MR. CORBIN: No objection, Your Honor.

18 THE COURT: All right. Ladies and gentlemen, as
19 I've mentioned to you before -- well, first of all, the
20 witness is qualified as an expert in the field of general
21 surgery.

22 As I've explained to you before, you give his
23 testimony the weight that you believe it deserves and as I
24 mentioned earlier, you do not have to accept testimony of
25 an expert just because it comes from an expert.

Glen Strickland - Direct Examination by Mr. McDow

1 All right, Mr. McDow.

2 MR. MCDOW: Thank you, Judge.

3 BY MR. MCDOW:

4 Q Dr. Strickland, at my request you agreed to review
5 the medical records in the way of Dr. Williams' care and
6 treatment in the care of Ms. Atkinson?

7 A Yes, sir.

8 Q Okay. Do you have a list of what records you did
9 review in this case?

10 A I've reviewed the medical records from Richland;
11 I've reviewed the plaintiff's witness who were -- the names
12 were Dr. Irvin, there's a Dr. Belaro, Dr. Bailey. And then
13 I've read Dr. Kohler, who's the GYN oncologist for MUSC;
14 Dr. Terry Smith, Dr. Parker, and of course, Dr. Williams.

15 Q All right. And you have -- did you bring your
16 notes with you today relative to chronology and so forth?

17 A I did.

18 Q Yeah, it's very -- if you need to refer to that,
19 please do.

20 All right. You mentioned reviewing the records.
21 Did you review any of the actual radiology films?

22 A I did not review the original films, I reviewed --
23 I didn't review all the films, I saw some of the films. I
24 reviewed probably most of the radiologists' reports. It's
25 about a 2,000 page record.

Glen Strickland - Direct Examination by Mr. McDow

1 Q All right. Very good. Following your review of
2 all the medical records, did you then contact me with what
3 your impressions were?

4 A I did.

5 Q Okay. What was your initial impression of this
6 case after you reviewed the medical records?

7 A I felt like this was a very difficult case and
8 given the difficult circumstances, the doctors taking care
9 of her did a good job. They did the best they could.

10 Q Dr. Strickland, did you see anything in the
11 medical records that indicated to you that Dr. Jimmy
12 Williams had violated the standard of care or the treatment
13 that he gave Ms. Atkinson?

14 A No, sir.

15 Q Doctor, do you have an opinion to a reasonable
16 degree of medical certainty that Dr. Williams complied with
17 generally accepted standards of care?

18 A I believe he did comply.

19 Q Dr. Strickland, are you planning on giving your
20 opinion on the informed consent process as it relates to
21 the initial surgery on April the 25th, 2007?

22 A No, sir.

23 Q Why not?

24 A Well, the question about whether or not she should
25 have had the first operation really deals with

Glen Strickland - Direct Examination by Mr. McDow

1 gynecological cancers and I'm really not an expert in that
2 area, so I can't comment about that.

3 Q All right. Today, we're going to ask you a number
4 of questions about your medical opinion. Do you agree that
5 when you answer those questions and give the jury opinions,
6 you will be doing so to a reasonable degree of medical
7 certainty?

8 A Yes, sir.

9 Q Dr. Strickland, in your opinion, did Dr. Williams
10 comply with the standard of care in treating this patient
11 in the immediate post-operative period after April the
12 25th, 2007?

13 A Yes, sir.

14 Q What about over the next 33 days before going back
15 to surgery on May 28th, 2007? Do you have any opinion as
16 to whether that complies with the standards of care there?

17 A He met the standards of care, yes, sir.

18 Q And, Doctor, do you have an opinion to a
19 reasonable degree of medical certainty as to whether or not
20 Dr. Williams complied with the standard of care with the
21 return and performance of the second surgery?

22 A He met the standards of care, yes, sir.

23 Q In your opinion, did Dr. Williams comply with the
24 standards of care in obtaining a consult by Dr. Parker on
25 May the 21st, 2007?

Glen Strickland - Direct Examination by Mr. McDow

1 A Yes, sir.

2 Q Do you believe a surgical consult should have been
3 obtained any earlier?

4 A No. I think that the family requested that. I
5 think that everything was done up until that point was done
6 for her and to the best of the treating doctor's ability to
7 take good care of her and Dr. Parker by reputation is a
8 very good general surgeon and I think it was appropriate to
9 get him involved.

10 Q Have you rendered general surgery second opinion
11 such as that rendered by Dr. Parker in this case?

12 A Yes, sir.

13 Q Does Dr. Williams have a right to rely on the
14 second opinion of Dr. Parker?

15 A Yes, sir.

16 Q In your opinion to a reasonable degree of medical
17 certainty, did Dr. Williams comply with generally accepted
18 standards of care with the surgery of May 28th, 2007?

19 A He did.

20 Q Now, Dr. Strickland, let me go back and ask you
21 some of the specific information in the medical records.
22 In your opinion, was Ms. Atkinson ever septic between the
23 first and second surgery?

24 A No.

25 Q Okay. Tell the jury what you mean by septic?

Glen Strickland - Direct Examination by Mr. McDow

1 A Septic -- there's a lot words y'all heard that are
2 descriptive and there's not a literal definition that you
3 can go by because it requires a lot of the opinion of the
4 doctor standing at the bedside. But if you're asking me to
5 tell you what septic means, septic is a sign of
6 overwhelming infection in somebody. Whatever the source
7 is. It could be a pneumonia; it could be a bladder
8 infection; it could be anything where there's pus in the
9 body.

10 And when somebody loses their ability to overcome
11 that infection, then things happen. Your heart rate goes
12 sky high. And when I say sky high, I'm talking about 120,
13 130, okay. Blood pressure drops. The patient becomes
14 neurologically impaired and confused. That's septic and it
15 would be the same regardless of the source of the
16 infection.

17 Q Was she -- you used the term nontoxic?

18 A Right.

19 Q What do you mean by nontoxic?

20 A Toxic is a word that is -- again, a lot of things
21 in medicine are art, you know. We're not as much
22 scientific as we have a lot of judgement calls. Toxic is a
23 descriptive -- description that a surgeon would use or a
24 doctor would use describing a patient that has an
25 overwhelming infection who are septic and therefore they

Glen Strickland - Direct Examination by Mr. McDow

1 look toxic. They are incredibly ill.

2 Q Did you -- did you ever see where -- between the
3 first surgery and the second surgery was she toxic?

4 A No, sir.

5 Q Do you believe that Ms. Atkinson ever had a small
6 bowel obstruction while Dr. Williams was treating her at
7 Palmetto Health Richland?

8 A She had a partial small bowel obstruction.

9 Q What about an ileus?

10 A An ileus, again, that's another word -- that's one
11 of those words we use. It's descriptive again. And I want
12 to illustrate that to you a little bit. An ileus is a
13 nonmechanical obstruction. It's a pseudo-obstruction. So
14 if I have the flu and my gut hurts real bad and I'm bloated
15 and I'm nauseated, I don't have bowel sounds if I had a
16 stethoscope and listened to my abdomen. But I don't need
17 an operation. I have the flu. So that's an ileus. Okay?
18 As opposed to a mechanical small bowel obstruction, which
19 is described by degrees. It's either a partial obstruction
20 or a complete obstruction.

21 Okay. So an ileus is a descriptive term. It's
22 nothing you could see or do.

23 Q Are patients after having surgery on -- involving
24 their bowel prone to having post-operative ileus?

25 A Yes.

Glen Strickland - Direct Examination by Mr. McDow

1 Q Why is that?

2 A Well, you're handling their intestines and as a
3 part of the coping mechanism, the body shuts down and tries
4 to recuperate and you get bloated, you get nauseated, you
5 lose your bowel sounds, and you know, as time goes on,
6 that'll recover.

7 Q All right. Dr. Strickland, does sometimes a
8 post-op ileus and post-op partial small bowel obstruction
9 present in the same manner?

10 A Yes.

11 Q What would be some of the common signs and
12 symptoms between those two?

13 A Well, again, a partial small bowel obstruction is a
14 partial mechanical obstruction which the body tries to
15 overcome and over time it either overcomes that and you
16 regain all your gut function again; or it doesn't and it
17 may shut down. And if it shuts down, you lose your bowel
18 sounds, and you could say you have an ileus. Okay. So you
19 lose your bowel sounds, you get bloated, all the -- air
20 gets in our gut when we talk and swallow. It's normal that
21 the air gets in. So if the air doesn't move through
22 because the bowel's not propulsing things through we get
23 bloated and that's an ileus.

24 Q Doctor, in your opinion, did Dr. Williams
25 appropriately manage the patient for a partially small

Glen Strickland - Direct Examination by Mr. McDow

1 bowel obstruction?

2 A Yes, sir.

3 Q Are you critical of Dr. Williams for not inserting
4 the NG tube after the first surgery until one was ordered
5 by Dr. Smith on May 27th, 2007?

6 A I'm not critical. Let me explain why. I'm 55
7 years old. When I first did my training, a lot of things
8 were set in stone and those gastric tubes were ordered on
9 everybody. We did a lot of open big incisions on
10 everybody. Things were mandated. What we've learned over
11 time is, some of the things we did really didn't make sense
12 and we did them because we were taught to do them. One of
13 those things was the NG tube. An NG tube is a nasogastric
14 tube; it's a silicone tube, it's about two and a half to
15 three feet long. They come in different diameters. Some
16 of them are as big as your little finger. And you stick it
17 through the nose, down the back of the mouth, into the
18 stomach, and you can imagine how that feels, having that
19 tube. And if it's not going to benefit you, you certainly
20 don't want to do that to somebody. Besides the fact it
21 doesn't feel good, what it does is it makes them not get
22 out of bed. So we want people to get up and walk,
23 especially in conditions like this where you have a partial
24 bowel obstruction or an ileus. You recover your bowel
25 function when you're out of bed and you're walking. If I

Glen Strickland - Direct Examination by Mr. McDow

1 put that three foot long finger wide tube in somebody's
2 nose, they're not going to want to get out of bed.

3 Q Uh-huh.

4 A They're not going to want to walk and it actually
5 is a set up for pneumonia. We used to always put
6 nasogastric tubes in people in the intensive care unit on a
7 ventilator, but we learned they aspirate. They throw up
8 along the tube and it gets in their lungs. So there's a
9 lot of reasons now that we've gotten away from using NG
10 tubes without good reason.

11 Q You mentioned aspirate. What does aspirate mean?

12 A When you throw up and it goes into your lungs.
13 That's aspiration.

14 Q Did you note in -- well, let me back up. In your
15 opinion, was it a standard of care not to place an NG tube?

16 A Yes.

17 Q Did you note in the progress notes where Dr. Smith
18 suggested an NG tube to the patient, but she refused?

19 A She did refuse, he did suggest that. I think Dr.
20 Smith's opinion at that time, you know, no offense Dr.
21 Smith's a little bit older than us, he's old school, he's a
22 very good surgeon, that was his opinion at that time. She
23 refused it anyway.

24 Q Doctor, are you critical for Dr. Williams for
25 failing to order a CT scan at any time?

Glen Strickland - Direct Examination by Mr. McDow

1 A No.

2 Q Did he meet the standard of care by not -- did he
3 not meet the standard of care by not ordering a CT scan?

4 A He did not.

5 Q Why?

6 A Well, this lady had a partial mechanical small
7 bowel obstruction. That's what she was being treated for,
8 that's what she had. She had a small bowel follow through
9 ordered for early post-op which showed that -- small bowel
10 follow through is when you drink a jug of barium or
11 gastrografin and a radiologist takes x-rays of your
12 abdomen, follows it all the way through your small
13 intestine until it either hangs up, it leaks out, or it
14 reaches the colon, at which point the test is over. So if
15 you think somebody has a partial small bowel obstruction
16 and you want to know how it's doing, you get a small bowel
17 follow up. That's the test of choice.

18 CAT scan is a 3D image of your bowels, which does
19 not tell you whether or not contrast is going to make it.
20 That's not the purpose of a CT scan. You see, is it going
21 to make it to the colon or not? The CAT scan is a test
22 that's done in fifteen seconds now, so fast. You swallow
23 contrast, you get a fifteen second image, but that's it.
24 You don't get those delayed films to see if the contrast
25 actually makes it to the colon.

Glen Strickland - Direct Examination by Mr. McDow

1 The CT scan is radiation also. So you don't really
2 order radiation when it can cause some -- cause some other
3 things like that. So that's an expensive test. It's
4 also -- it's a lot of reasons. You want to be specific
5 about why you order the appropriate test.

6 Q Doctor, let me stop you right there. We have not
7 pulled up any radiology reports themselves, but you
8 mentioned something about multiple films or series or
9 photos of the small bowel follow through. How does that
10 work? Explain what exactly a radiologist would be looking
11 at, if you know?

12 A Again, if I order a small bowel follow through,
13 they're going to give you a big jug of chalky material to
14 drink. You're going to go down to the x-ray part and
15 they're going to take a film to see where it is. They're
16 going to keep you down there for however long it takes,
17 taking films until it makes it to the colon or gets
18 obstructed. So a normal small bowel follow through, you've
19 got to drink barium right now, the test will be over in
20 probably an hour. It makes it to the colon there's no
21 obstructed.

22 If you're partially obstructed, it will be delayed.
23 So you'll need to have multiple films to show that, okay,
24 it hung up here in the small bowel. This 16 to 18 feet of
25 bowel, where did it hang up, and is it going to squeeze

Glen Strickland - Direct Examination by Mr. McDow

1 through a little opening so it's a partial obstruction or
2 is it completely obstructed and it's not going to move
3 anymore, complete obstruction. So the radiologist has to
4 keep taking films until he knows to answer to that. If
5 it's normal, it could be over in an hour, if it's abnormal,
6 I've seen them go six to eight hours.

7 So there are anywhere from four or five films to
8 look at to maybe 15 or 20.

9 Q Doctor, in your opinion to a reasonable degree of
10 medical certainty, did Dr. Williams comply with the
11 standard of care for ordering small bowel follow through?

12 A He did the right test; that's what I would have
13 ordered. If you're dealing with a partial small bowel
14 obstruction or the question is, is this an ileus or
15 mechanical obstruction to get a small bowel follow through.

16 Q You mentioned that's a chalky substance that would
17 be done with the small bowel follow through. Is that
18 barium?

19 A Barium can be used; gastrografin can be used.
20 There are other chalky-type liquids. They don't taste
21 good; they're thick, but it's what has to be done to get a
22 small bowel follow through.

23 Q In some testimony, I asked you to explain a little
24 more, the gastrografin and the difference of water soluble
25 and not soluble; what does that mean?

Glen Strickland - Direct Examination by Mr. McDow

1 A Okay. Gastrografin is a material that's thinner
2 than barium and you can drink that just like you can drink
3 barium. It can become diluted out the farther it goes into
4 the small intestine. Barium keeps the uniform density.
5 It's thicker. It's more like chalk, as opposed to
6 gastrografin, which may be more like a broth that you would
7 drink. Gastrografin is called water soluble, whereas
8 barium -- meaning it'll dilute out and the liquids over
9 time; whereas the barium won't.

10 Q Doctor, the upper GI, the small bowel follow
11 through that you mentioned was done with barium in this
12 case; is that right?

13 A That's correct.

14 Q Okay. Who chose the barium?

15 A Well, the radiologist ultimately is the one that
16 tells the technician which material to use. In this case,
17 an Upper GI small bowel follow through was ordered and
18 barium was the agent that was used.

19 Q Does it concern you in this case that barium was
20 chosen?

21 A No. As a matter of fact, we need an example. You
22 have to make sure the patient or the x-ray gives you the
23 answer. If I choose gastrografin -- let me back up another
24 step. I can -- I can write down gastrografin or barium
25 swallow all day long; the radiologist is going to do

Glen Strickland - Direct Examination by Mr. McDow

1 whichever one he wants because that's his department. If I
2 start with gastrografen and can't see -- well, because it's
3 water soluble, it gets diluted as it goes down that 16 to
4 18 feet of bowel, you just can't see it anymore, then you
5 back up if you don't have your answer to your question and
6 do a barium swallow because it's not going to become
7 diluted. You can see it all the way through, okay. So you
8 can't stop with an indecisive test. If your gastrografen
9 swallow doesn't tell you what you need to know, then that
10 step would be there.

11 Q Doctor, did, in your opinion, a CT scan ever need
12 to be done?

13 A Not when he's treating a partial small bowel
14 obstruction. That's not a definitive test. In fact, I
15 routinely admit people to the hospital at Lexington when
16 I'm on call to the emergency room. The ER doctors, they
17 order CT scans, they get a interpretation by the
18 radiologist says small bowel obstruction, I'll routinely
19 admit those people and find out the CT scan was over-read;
20 it was wrong. I'll order a small bowel follow up the next
21 day, it makes it all the way through the gut and the
22 patient gets discharged. The CT scan is not the right test
23 for a small bowel obstruction.

24 Q Doctor, did you review the various radiology
25 reports from this case?

Glen Strickland - Direct Examination by Mr. McDow

1 A I did.

2 Q Okay. You were mentioning, I think, at the
3 beginning, you recall the first one being done on May the
4 2nd?

5 A Right.

6 Q Okay. And then a series of follow-up films after
7 that. Specifically one on May the 12th, 2007. My first
8 question is: Were the KUB's that were ordered appropriate?

9 A Yes.

10 Q Okay. And why were they ordered and followed up?

11 A The x-rays -- the follow-up films show you the
12 progression or the obstruction of contrast as it moves
13 through the bowel and the small bowel follow through, I
14 believe was on the 2nd. That's the film or the test you
15 were talking about, May the 2nd.

16 Q The follow through was on May the 2nd; that's
17 correct?

18 A Right.

19 Q And did you recall what the radiology report said
20 on May the 12th? And actually, I've got the radiology
21 reports here?

22 A Okay.

23 Q May the 12th?

24 A On May the 12th she had a KUB. That's a
25 descriptive term for just a plain flat film of the abdomen.

Glen Strickland - Direct Examination by Mr. McDow

1 And the impression of the radiologist is there's evidence
2 of marked delay in gut trains; there's a large amount of
3 contrast remains in dilated portions of small intestine as
4 well as in nondilated colon. A small collection of
5 contrast with somewhat angular margins in the left lower
6 quadrant appears less prominent than on previous films.

7 Q Doctor, it's mentioned there about angular margins
8 in the left lower quadrant. Does that cause you any
9 concerns about there being a barium leak or a small bowel
10 perforation leak at that location or anything in that
11 regard?

12 A If you look at the total picture here, there are
13 multiple films and the radiologist early on said, look at
14 this one area, this could be some contrast outside of the
15 bowel, suggests further films. And this -- this is what --
16 this is more films. Watching not only that area, but also
17 went on and got a later -- later interpretation by a
18 radiologist, says in retrospect, that area we're talking
19 about goes away. So the chance of a perforation or a leak
20 is unlikely.

21 Q Doctor, go back and take a look. The evening of
22 the small bowel follow through on May the 2nd, can you go
23 next to the radiology film on May the 3rd?

24 A You're talking about the KUB?

25 Q Well yeah. I want to start -- go back and go

Glen Strickland - Direct Examination by Mr. McDow

1 through each one of them with you. May the 2nd was the
2 first one. That's the small bowel follow through. Does it
3 give any indication of perforation at that point?

4 A No.

5 Q Okay. They're in reverse chronological order, so
6 if you go to the back page, that's May the 2nd.

7 A All right.

8 Q If you flip the page, May the 3rd. Any indication
9 there of the small bowel perforating?

10 A No.

11 Q May the 4th, any indication of the small bowel
12 perforation?

13 A No, sir.

14 Q Let me ask you this question. On May the 7th,
15 there was an abdomen -- are you there on page 27? Abdomen
16 flat and upright and PA over the chest and it indicates
17 mild, bilateral, both lobes, atelectasis. What is that?

18 A Atelectasis is when the lungs don't fully expand
19 and you get mucus in your lungs and airways collapse. And
20 it looks -- it looks sort of mushy on the x-rays. It's not
21 fully expanded and aerated. So atelectasis is just word
22 for collapsed -- partially collapsed airways.

23 Q All right. Doctor, then that gets us up to the
24 next KUB that was done on May the 12th. You mentioned
25 there about the angular margins.

Glen Strickland - Direct Examination by Mr. McDow

1 A Right.

2 Q Possibility that this is extraluminal focus of
3 contrast and is not entirely excluded, but this is felt
4 less likely as this collection appears smaller than a
5 previous exam. Therefore, it is more likely to be an
6 abnormal segment of bowel. You see that?

7 A Yes.

8 Q Now, the next KUB was done on 05/17. Does that
9 give you any indication as to what happened to the angular
10 margin that was referenced before?

11 A Well, the radiologist felt like it was just
12 contrast in a contorted piece of small intestine and as
13 time went on, it became more obvious that that's what it
14 was.

15 Q There's a KUB done on May the 21st. Any
16 indications there that it was leaking barium?

17 A No, sir. But it does say that findings are
18 worrisome for partial small bowel obstruction.

19 Q Doctor, in your opinion, did she have a
20 perforation of the small bowel between the first and second
21 surgeries?

22 A No.

23 Q All right. What do you base that upon?

24 A Well, we make two liters of green fluid in our gut
25 every day, even if we don't eat. The stomach, the small

Glen Strickland - Direct Examination by Mr. McDow

1 intestine, the liver, colon. Two liters. If I had a
2 perforation, I mean, think about this. This is a garden
3 hose that two liters is running through every ay. If I had
4 a perforation or a hole, it's a hole. If I had a hole in
5 that, don't you think two liters would leak out. That's my
6 reasoning behind that.

7 The second thing is there were drains in the
8 abdomen, which surely would have shown lots of drainage.
9 If two liters, 2,000 cc of fluid in 24 hours -- if there
10 was a hole in there, you would think those drains should
11 have shown it. You know, high volumes out.

12 Q Doctor, there are numerous summaries here prepared
13 by Mr. Corbin related to tachycardia. Have you reviewed
14 the tachycardia references within the hospital records?

15 A I have.

16 Q What did that tell you about your opinion?

17 A Tachycardia is high heart rate. High heart rate,
18 it's a sign of distress for whatever reason. When a
19 surgeon talks about tachycardia -- anybody -- yet, they're
20 all different readings of tachycardia. Okay. So resting
21 heart rate, sitting here, mine's probably 80, you know
22 because I'm talking to you guys. It should be about 70,
23 but if I'm in pain, it's going to go up by degrees. Her
24 heart rate was in the low 100 range which is consistent
25 with being sick, in the hospital, patient's running a

Glen Strickland - Direct Examination by Mr. McDow

1 low-grade fever, maybe needing high -- more IV fluids than
2 she was getting. I mean, it's a catch up game. It's an
3 everyday volume status analysis. How much urine did she
4 put out? And she's got tubes in her. How much did we suck
5 out that way? How much blood did we draw? So if I draw
6 too much blood from somebody, their heart rate's going to
7 go up. They don't have to have a hole in the bowel.
8 There's lots of reasons for your heart rate to go up.

9 So to a surgeon, who deals with gut everyday,
10 things that make me most concerned about potential
11 catastrophes involve heart rates that are 120 or higher.
12 Low-grade heart rates: 100 -- 95, 100, sure I'm concerned,
13 I'm going to look for it. Most of the reasons are
14 atelectasis, which is the lungs not expanding. I've got a
15 fever, 99, 100 from evolving pneumonia possibly. But
16 catastrophic things involve high, high heart rates, bot low
17 grade heart rates.

18 Q With the 120, would you be concerned about that
19 for -- for to be over a period of time or would it be if it
20 was one and dropped back down? What would that -- how
21 would that play role in your opinion?

22 A You look -- you look at trends, you don't look at
23 any one heart rate, okay. I mean, it makes sense, shift
24 change, different nurses take vital signs. If you see a
25 consistent pattern of progressively rising anything, you've

Glen Strickland - Direct Examination by Mr. McDow

1 got to really pay attention to it. You know, if the heart
2 rate's 120 once, then that's not as significant as going
3 back and looking at the numbers rising and being sustained
4 over days. That's what we do.

5 Q Doctor, there's an exhibit here with episodes of
6 nausea and vomiting. Did you note the nausea and vomiting
7 in the record?

8 A Yes, sir.

9 Q Do you have any concerns that would cause you to
10 believe that there was perforation between the first and
11 second surgery based on the number of times she had nausea
12 and vomiting documented?

13 A No, sir. Nausea and vomiting is a nonspecific
14 term. I mean, it's not normal to have nausea and vomiting.
15 There's reason for it. There are bunch of reasons for it.
16 So you want to figure out why. Again, this lady has x-rays
17 showing you over 30 days that she has a partial small bowel
18 obstruction. This is interpretation of the radiologist.
19 So again, go back to that garden hose that's partially
20 kinked off somewhere. Some of that's going to back up and
21 make you bloated and nauseated and if it gets in your
22 stomach, you're probably going to throw it up. That's
23 complicated by the fact that you're getting narcotics,
24 which slow down your bowel functioning. You're in pain,
25 you're not getting out of bed. All those things tend to

Glen Strickland - Direct Examination by Mr. McDow

1 make you bloated.

2 So it -- to me, it's consistent with the things
3 they were working with. Which is their impression was she
4 had a partial small bowel obstruction, it fit the vital
5 signs; it fit the temperature; it fit, more importantly,
6 the x-rays. And this lady was having bowel movements. She
7 was never completely obstructed. It was partially
8 obstructed.

9 Q Okay. Doctor, did you review the information that
10 was relevant to the drains and the input and the output in
11 those drains?

12 A I did.

13 Q There was an entry in there, Mr. Corbin has
14 pointed out, related to brown-green, foul-smelling the
15 first couple of days; did you note that?

16 A I did.

17 Q Okay. In your opinion, was that indicative of a
18 small bowel perforation at that time?

19 A Not at that time, no, sir. Here's my reasoning:
20 There were three drains. Two of them were beneath the
21 skin, not in the abdomen. One was in the abdomen. Let's
22 go back to the hole. I'm making two liters of green fluid
23 everyday. That is the color of which our bowel makes, if
24 I've got a hole, those drains ought to pick up at least
25 half of it, wouldn't you think? At least a liter.

Glen Strickland - Direct Examination by Mr. McDow

1 The volume of drainage, was what? It was down in
2 the 15 maybe 100 cc, 150 cc in a day, 24 hours. So it's
3 consistent with a wound that's weeping and draining, but
4 it's not a perforation with a frank hole and gross
5 spillage. That just wasn't -- it just wasn't there.

6 Q Doctor, did the amount of drainage, the output as
7 recorded from the drains, decrease over time?

8 A It went down over time. And let me make one other
9 point. In addition to making two liters of fluid in our
10 gut everyday, we make about a liter of peritoneal fluid in
11 our gut; it bathes our intestines every day. So if you see
12 a drain in me right now, it's going to drain some fluid
13 because I'm making fluid that has to keep the bowel from
14 getting sticky and stuck together. So those drains are not
15 going to not put out anything; I'm supposed to put out
16 something because I'm making peritoneal fluid everyday.

17 Q And what leads to the drains being removed?

18 A The drainage went down and the drains a foreign
19 body, it's a two way street, if it's not serving a purpose,
20 the drainage went down, it's no longer need it, you pull it
21 out because they can be infected. Anything we put in can
22 infect. So when you're done with them, get them out.

23 Q All right, Doctor, let me -- a couple -- take you
24 next to the second surgery on May the 28th, 2007. First,
25 did you review that operation that day?

Glen Strickland - Direct Examination by Mr. McDow

1 A Yes, sir.

2 Q Doctor, were you surprised that it was not a
3 specific area of obstruction found in the second surgery?

4 A No, sir. She isn't, they've said, a lot of times,
5 she's gotten multiple operations. And every time you cut
6 somebody, they make a scar and they heal. She had
7 adhesions, or scar tissue, that's all that means, up and
8 down every piece of her intestine. Both -- I would suspect
9 colon as well as small intestine, which is what we're
10 talking about today. So there was no one area that was
11 stuck or adhered or scarred, the whole bowel's been
12 touched.

13 I read three operations in Hartsville -- maybe I'm
14 wrong, maybe two. There were three different major things
15 done to her before she got here and that alone would have
16 caused scar tissue up and down her intestine, in addition
17 to the six she had here.

18 Q Doctor, in your opinion, did she ever have an
19 abscess?

20 A No, sir.

21 Q What is an abscess?

22 A An abscess is a collection of pus. It can make you
23 septic if it's not drained. Septic, remember? Pressure
24 down, heart rate up, white blood cell count up. If it's
25 fairly insignificant, a lot of them we can resolve on our

Glen Strickland - Direct Examination by Mr. McDow

1 own without help. So an abscess is an collection of pus
2 which you have to deal with if the person is incapable of
3 dealing with it themselves and that would involve either
4 medication or drains or worse.

5 Q Doctor, what do you base your opinion on that she
6 had no abscess at the time of the second surgery?

7 A Well, the description of the operative findings,
8 first of all, there was no abscess described; there's no
9 reason not to say there was an abscess if it's there. Her
10 heart rate didn't meet the septic or the toxic range. She
11 was observed 30 -- or 32 days between the two cases and
12 never did she have a temp of 102, 101.5. Never did she
13 have a heart rate of 120, 130. It just didn't fit, you
14 know.

15 Q Doctor, you mention white blood cell. Did you
16 take a look at the labs that are in the medical records?

17 A Yes, sir.

18 Q Did you note -- well, first off, can -- after
19 surgery, are patients known to have an increase in their
20 white blood cell count?

21 A After surgery, we have what's called a stress
22 response. It's fight or flight, you've probably heard of
23 it, response where our adrenal glands kick in and part of
24 that response is our white blood cell count will go up. At
25 Lexington, a normal white blood cell count is up to 11,000.

Glen Strickland - Direct Examination by Mr. McDow

1 I can't speak for Richland without looking at the labs, but
2 after a major abdominal procedure, it's usual for our white
3 blood cell count to jump up. And again, at Lexington, 15
4 to 16,000, but it'll trim back down if it's insignificant,
5 if it's secondary to surgery.

6 Q Doctor, if you did, looking at the labs in this
7 case, did you note whether there was any rise in the white
8 blood cell count indicating infection?

9 A There was none of that. However, when -- right
10 before Parker operated on her --

11 Q Yeah, between the first and second surgery.

12 A Between the first and second? No, sir.

13 Q Okay. What about the surgery by Dr. Parker?

14 A Well, things change. She did get septic. Again,
15 there was a change in vital signs, her heart rate when way
16 up, her temperature went way up, the drainage went way up.
17 Her white blood cell count for the first time went way up.
18 That's when she changed.

19 Q Doctor, how did she look on June the 3rd?

20 A June the 3rd, according to Dr. Parker, she was
21 sick. And things had changed and she did needed an
22 operation. In his opinion, she looked toxic.

23 Q Would you have taken her back to surgery on June
24 3rd like Dr. Parker did, based on the findings?

25 A Based on what they described, she needed to be --

Glen Strickland - Direct Examination by Mr. McDow

1 yes. The answer's yes.

2 Q Doctor, did you review the June 3rd operative
3 note?

4 A Yes, sir.

5 Q Did you note that there was a .5 and a one
6 centimeter hole?

7 A Yes, sir.

8 Q Do you have an opinion as to where this hole came
9 from?

10 A I think, again, this lady's had lots of operations
11 on her small intestine. And anytime you cut it and every
12 time you take down adhesions and scars, the bowel is
13 stressed. In her case, she's had multiple operations, the
14 walls are thin to begin with, she's had a chronic small
15 bowel obstruction, so the bowel has been dilated for a
16 period of time. Dilated and then not dilated, so it
17 stretches the gut. I think this area probably perforated
18 just from the chronic wear and tear and the pressure from
19 the partial small bowel obstruction.

20 Q In the note there, there's mention of succus
21 entericus, do you see that?

22 A Yes, sir.

23 Q All right. What is succus entericus?

24 A That is that two liters of green stuff I said the
25 gut makes every day. That -- when it comes from the small

Glen Strickland - Direct Examination by Mr. McDow

1 intestine, that is the medical word for that. Succus
2 entericus.

3 Q Did you see signs succus entericus based on the
4 May 28th operative day by Dr. Williams?

5 A No.

6 Q Okay. Doctor, we mentioned nausea and vomiting.
7 We mentioned fever; we mentioned the wound drainage, the
8 drain amounts. I've failed to ask you about the abdominal
9 distention between the first and the second surgery. If
10 you rely on what's in the records related to abdominal
11 distention, in your opinion, it's not a small bowel
12 perforation?

13 A There was --- there -- a small bowel perforation
14 should have presented with high volumes of drainage from
15 the drains in the abdomen. This lady was bloated and
16 nauseated because she had a partial obstruction in which
17 backed that fluid up and made her bloated and the x-rays
18 were consistent with that. The x-rays showed dilated
19 bowel, nondilated bowel, barium that made it through the
20 small intestine to the colon. I mean, you had -- you can't
21 look at any one thing and come up with a decision. You
22 have to look at everything that's done together to come up
23 with a partial small bowel obstruction.

24 MR. MCDOW: One minute, Judge.

25 THE COURT: All right.

Glen Strickland - Direct Examination by Mr. McDow

1 BY MR. MCDOW:

2 Q Dr. Strickland, based on your review of the chart,
3 would you have done anything differently than Dr. Williams
4 did?

5 A No, sir.

6 Q Dr. Strickland, your opinion to a reasonable
7 degree of medical certainty, did Dr. Williams comply with
8 generally accepted standards of care?

9 A Yes, sir. He definitely did.

10 Q I have no further questions. Answer any questions
11 Mr. Corbin has. Thank you.

12 THE COURT: All right. Mr. Corbin, would you like
13 to begin now or wait until after lunch?

14 MR. CORBIN: I'd prefer a lunch break, Your Honor.

15 THE COURT: All right.

16 Ladies and gentlemen, what we're going to do is
17 we're going to break. It's quarter to one. We'll get back
18 together -- please be here promptly at two o'clock. We
19 will start at that time. You may not discuss the case and
20 I look forward to seeing you at that two o'clock.

21 (Whereupon the jury left the courtroom at 12:44
22 p.m.)

23 THE COURT: All right. Dr. Strickland, you may not
24 discuss your testimony with anyone during the break.

25 And gentlemen, if y'all could be back at quarter

Glen Strickland - Direct Examination by Mr. McDow

1 till two, what I want to do and Mr. McDow and Mr. Corbin,
2 I'll see you in the back in just a few minutes. I just
3 want to make sure we have an organized plan for this
4 afternoon. Certainly, your questions can be fully covered,
5 but what I wanted to do was somewhat avoid some repetition.

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

7 **THE COURT:** All right. I'll see you back in my
8 office in just a minute.

9 (Whereupon, a recess was observed for lunch.)

10 **THE COURT:** All right. Mr. McDow, is the Defendant
11 ready?

12 **MR. MCDOW:** Yes, Your Honor.

13 **THE COURT:** Plaintiff ready?

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

15 **THE COURT:** All right. You may have a seat.

16 If all the jury is back, we can bring them in.

17 **MR. MCDOW:** Can I give you my copy of the jury
18 charges right now?

19 **THE COURT:** You can. You can hand them on up.
20 Just give him a copy at the same time.

21 Mr. Corbin, you can give me yours later.

22 **MR. CORBIN:** At the break time, we're ready. Yes,
23 sir.

24 **THE COURT:** All right.

25 (Whereupon, the jury entered the courtroom.)

Glen Strickland - Cross-Examination by Mr. Corbin

1 **THE BAILIFF:** The jury's all present, Your Honor.

2 **THE COURT:** All right. Okay ladies and gentlemen,
3 we're ready to continue.

4 Mr. Corbin, you can cross examine the witness.

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

6 **CROSS-EXAMINATION**

7 **BY MR. CORBIN:**

8 Q Good afternoon, Dr. Strickland. How are you?

9 A Good afternoon, sir.

10 Q And we had a chance to speak before in a
11 deposition and you testified eight or ten other times in
12 some other malpractice cases. Correct?

13 A Correct.

14 Q And we've gone through all that. Right?

15 A Right.

16 Q But you always testify on behalf of the doctor?

17 A I've been asked to testify once on behalf of a
18 plaintiff and I thought they didn't have a case.

19 Q Yes, sir.

20 A And that's the only time I've been asked.

21 Q So every time you've actually testified in court,
22 it's always been in favor of the physician. Correct?

23 A Yeah.

24 Q And you know Dr. Williams?

25 A Say that again, I'm sorry.

Harris Parker - Direct Examination by Mr. McDow

1 **THE COURT:** All right. Come on up please.

2 **DR. HARRIS PARKER,**

3 having been duly sworn, testified as follows:

4 **THE CLERK:** Have a seat in the witness box and
5 state your full name for the record, please.

6 **THE WITNESS:** Harris Harper Parker, III.

7 **MR. MCDOW:** Okay, great.

8 **DIRECT EXAMINATION**

9 **BY MR. MCDOW:**

10 **Q** All right. Dr. Parker, my name is Bill McDow, I
11 represent Dr. Williams in this case. Your deposition was
12 taken some time ago. I have some questions for you today.
13 I would ask that you make sure you please speak loud enough
14 so that if I can probably hear, then this last juror over
15 here should be able to hear you as well.

16 Dr. Parker, tell the jury where you went to
17 college, please.

18 **A** I went to the University of South Carolina.

19 **Q** And what year did you finish?

20 **A** I graduated in '94.

21 **Q** And did you then go to medical school?

22 **A** I did.

23 **Q** And where did you go to medical school?

24 **A** University of South Carolina.

25 **Q** And what year did you finish medical school?

Harris Parker - Direct Examination by Mr. McDow

1 A '98.

2 Q And after you finished medical school, did you
3 then do an internship and a residency?

4 A In general surgery at Palmetto Health.

5 Q And what year did you finish your general surgery
6 residency?

7 A 2004, I believe.

8 Q Did you do anything after you completed your
9 residency in general surgery?

10 A I joined a private practice.

11 Q And where have you worked? What's the name of
12 your practice?

13 A At that time, I joined Surgical Associates of South
14 Carolina.

15 Q Okay.

16 A We currently are now integrated with Palmetto
17 Health.

18 Q And do you -- what type of surgeries do you
19 perform?

20 A A full ray of general and vascular surgery.

21 Q Are you Board certified?

22 A Correct.

23 Q By what group and what areas?

24 A American College of Surgeons in general surgery.

25 Q Dr. Parker, were you involved in the care of Ms.

Harris Parker - Direct Examination by Mr. McDow

1 Atkinson in May and June of 2007 while she was at Palmetto
2 Health, Richland?

3 A Yes.

4 Q How did you become involved?

5 A I was asked to offer a second opinion.

6 Q And who asked you to render a second opinion?

7 A Dr. Williams.

8 Q Doctor, is there a difference to you between being
9 asked for a consultation and for a second opinion?

10 A In general, yes. A second opinion implies they'd
11 like your opinion on something, a specific area. A
12 consult, in general for us, implies that you would assume
13 the management of that problem. So, naturally to say, if
14 we see a puncture on a leg as a second opinion, here's my
15 opinion, I'm glad to help where I can. A consult would
16 mean that I would assume care of that and manage that
17 particular problem.

18 Q Doctor, did you, in fact, examine Ms. Atkinson in
19 this case?

20 A I did.

21 Q Okay. And as a result of that particular
22 examination, did you render a consultation or a second
23 opinion note?

24 A Correct.

25 Q Okay.

Harris Parker - Direct Examination by Mr. McDow

1 MR. MCDOW: May I approach the witness, Your Honor?

2 THE COURT: Yes, sir.

3 BY MR. MCDOW:

4 Q Dr. Parker, I'm first going to show you what has
5 been marked as Defendant's Exhibit 5 and I'll represent to
6 you that I pulled those out of the Palmetto Health records.
7 If you need to refer to anything else in the Palmetto
8 Health records, we have a complete volume here. Those
9 should be -- well, identify for the jury, please, what
10 three documents are in that particular exhibit?

11 A The first one appears to be a radiology note, not
12 of mine, but the second one with my hand written note of
13 5/21, and another hand written note on 6/02 by myself, and
14 another note on 6/03.

15 Q All right. And I want to show you what's been
16 marked as Defendant's Exhibit 2 and that should be the
17 consultation note, or second opinion note from May the
18 21st; is that correct?

19 A That's correct.

20 Q Okay. Doctor, first, if you -- so you read
21 everything. Hand written progress note and then dated a
22 second note. Could you read your hand written note into
23 the record for us, please?

24 A Sure. That second note really is not a second
25 note; it's just a dictated form. I write a brief note in

Harris Parker - Direct Examination by Mr. McDow

1 the chart and then document that I dictated the physician's
2 note. It's not really a second note. So 5/21/2007, I
3 said, asked to see patient secondary to partial --
4 questionable partial bowel obstruction --

5 Q Okay. Let me slow you down a little bit?

6 A Oh, that's fine.

7 Q Ask that you slow down since the court reporter
8 behind you is taking everything down and the jury might be
9 able to understand you a little bit better.

10 A Okay. I was asked to see the patient secondary to
11 questionable small bowel obstruction and I put that D,
12 which means the full note dictated.

13 A 59-year-old Caucasian female, status-post
14 exploration 4/25 with extensive adhesiolysis. Multiple
15 previous operations, I put ops. Failure to progress with
16 PO diet. Nausea however, still with reported bowel
17 movements. Abdomen, full. Contrast in the Upper GI within
18 the dilated loops of small bowel consistent of a PSBO,
19 partial small bowel obstruction. Suspect she'll come to
20 exploration as she has failed non-operative management
21 although attempts at prep from above may be reasonable.
22 Will discuss with Dr. Williams. Wrote that I updated
23 family at length.

24 Q What was that -- follow along, what was that last
25 line?

Harris Parker - Direct Examination by Mr. McDow

1 A Updated family at length.

2 Q All right, Doctor. Did you then, in fact, do a
3 full note of dictation?

4 A That's correct.

5 Q All right. Under your dictated note, what was
6 your review of symptoms?

7 A You're referring to the history of present illness?

8 Q Yes, please.

9 A Fifty-nine year old Caucasian female. Status-post
10 exploration on 4/25, bilateral salpingo-oophorectomy,
11 that's taking out your ovaries bilaterally, and significant
12 intra-abdominal adhesions with prolonged adhesiolysis. She
13 is known to have failure to progress with P0. Was asked to
14 see the patient for the above. She reports some nausea,
15 but denies fever or chills. She does, however, report
16 small bowel movements, has sensation of fullness of the
17 abdomen.

18 Q Doctor, you did examine the patient?

19 A I examined the patient on 5/21.

20 Q Right. So would you have actually seen the
21 patient, physically, that day?

22 A To examine the patient?

23 Q Yes.

24 A Yes.

25 Q And what was the reason for the consultation?

Harris Parker - Direct Examination by Mr. McDow

1 Right above that? That you have in your note.

2 A Reason for consultation is for second opinion on
3 small bowel obstruction.

4 Q Okay. What did you note for her past surgical
5 history?

6 A Past surgical history: Significant exploration
7 of -- exploration for bowel obstruction and gangrenous
8 bowel.

9 Q Okay. There are two blanks on that document. Do
10 you know what that would have been?

11 A I assume either they were looking for a typo,
12 either they couldn't understand a portion of what was
13 said --

14 Q Okay.

15 A -- that I wrote.

16 Q I think I asked you about review of symptoms and I
17 mixed that up with history of present illness. What do you
18 mean under Review of Symptoms where you have negative for
19 chronic bowel or bladder bleeding, hematologic, cardiac,
20 pulmonary, visual or hearing loss, or musculoskeletal
21 complaints; review of symptoms otherwise nonrevealing.
22 What does that mean?

23 A I think you mean Review of Systems.

24 Q Systems, sorry?

25 A Okay. And that's more of a chronic -- review of

Harris Parker - Direct Examination by Mr. McDow

1 systems is trying to obtain what kind of chronic issues
2 that she may have relative to what I'm involved in, not
3 specifically asked this question.

4 Q Okay. What were her vital signs under physical
5 examination when you examined her?

6 A Documented here, she is afebrile, heart rate in the
7 70's to 100, blood pressure in the 130's over 80's.

8 Q And did -- what did you describe her as being
9 under General Physical Exam?

10 A I described her as being a well-developed, well
11 nourished Caucasian female, sitting up in bed. No apparent
12 distress, nontoxic, alert and appropriate.

13 Q Okay. And then what did you put under heart? Did
14 you check her pulse or --

15 A Rate -- well, we documented her pulse in the 70's
16 to 100.

17 Q Okay.

18 A And her heart in her examine is regular rate and
19 rhythm.

20 Q Okay. Did you examine her abdomen that day?

21 A We did.

22 Q And what did you find her abdomen to be at that
23 time?

24 A It said, soft and full. Midline drift. I suspect
25 that means dressed, i.e., from the incision. Mildly

Harris Parker - Direct Examination by Mr. McDow

1 tender, no peritoneal signs, no masses.

2 Q Okay. What are you looking for when you say no
3 peritoneal signs? What does that mean?

4 A Peritoneal signs, for us, are important, especially
5 for somebody with a bowel obstruction. They actually
6 determine whether they have a toxic abdomen and something
7 to suggest that they're hurting. People describe -- ever
8 had a family --- appendicitis, they hurt when they go to
9 the hospital, when they cough it hurts, when you tap on
10 their belly, it hurts. Those are signs of peritoneal
11 irritation.

12 Q Okay. How would you determine that there were no
13 masses?

14 A By palpation.

15 Q And by palpation, what do you mean?

16 A Touching on the abdomen.

17 Q What do you mean by nontoxic in your dictation?

18 A Well, I mean, you really need a lot of information,
19 you really see a train -- you need a lot of information
20 just by looking at somebody. It's essentially the motherly
21 or fatherly instinct of being able to look at your child
22 and say, that -- that -- my child is sick, before you know
23 something's happening. In that instance, she's nontoxic;
24 she doesn't look ill.

25 Q All right. Doctor, then under Laboratory Data,

Harris Parker - Direct Examination by Mr. McDow

1 what did you note?

2 A Laboratory data: White count of -- white blood
3 cell count of, infection count of 7.5, hemoglobin 10.4,
4 potassium of 4.2, with a creatine of 0.5; magnesium 1.7.
5 Want more than that?

6 Q Yeah, keep going?

7 A Imaging studies routine -- revealing retained small
8 bowel contrast within the bowel loops of small bowel.
9 Positive gas in the colon.

10 Q Doctor, what were you looking for with a white
11 blood cell count of 7.5?

12 A Again, I'm looking for whether it is elevated or
13 normal, that being a normal number.

14 Q And what would it mean if it was elevated in the
15 context that you saw Ms. Atkinson on that day?

16 A Specifically in that context, probably wouldn't
17 have had a lot. But it's a piece of the puzzle to try to
18 determine whether someone's ill or not ill. Which means in
19 isolation are not as helpful, but a culmination of an
20 entire picture of what we really used.

21 Q And that was going to be my next question. Does
22 the culmination of these -- this laboratory data help you
23 with your assessment?

24 A Sure. If we were to call a partner or tell someone
25 what's kind of going on with a patient, report to them you

Harris Parker - Direct Examination by Mr. McDow

1 got a nontoxic patient, no apparent distress, who's alert
2 and appropriate with a normal white count and a normal
3 heart rate. That's very helpful in describing a picture of
4 a patient, kind of painted image of your -- a patient in
5 your mind.

6 Q Okay. Doctor, when you refer to the imaging
7 studies there, did you actually look at the radiology films
8 yourself or were you looking at the radiology reports? Or
9 both?

10 A Right. I did not document specifically what was
11 done. I can tell you that from surgical training, we were
12 trained to look at the images in addition to what was sent
13 by radiology. So, I did not document this, but my normal
14 pattern would be to review the images and the report.

15 Q All right, Doctor. Based on your review of the
16 radiology reports and the films, what did they tell you
17 about a perforation?

18 A Perforation? I would not suggest that at all.
19 That wasn't my thought process in this patient this day.

20 Q In your opinion, did she have an abscess in her
21 abdomen at that time?

22 A Had nothing to suggest that based on the evaluation
23 of that day.

24 Q Did she have any signs of clinical sepsis that you
25 appreciated at the time of your second opinion?

Harris Parker - Direct Examination by Mr. McDow

1 A You know, sepsis is defined by many people in many
2 different ways. From a surgeon's standpoint, sepsis for us
3 is someone who has overwhelming toxicity with potential
4 infection in their blood or an unstable state. So she
5 would fit none of my criteria for sepsis.

6 Q Is there anything in your examination based on
7 laboratory data as well as her physical examination to
8 indicate she was having any type of organ failure?

9 A Organ failure? I certainly don't see anything to
10 suggest any organ failure, no.

11 Q All right. Did she have any signs or symptoms in
12 your review examination to cause you to believe she had a
13 bowel perforation at that time?

14 A No.

15 Q In your opinion, to a reasonable degree of medical
16 certainty, did she have a leak or perforation at that time
17 that either you or Dr. Williams at that point had not
18 diagnosed?

19 A Not when we examined -- not when I examined her on
20 5/21, no.

21 Q Doctor, in your opinion, did she most likely have
22 a partial small bowel obstruction at that time?

23 A Yes. Based on our examine and -- they -- yes.

24 Q All right. Dr. Parker, did you discuss the option
25 of surgery with Ms. Atkinson at that time?

Harris Parker - Direct Examination by Mr. McDow

1 A In my notes here, is that we updated her family at
2 length. I did not document in this specific area which
3 family member was present, but did discuss options, how we
4 would -- options for proceeding, and put in there way that
5 questions were answered. So yes. We had that conversation
6 documented here.

7 Q Okay. All right. On page 2 of your full note
8 dictation, for this plan, that you were looking at, your
9 hand-written note. Please read into the record what your
10 plan was and see if that refreshes your memory about any
11 statement.

12 A You said the hand-written note?

13 Q Well, no. Look at your dictated note.

14 A Uh-huh.

15 Q Under plan on Page 2.

16 A Yes.

17 Q And then, what is that first line?

18 A I'm sorry. I thought you were referring to the
19 hand-written note on 5/21 that said updated family. The
20 dictated note, I had a lengthy discussion at the bedside
21 with the patient and her husband. Discussed the x-ray
22 findings and those potential options and given her interest
23 in, quote, maximal medical management, end quote, you want
24 me to read the rest of it.

25 Q Yes, keep going?

Harris Parker - Direct Examination by Mr. McDow

1 A We would attempt catharsis from above with Fleets
2 Phospho Soda. If this is not successful, I anticipate that
3 she will require exploration. Questions answered. Will be
4 glad to help in any way possible.

5 Q Doctor, as -- what did you mean by attempt
6 catharsis from above and maximum medical management?

7 A My guess is, you had to refer to the notes on that
8 day, but my understanding of my recollection is that they
9 were going to attempt to flush through some of the contrast
10 that was present from a previous study in her small bowel
11 to see if they can move this on through. I guess I should
12 step back just for a second. Contrast remains in the small
13 bowel, if you can move it through the colon, often you
14 could open up a partial obstruction. And my hand written
15 note just above this reports that she had contrast
16 remaining in the core of the small bowel.

17 So that was the catharsis. Catharsis means to move
18 through. You might be constipated and drink some Maalox or
19 some Mag-citrate at home to move things through.

20 Q What was Ms. Atkinson's decision at that time
21 based on your conversation with her family?

22 A They did not want to proceed with surgery at this
23 point. They would hope with some of the maneuvers we
24 talked about that we could resolve this medically and not
25 proceeding with surgery.

Harris Parker - Direct Examination by Mr. McDow

1 Q Was her decision at that time reasonable?

2 A I think it's a acceptable decision. Based on her
3 clinical presentation.

4 Q Was there anything about her condition at that
5 time that warranted an emergency surgery?

6 A No.

7 Q Did you suspect that she likely would need to
8 return to surgery?

9 A I did. And I commented the possibility existed.
10 If this did not work then we would -- then she would
11 require exploration. That was indicated if the catharsis
12 didn't work, and the bowel function didn't return, that
13 indeed, she may require exploration. That would be really
14 the only option for her.

15 Q Did you discuss your second opinion with Dr.
16 Williams?

17 A I did.

18 Q Is fecal vomiting in and of itself an indication
19 for immediate surgery?

20 A In isolation? No.

21 Q Doctor, you saw her -- anything else you recall
22 about that particular visit with the patient?

23 A No. Not that comes to mind at this point.

24 Q All right. You saw her again on June the 2nd,
25 2007, at the request of Dr. Smith; is that correct?

Harris Parker - Direct Examination by Mr. McDow

1 A I have a note on June the 6th, 2007, yes. Correct.

2 Q All right. Could you please read your hand
3 written note into the record for us?

4 A Bilious enteric, parenthesis proximal appearing,
5 end parenthesis, output from jp back -- do you want me to
6 explain this as I go along or just read it.

7 Q If you could explain it, that'd be great.

8 A Okay. I just don't want to lose everybody.

9 Bilious enteric means small bowel content coming
10 from the bowel and I put proximal, which means -- there's a
11 difference in what's in the early part of your small bowel
12 versus the end of your small bowel and it's important to
13 predict, kind of, where our problem may be, if there is
14 one. And I put proximal, which means, more likely a
15 thinner type of fluid. Jp or Jackson Pratt is essentially
16 a drain that's placed with a little catheter that's in the
17 belly and it gives you an idea of what's in the belly. It
18 comes through a bulb on the outside so you can kind of see
19 it.

20 Temperature 100.3, otherwise, I said without
21 significant temperature. Her last white blood cell count
22 was 10, and it was yesterday. Some nausea, abdomen is
23 soft, she is appropriately tender, meaning that after her
24 operations you'd expect her to be somewhat tender, without
25 gross peritonitis, which we covered earlier. Her heart

Harris Parker - Direct Examination by Mr. McDow

1 rate is in the hundreds, however, they did note one at 140
2 as an isolated number and at 0400 I discussed -- here, I
3 said I discussed with the RN questioning the validity of
4 that single reading. It wasn't some ridiculer numbers.
5 Smiling, conversive, no apparent distress, nontoxic.
6 Lengthy discussion with patient slash daughter-in-law at
7 bedside. Options reviewed with pros and cons. Options, we
8 discussed the potential options as far as surgery, which is
9 not optimum management and the risks. I believe she'll
10 come to exploration, however, she will not agree at the
11 present, despite the implications as reviewed. So she's in
12 the hospital and says, here's the situation, here are the
13 pros and cons of the operation, you may choose not to have
14 them, understanding that if you choose not to have them,
15 there are implications to that decision.

16 NG tube is accepted for now. Await decision.
17 However, suspect, regardless of intervention, it will be
18 involved -- it, being the surgery -- with probable ostomy
19 and long term TPN, if successful at best. Then discuss
20 with Dr. Smith.

21 Q The NG tube accepted for now, do you recall having
22 a discussion with Ms. Atkinson about the NG tube?

23 A We were hoping to, you know -- did I have an
24 individual conversation with her regarding the NG tube?

25 Q Well, yes, first.

Harris Parker - Direct Examination by Mr. McDow

1 A Well, she agreed to placing the NG tube now that we
2 had a change in our situation. She agreed to having an NG
3 tube placed for an hour, which means, an hour each day.
4 She agreed to for now.

5 Q And was that NG tube, I guess, went ahead and was
6 put in?

7 A You'd have to look at the records. I assume.

8 Q Okay.

9 A You'd have to look at the notes there.

10 Q All right. Was this change in her condition from
11 when you had seen her on May the 21st?

12 A Yes.

13 Q Now, Doctor, turn to page -- in that exhibit, did
14 you then again see her on June the 3rd, 2007?

15 A Right. At 8:30, it says.

16 Q All right. If you could read that and explain
17 your findings there.

18 A I just -- I put in a note that I discussed with the
19 husband by telephone last PM and again with the patient and
20 husband at the bedside today. They have now agreed to
21 exploration. Her heart rate is now in the 130s, suggesting
22 it's higher than -- greater than much earlier -- and white
23 blood cell now is 32,000, an elevated number. She has
24 greenish output from the back in the jp. Her abdomen now
25 is tender. I've discussed with them the indications,

Harris Parker - Direct Examination by Mr. McDow

1 alternatives, expected outcomes, proposed benefits, and
2 potential complications including, but not limited to
3 hemorrhage, infection, cardio-pulmonary slash wound
4 complications, leaks, fistula, abscess, need for additional
5 procedures slash ostomy, quotation, short gut, end
6 quotation, syndrome, and even death. Opportunity for
7 questions has been provided -- opportunity for questions
8 provided. They understand, have no further questions, and
9 wish to proceed. Discuss with Dr. Smith today.

10 Q Doctor, did you, in fact, take her to surgery on
11 June the 3rd, 2007?

12 A I did so. I believe so, but if you send me that,
13 I'll make sure that date's correct.

14 Q That's what I'll do. I'm going to hand you
15 Defendant's Exhibit 6, 7, 8, and 9 -- 6, 7, 8, 9. It
16 should correspond to the four surgeries.

17 A So, yes. Your question. The date of the surgery
18 is 6/3/2007.

19 Q Doctor, again, her condition changed from June the
20 2nd to June the 3rd?

21 A Correct.

22 Q All right. Doctor, had she, on June the 3rd,
23 declared herself at that time? I've heard that used as a
24 term for --

25 A On the third? Yes.

Harris Parker - Direct Examination by Mr. McDow

1 Q -- surgeon word. What would declared mean?

2 A Declared to me is meaning that she'll -- she has at
3 this point come to demonstrate that she is -- really has no
4 further options other than surgery. She has -- you know,
5 we're kind of sitting there seeing whether she'd be better,
6 would she be better. At this point, she'd become toxic,
7 her heart rate's 130; her white count's around 32,000. She
8 has a tender abdomen. At this point, it's time to operate.

9 Q Doctor, what did you find in your operation?

10 A You're referring to 6/3.

11 Q Yes, sir?

12 A Succus within -- under her findings. Succus with
13 an inch of her cavity, significant intra-peritoneal
14 inflammatory process with thickened small bowel.

15 Proximally a 0.5 to 1 --- area of small bowel perforation
16 in the very proximal jejunum, just distal to the Ligament
17 of Treitz; intact small bowel anastomosis; small bowel
18 perforation; distal small bowel, just proximal to the
19 anastomosis. That's a lot of explanation. You want me
20 to --

21 Q Well, did you find a perforation?

22 A There were two areas noted here. One, Ligament of
23 Treitz -- the small bowel starts, essentially, just passed
24 your stomach and runs across your spine in kind of a
25 spaghetti fashion all the way down to the colon on the

Harris Parker - Direct Examination by Mr. McDow

1 right side. The Ligament of Treitz is the marker,
2 essentially, between the duodenum proximal to the small
3 bowel to the remainder of the small bowel, it's just a
4 location.

5 So two areas. One there and then one in the more
6 distal small bowel. That is proximal or upstream to the
7 anastomosis that had been previously done.

8 Q So upstream from the previous anastomosis?

9 A Correct.

10 Q Do you have an opinion to a reasonable degree of
11 medical certainty about the cause of the perforation you
12 found?

13 A No.

14 Q Do you have an opinion when the perforation did
15 happen?

16 A Time frame would not be minute, but essentially,
17 more than 24 hours, 12 hours. In that fresh perforation,
18 you come in the hospital and you have a perforated ulcer,
19 having right knee pain and come to the hospital and
20 perforate your stomach, you have bile in your belly, but
21 not a lot of inflammatory change, like a peal or imaging or
22 a film. If it goes on for a while, your body has a
23 reaction to that. So it's more than just a couple hours,
24 if you will.

25 Q Dr. Parker, you reference in here, the remainder

Harris Parker - Direct Examination by Mr. McDow

1 of the small bowel was visualized with approximately 7 to 8
2 centimeters of small bowel remains; is this correct?

3 A This is on the second page?

4 Q Second page, yes.

5 A My suspicion is that that is not a correct number,
6 I suspect that's a -- that's an error in that. I recall --

7 Q It was an error in dictation?

8 A Correct. That would read 70 to 80 centimeters of
9 small bowel.

10 Q It was 70 to 80 centimeters of bowel there before
11 you removed anything?

12 A The remainder of the small bowel, so I hadn't done
13 anything yet. So when you start an Op Report, you start
14 off, I opened it up, this is what I found. And that's what
15 it is. Inflammatory reaction, perforation we talked about.
16 And the remainder of the small bowel, visualized 70 to 80
17 centimeters of bowel remains. So that number was before I
18 had done anything.

19 Q Would 7 to 8 centimeters of small intestine be
20 sustainable for life?

21 A No.

22 Q All right, Doctor. I'm going to try to get
23 through a little bit quicker for you. Could you look at
24 your June 5th, 2007 note.

25 A Yes.

Harris Parker - Direct Examination by Mr. McDow

1 Q And did she again have a perforation at that time?

2 A Finding, succus with a small bowel perforation
3 approximately 15 centimeters proximal to the small bowel
4 line, correct.

5 Q And did you have an opinion as to how this
6 perforation occurred?

7 A I don't know specifically, but I think if you
8 reviewed back to the previous operative description, it
9 describes an area of a little darkening of the small bowel.
10 Since it wasn't leaking it was kind of -- can I refer back
11 to the other one?

12 Q Yeah. Absolutely.

13 A Here it is. There was a -- just adjacent to the
14 anastomosis seem to also appeared to be a fairly indurated
15 and somewhat darkened in appearance piece of -- portion of
16 the small bowel. Although, I said -- although, no leak was
17 appreciated. So, it's a continuum -- the bowel's a
18 continuum and the process is a continuum. So you're
19 looking at the bowel and you see things that are frankly
20 open that are leaking and then you see some areas that are
21 not yet open.

22 Now, whether they'll progress to something, you
23 don't know, i.e., the reason you go back in 48 hours is the
24 general accepted plan, to go back and see if that -- if
25 something else is leaking.

Harris Parker - Direct Examination by Mr. McDow

1 Q All right. And then did you go back in on June
2 the 7th?

3 A Correct.

4 Q What was the purpose of the June the 7th surgery?

5 A Well, when you do the first operation as I said,
6 you generally go back 48 hours later, that's what we did on
7 the 5th. And then, we call that damage control, When we
8 stop the problem before you move on to definitive
9 operations. And so, since we went on the 3rd, went back on
10 the 5th, we still found a leak, so the clock kind of sets
11 back over. You're back to 48 hours again so you kind of go
12 back again in 48 hours to make sure that, again, nothing's
13 wrong. So that's the reason for the 6/7/2000 (sic)
14 operation.

15 Understand that the whole time, her abdomen was
16 open, it's just got a packing in it, so you're not closing
17 up the incision, suture, and opening back up. It's got a
18 packing. So you've got to go back anyway because you've
19 got packing in it. The reason to go back is to assure that
20 nothing else is a problem. You want to stop the danger.

21 Q And did you go back one more time on June the
22 11th?

23 A I did.

24 Q And what was the purpose of that surgery?

25 A So the purpose of that -- see between the 5th and

Harris Parker - Direct Examination by Mr. McDow

1 7th, the 7th, I didn't find anything. At that time, I
2 hooked her -- connected her bowel back in continuity. Then
3 you would wait longer to go back finally to say, is the
4 area I hooked together, is it good? Is what I did worked.
5 Has it worked? And so you go back and you look at that and
6 indeed it has. So I said everything looks good, there's no
7 further problems in the belly that I can ascertain, and so
8 we close up the belly and take that packing out and close
9 up the belly at that time.

10 Q Did you continue to follow Ms. Atkinson during the
11 remainder of that hospitalization?

12 A Sure. You know, I don't have those in front of me.

13 Q That's okay. Doctor, I have an exhibit,
14 Plaintiff's Exhibit 34 and I'm just going to turn to page
15 16. These are your -- I represent these are your office
16 notes. And one question, did you continue to follow Ms.
17 Atkinson after she got out of the hospital?

18 A Correct.

19 Q And I'm not going to go through all of those,
20 they're in evidence. I just want you to tell us how she
21 was doing on -- if that was your last office visit, what
22 date that is and how you found her at that time?

23 A Okay. I -- you know what you want me to turn to?

24 Q The page that I turned to you, what date --

25 A The date of this page is 9/16/2008.

Harris Parker - Cross-Examination by Mr. Corbin

1 Q Okay. And is that an office note where she came
2 to see you?

3 A Correct.

4 Q And what did you find her -- read that into the
5 record; tell the jury that?

6 A Follow up abdominal exploration. She is gaining
7 weight and is now complaining of some fullness in her
8 abdomen and that she needs to start, quote, backing off,
9 end quote, her eating. She looks very good. Her midline
10 has essentially epithelialized. Her abdomen is soft and
11 appropriate. Her bowel movements has decreased. She has
12 seen Dr. Kimbrell as well as Dr. Eisman (phonetic), I
13 believe, the binder's covering that up. She has nothing,
14 from our standpoint, with regards to surgery. She needs
15 nothing further from our standpoint with regards to
16 surgery. I think she should continue the current course
17 and return as needed.

18 Q That's all we have. Thank you very much. Answer
19 any questions that Mr. Corbin may have.

20 THE COURT: Mr. Corbin?

21 MR. CORBIN: Yes, sir.

22 **CROSS-EXAMINATION**

23 **BY MR. CORBIN:**

24 Q Good afternoon, Dr. Parker. How long have you
25 known Dr. Williams?

Harris Parker - Cross-Examination by Mr. Corbin

1 A I don't know the exact number. It would be during
2 med school.

3 Q Since med school?

4 A Yes, sir.

5 Q Been friends with him since about med school?

6 A He was my attending in med school and he's a
7 colleague at work, yes.

8 Q And he's a colleague where you work?

9 A Correct.

10 Q Yes, sir. The four surgeries that you
11 performed -- and you're aware that Faye believes you saved
12 her life, correct?

13 A You had mentioned that in the deposition.

14 Q Yes, sir. The four surgeries that you performed,
15 those were necessary because of complications from Dr.
16 Williams' second surgery, correct?

17 A They were necessary because she had a bowel
18 obstruction.

19 Q Yes, sir. And the -- you talked about doing the
20 second look when you did the operations on Faye. You knew
21 you had a complex surgery, you went in, you tried to fix
22 what you could, you found a couple of perforations. Did
23 you cause those perforations? Or were they there when you
24 opened her up.

25 A They would have been there before I opened her up.

Harris Parker - Cross-Examination by Mr. Corbin

1 Q Yes, sir. So you opened her up and you found the
2 remaining small bowel she had was -- and we corrected, it's
3 not 7 or 8 centimeters, it's 70 or 80 centimeters, correct?

4 A That's what we discussed in our deposition.

5 Q Yes, sir. And so before you removed anything, you
6 opened Faye up and you looked around and she had 70 to 80
7 centimeters left, correct?

8 A Small bowel, you're referring to?

9 Q Yes, sir. Yes, sir.

10 A That's what the dictation reflects.

11 Q Yes, sir. And a normal person, a 5 foot 2 female,
12 would have about 16 or 18 feet of small bowel?

13 A That's a statement.

14 Q Yes, sir. A question.

15 A I haven't done the math to know exactly how many
16 feet a 5 foot 2 person would have.

17 Q Well, it's --

18 A They'd have more than 70 or 80, how about that.

19 Q Yes, sir. How about, accept to be true, there's
20 been testimony that a female, 5 foot 2, like Faye, would
21 have a normal small bowel length of about 16 to 18 feet.
22 Does that sound about right?

23 A I can't really dispute it; I don't know short of
24 looking that up.

25 Q Okay.

Harris Parker - Cross-Examination by Mr. Corbin

1 A We generally talk and figure out often in --

2 Q Centimeters squared?

3 A Centimeters.

4 Q Yes, sir.

5 A Or certain centimeters.

6 Q Yes, sir. But the 70 or 80 centimeters, that's
7 about two and a half feet?

8 A Well, there are 2.54 centimeters per inch.

9 Q Yes, sir.

10 A Twelve inches in a foot, so --

11 Q So 30 times 2 and a half is 75. So two and a half
12 feet?

13 A Close.

14 Q So from -- assuming normal bowel is 16 to 18 feet,
15 when you got involved after Dr. Williams' surgeries, she
16 had two and a half feet left?

17 A She had 70 to 80 centimeters of small bowel when we
18 operated on her, best that I could ascertain.

19 Q The second look that you talked about. You
20 realized that when you saw Faye, it was going to be a
21 complex, difficult, and maybe even a life threatening
22 situation with her, correct?

23 A Yes.

24 Q Yes, sir. And you were going into a difficult
25 situation and you planned ahead of time. Even though you

Harris Parker - Cross-Examination by Mr. Corbin

1 didn't have much time to plan ahead of time, but you did.

2 I'm going to do this second look, correct?

3 A I'm not sure -- the second look.

4 Q You left the belly open?

5 A Which one are you referring to?

6 Q Your first surgery, sir.

7 A Okay.

8 Q Okay.

9 A First surgery.

10 Q Yes, sir. You go in, you find two perforations, a
11 couple liters of succus, a mess, and you plan to leave her
12 open and come back later, correct?

13 A Correct.

14 Q And you left her open, you didn't sew her back up
15 at that time, correct?

16 A That's correct.

17 Q Because you wanted to be able to investigate in
18 the next couple of days without more traumatic surgery.
19 Let me see if she has anymore leaks; is that fair?

20 A Well, without traumatic surgery, I don't think
21 that's exactly right because all surgery has some trauma.
22 that led up to it, but you're referring to sewing her up,
23 we don't sew her up. The reason we leave her open is, it's
24 almost like if we had a zipper, but most of the time we
25 don't do that, we just pack them open so we can go right

Harris Parker - Cross-Examination by Mr. Corbin

1 back and we don't put trauma on the tissue, sewing it every
2 time. There's no point in putting sutures through the
3 skin, just leave it open.

4 Q And that's what surgeons do in these situations?

5 A That's what many of us do in these situations.

6 Q Yes, sir. And that is less traumatic than sewing
7 this patient back up and then waiting several, several days
8 and then opening the patient back up and looking around
9 again. Correct?

10 A I guess it's less -- I mean, we think it's less
11 traumatic not to have the sutures there.

12 Q Yes, sir. And the time between your second looks,
13 was it 33 days?

14 A I think we did our first operation on the 3rd, our
15 second operation on the 5th as I recall, the third on the
16 7th, the fourth on the 11th.

17 Q Yes, sir.

18 A I missed the -- I don't see the 33 days.

19 Q Thank you, Dr. Parker.

20 THE COURT: Redirect?

21 MR. MCDOW: Nothing further?

22 THE COURT: Step down. Thank you, sir.

23 MR. MCDOW: May I ask that Dr. Parker be excused?

24 THE COURT: Any objections?

25 MR. CORBIN: No, sir.

Matthew Kohler - Direct Examination by Mr. McDow

1 **THE COURT:** All right. Thank you, sir.

2 Anybody on the jury need to take a break? Don't be
3 shy.

4 (WHEREUPON there was no response from the jury.)

5 **THE COURT:** Okay. If you'd like, you can call your
6 next witness, Mr. McDow.

7 If anybody on the jury wants to stand up and
8 stretch, you can do that. I'm going to do it in just a
9 second.

10 Okay, Mr. McDow?

11 **MR. MCDOW:** At this time, we call Dr. Matt Kohler
12 to the stand.

13 **THE COURT:** Dr. Kohler, come on up.

14 DR. MATTHEW KOHLER,
15 having been duly sworn, testified as follows:

16 **THE CLERK:** Have a seat in the witness box, state
17 your full name for the record, please.

18 **THE WITNESS:** My name is Dr. Matthew Kohler.

19 **DIRECT EXAMINATION**

20 **BY MR. MCDOW:**

21 Q Dr. Kohler, let me show you what's been marked as
22 Defendant's Exhibit No. 10. I ask if you recognize that
23 document.

24 A I do.

25 Q Okay. What is that please?

Matthew Kohler - Direct Examination by Mr. McDow

1 A It looks like my Curriculum Vitae.

2 Q I reviewed that with Dr. Strickland, so I'll go
3 over it a little more with you. First off, Dr. Kohler,
4 where do you live?

5 A I live in Mount Pleasant, South Carolina.

6 Q Where are you from originally?

7 A My family's originally from the mid-west,
8 Wisconsin.

9 Q And what is your professional occupation?

10 A I am a Board certified gynecologic-oncologist and
11 obstetrician gynecologist.

12 Q And how long have you -- well, first off, where do
13 you work?

14 A I work at the Medical University of South Carolina
15 in Charleston.

16 Q How long have you worked in that particular area,
17 MUSC?

18 A Fourteen and a half years.

19 Q Doctor, let's go back and take a look at your CV
20 and your education. Where did you receive your
21 undergraduate education?

22 A Yale University.

23 Q And what year did you finish Yale?

24 A I graduated in 1983.

25 Q And then where did you go to medical school?

Matthew Kohler - Direct Examination by Mr. McDow

1 A I attended medical school at Duke University in
2 Durham.

3 Q And when did you finish medical school at Duke?

4 A I finished medical school in 1987.

5 Q Doctor, what'd you do after you finished medical
6 school?

7 A I entered a four-year residency in obstetrics and
8 gynecology at Duke also.

9 Q And did you do anything after you completed your
10 residency?

11 A After a four-year residency, I stayed on at Duke
12 and did a three-year fellowship in gynecologic-oncology
13 also at Duke.

14 Q What did that involve in the fellowship at Duke?
15 What all was involved in that program?

16 A The first year is devoted to the basics, laboratory
17 research; and the next two years are intensive training in
18 clinical medicine, in radical gynecologic pelvic surgery,
19 and treatment of genuine cancer.

20 Q All right. And Doctor, after you completed your
21 fellowship, where did you go?

22 A I accepted a faculty acquaintance at the University
23 of California Irvine in Southern California.

24 Q How long were you out in California?

25 A For three and a half years.

Matthew Kohler - Direct Examination by Mr. McDow

1 Q And what did your job duties consist of while you
2 were out there?

3 A I was an assistant professor on a faculty for a
4 medical school and a teaching hospital there and I also did
5 significant clinical work in the community.

6 Q What do you mean by clinical work?

7 A Surgery.

8 Q Okay. Doctor, then, when you were in California,
9 where did you go next?

10 A My oldest child had bad asthma at the time and was
11 intolerant to smog of Southern California, so we moved back
12 east and I took a faculty position at the Medical
13 University of South Carolina in Charleston.

14 Q In your duties at the Medical University of South
15 Carolina, do you teach the residents?

16 A Correct, I do.

17 Q Do you also have your own patients?

18 A Many.

19 Q Do those patients get referred to you from outside
20 private physicians?

21 A Yes.

22 Q Doctor, on your CV -- or, do you belong to any
23 groups or organizations, just briefly?

24 A Yes. I'm a member of the American College of
25 Obstetrics and Gynecology; I'm a member of the Society of

Matthew Kohler - Direct Examination by Mr. McDow

1 Gynecologic Oncology; and so forth.

2 Q All right. Have you published any articles,
3 journals, or chapters in books?

4 A Yes. Last I checked, I had approximately 55
5 peer-reviewed publications and probably another half dozen
6 book chapters. Probably about 60 publications all total.

7 Q Have you taken any grants and done investigations?

8 A Yes, I have obtained some grants along the way.
9 Mainly these days pharmaceutical grants and the like
10 because I'm very busy clinically.

11 Q You spoke in a lecture in Greece?

12 A Yes. I regularly give lectures to medical
13 school -- medical students, residents, and faculty
14 presentations at grand rounds, outside presentations and
15 the like.

16 Q Doctor, you mentioned that you are Board
17 certified. I'm not sure if you're said or followed up that
18 by what particular boards?

19 A I am Board certified in both obstetrics and
20 gynecology and gynecologic oncology by the American Board
21 of Obstetrics and Gynecology.

22 Q Dr. Kohler, do you treat patients who present with
23 pelvic masses in your medical practice?

24 A Many.

25 Q Do you treat patients with partial or complete

Matthew Kohler - Direct Examination by Mr. McDow

1 small bowel obstructions both preoperatively and
2 post-operatively?

3 A Absolutely.

4 Q Do you treat patients with post-op ileus?

5 A Yes.

6 Q Do you treat patients who are like Ms. Atkinson in
7 this case?

8 A On an occasion.

9 Q Okay. Doctor, are you familiar with the standards
10 of care, particularly in 2007, applicable to gynecology
11 oncologists through patients such as Ms. Atkinson?

12 A I am.

13 **MR. MCDOW:** Your Honor, at this time, we present
14 Dr. Kohler as an expert in the field of gynecology oncology
15 surgery and care associated with the issues in this case.

16 **MR. CORBIN:** No objections, Your Honor.

17 **THE COURT:** All right. Ladies and gentlemen, my
18 earlier instructions hold true as well. This witness is
19 qualified as an expert in gynecologic oncology and --

20 **MR. MCDOW:** Surgeries and follow-up of this type.

21 **THE COURT:** Right -- and surgery. Ladies and
22 gentlemen, you give the testimony of the witness, the
23 weight that you believe it deserves.

24 All right.

25 Q Dr. Kohler, at the request of the defense counsel,

Matthew Kohler - Direct Examination by Mr. McDow

1 have you reviewed the pertinent medical records of the
2 plaintiff in this case for her medical problems starting
3 with her referral to Dr. Williams in March and April 2007
4 time frame?

5 A I have.

6 Q Did those records include the office notes of the
7 South Carolina Oncology Associates as well as additional
8 records for various procedures that were performed for the
9 plaintiff?

10 A They did.

11 Q Did those records also include surgeries done by
12 Dr. Williams and by Dr. Parker?

13 A Yes.

14 Q Doctor, you took some things up to the witness
15 stand with you. Please feel free to review your notes or
16 chronologies or whatever else you may have prepared. My
17 question is, will you list for the jury what records you
18 have with you?

19 A I have reviewed a vast number of in-patient medical
20 records on Ms. Atkinson. I've reviewed all of the
21 operative notes; I've reviewed the in-patient consultation
22 from Dr. Parker. I've reviewed the radiology reports, the
23 laboratory data, nurses notes, progress notes from
24 physicians in the chart, and many, many depositions where
25 individuals said they have served as experts on this case.

Matthew Kohler - Direct Examination by Mr. McDow

1 Q Do you recall which depositions you reviewed?

2 A Both those for the plaintiff and the defense.

3 Q All right. Doctor, did you rely on medical
4 records and depositions in forming your opinions in this
5 case?

6 A Yes, along with the review of pertinent medical
7 journals.

8 Q All right. And my next question's going to be,
9 did you also review some medical journals, articles, or
10 literature?

11 A I did.

12 Q Doctor, based on your review of the plaintiff's
13 medical records, the depositions in this case, medical
14 literature, your background experience and training, have
15 you formed an opinion to a reasonable degree of medical
16 certainty as to whether or not Dr. Williams' medical care
17 in this case complies with the generally accepted standards
18 of care?

19 A Yes, I have.

20 Q What is that opinion?

21 A That Dr. Williams most definitely complied with the
22 standard of care.

23 Q Dr. Kohler, in your opinion, did Dr. Williams get
24 an adequate history and do an adequate physical exam to
25 diagnose Ms. Atkinson's pelvic mass?

Matthew Kohler - Direct Examination by Mr. McDow

1 A Absolutely.

2 Q Okay. Did Dr. Williams comply with the standard
3 of care and communications he had with Ms. Atkinson
4 regarding potential treatment options to deal with her
5 pelvic mass?

6 A Definitely.

7 Q Did Dr. Williams disclose the material risks,
8 benefits, and alternatives in which a reasonable
9 gynecology-oncology surgeon would disclose to comply with
10 the standard of care?

11 A Yes, I thought his preoperative discussion with the
12 patient as it is documented in his office note was
13 exemplary.

14 Q Was the surgical option in which the patient
15 accepted an appropriate method of treatment in your
16 professional opinion?

17 A Definitely.

18 Q Doctor, would you have done any additional testing
19 on Ms. Atkinson for purposes of offering her nonsurgical
20 option of following this mass with serial ultrasounds?

21 A I would not have.

22 Q Dr. Kohler, would you have recommended to the
23 patient that this pelvic mass be removed?

24 A Yes.

25 Q Tell the jury what you base your opinion on that

Matthew Kohler - Direct Examination by Mr. McDow

1 the mass needed to be removed as well as the fact that Dr.
2 Williams did not need to run additional tests and offer
3 nonsurgical options serial ultrasounds?

4 A I would base that on the entirety of my medical
5 training. I would base that on the community opinions and
6 the generally accepted standards of care that were in play
7 at the time that this patient had her surgery.

8 Q Doctor, what about the size of the mass,
9 septations, and the calcifications of the node on the CT
10 scan that came from Hartsville?

11 A I would refer first, Mr. McDow, to the CT scan from
12 Carolina Pines. Might I indulge for just a minute?

13 Q Please.

14 A So the CT scan from Carolina Pines, dated March the
15 30th, stated, quote, 12.8 by 9 centimeter right adnexal
16 mass with septations. This mass should be considered
17 ovarian neoplasm until proven otherwise, end quote. The
18 next summary of the pelvic portion of the CT is stated,
19 quote, Large cystic mass in the right adnexal. Worrisome
20 for ovarian carcinoma, end quote.

21 Associated with that was the finding of the
22 swelling of the right kidney, mild swelling of the right
23 kidney, which we call hydronephrosis. And in addition,
24 this patient, in my opinion, was clearly symptomatic from
25 her pelvic mass and the mass was easily palpable of

Matthew Kohler - Direct Examination by Mr. McDow

1 physical examination. Having been said to be centimeters
2 by Dr. Williams in exam. So this patient did not simply
3 have a scan detected mass, she had a clinically palpable,
4 symptomatic complex pelvic mass that on CT scan was felt to
5 be suspicious, in which, in my opinion, was absolutely
6 appropriate for surgical incision.

7 Q Doctor, what about the reference to the
8 calcifications around the outer margins of the mass?

9 A One has to be careful with calcifications because
10 while it's true that they can in some cases be associated
11 with benign disease, calcifications most definitely can
12 also be associated with malignancy. There is a phenomenon
13 where it's under the microscope, cirrus carcinomas of the
14 ovary, which are a highly aggressive form of cancer, have
15 microscopic calcifications, which in error can actually
16 show up as calcium on CAT scans. So calcium can be
17 indicative of benign situations, but it can also indicate
18 cancer on an occasion.

19 Q In a breast mammogram, do calcifications sometimes
20 show up? Is that what radiologists or oncologists would be
21 looking for?

22 A Yes. I don't want to portray myself as a
23 mammography expert, but yes, microcalcifications and
24 whatnot can be of concern.

25 Q Doctor, in your review of the records, did you

Matthew Kohler - Direct Examination by Mr. McDow

1 note the CA-125?

2 A I did.

3 Q All right. What is a CA-125?

4 A CA-125 is an antibody that was developed for --
5 created against a glycoprotein antigen, or protein, on the
6 surface of ovarian cancers. It was developed in the early
7 1980's by a gentleman named Dr. Robert Bass, initially as a
8 means to follow patients who had a known diagnosis of
9 ovarian cancer.

10 Q Did you note the value of the CA-125 in this case?

11 A I can't recall exactly, but it was limited within
12 normal range.

13 Q Okay. What role would that play in your decision
14 to take this patient into surgery or recommend that that
15 mass be removed?

16 A It would not have talked me out of surgery and the
17 reason for that is while the elevated CA-125 can be helpful
18 in post-menopausal patient, the fact that the CA-125 is
19 negative does not necessarily mitigate against the mass
20 being something bad. For example, we know that half of
21 early ovarian cancers have a normal CA-125. So one should
22 not be talked out of surgery simply because of the finding
23 of a normal CA-125 that's at stake.

24 Q All right, Doctor. Now, let's take a look at the
25 first surgery that was performed on April the 25th, 2007.

Matthew Kohler - Direct Examination by Mr. McDow

1 In your opinion, did Dr. Williams perform the first surgery
2 in accordance with generally accepted standards of care?

3 A Definitely.

4 Q Doctor, in terms of being medically aggressive, do
5 you believe Dr. Williams was over aggressive in this lysis
6 of adhesions?

7 A I don't have evidence of that.

8 Q Doctor, does the length of time in surgery related
9 to the lysis of adhesions concern you in this case?

10 A No, in fact, it's quite typical for complex
11 procedures that gynecologic oncologists do.

12 Q Doctor, do gynecology-oncologists get the most
13 complex and difficult cases?

14 A Without a question.

15 Q Have you had cases where you've experienced that
16 length of time in the lysis of adhesions?

17 A Every week.

18 Q Doctor, post-operatively, did you see any clinical
19 evidence of a small bowel leak or perforation between the
20 first and second surgeries?

21 A I did not.

22 Q Doctor, could you please address the drains that
23 have been discussed and those findings between the first
24 and second surgeries, please?

25 A Well, as I understand it, there were three drains.

Matthew Kohler - Direct Examination by Mr. McDow

1 One of which was in the abdominal peritoneal cavity. And
2 the other two of which had been placed in the subcutaneous,
3 which is to say the fatty tissues, in between the deep
4 layer which was closed with fascia in the skin. And the
5 reason for those latter two drains is that when Dr.
6 Williams closed the patient, he had to underline or
7 release, to some degree, the fatty tissue and the skin from
8 the underlying deep tissue in order to get enough mobility
9 to close the wound and that lessens the potential hollow or
10 dead space into which the drains were placed.

11 Q Doctor, did you review the input, output amounts
12 of the drain within the medical records?

13 A I did.

14 Q And what did those show?

15 A First of all, they did not show any outputs that
16 would be of any particular concern to me. And the second
17 thing that they show is a fairly consistent drop off,
18 generally, over time, in their amount and output. And
19 that's what we hope to see and that's what we'd expect to
20 see.

21 Q What would you expect to see if there is a small
22 bowel perforation for those drains? As far as the amount
23 is concerned?

24 A There would have been uncontrollable copious,
25 profuse, fluorescent green drainage pouring out of the

Matthew Kohler - Direct Examination by Mr. McDow

1 drains. The little suction grenades that maintain suction
2 on the drains would not have been able to keep up. The
3 drainage would have been spilling out into the bed sheets.
4 It would have been an obvious diagnosis.

5 Q And what do you mean when you say suction
6 grenades?

7 A Well, they're little plastic -- clear, rubber,
8 plastic devices that are squeezed and then hooked up to the
9 tubing and that -- and that squeeze if you will maintains
10 the suction on the device until they're empty.

11 Q Doctor, did you note that there was serosanguinous
12 and scant documentation regarding the drains?

13 A There was -- the nature of the drainage varied and
14 changed over time, but, for example on May the 16th, there
15 was no, quote, serosanguinous drainage. On 5/17, there was
16 no small serosanguinous drainage. Later on in the medical
17 record, there was additional notification or documentation
18 of that type of information. It varied. It did.

19 Q Doctor, did you review the lab values in this
20 case?

21 A I did.

22 Q Did you look at specifically the white blood
23 counts?

24 A I did.

25 Q Did those white blood counts ever elevate between

Matthew Kohler - Direct Examination by Mr. McDow

1 the first and second surgeries?

2 A They did not.

3 Q Doctor, do white blood cell counts normally rise
4 after surgery? Within the first few days?

5 A They can. It can simply be a stress response so we
6 don't panic over low elevations in the white count. We
7 look more for trends. For example, a consistently rising
8 white count particularly associated with the expression of
9 very immature white cells called bands. That, in
10 association with a patient who's appearing more clinically
11 ill, can be of great concern. But this patient's white
12 counts were always normal. Nor, did she ever have pandemic
13 (phonetic).

14 Q All right. Doctor, what would you be looking for
15 with an elevated white count?

16 A Well, again, it could be something that's benign,
17 simply a stress response to the recovery from surgery. It
18 can be a response to certain medications. For example, if
19 a patient gets some steroids, develops nausea, or whatnot,
20 post-op and Decadron, that can cause a burst in white count
21 or a slight rise. But obviously in a progressive situation
22 where the white count is increasing each and every day,
23 particularly when there are more neutrophils or bands being
24 expressed and particularly when a patient's clinical
25 scenario is deteriorating, then you need to worry about the

Matthew Kohler - Direct Examination by Mr. McDow

1 possibility of infection and even an abscess formation.

2 Q Doctor, did the white count in this case, between
3 the two surgeries, ever indicate to you any clinical signs
4 of infection?

5 A Not in the least.

6 Q Okay. Doctor, did she have any -- in your
7 opinion, did Ms. Atkinson have any clinical signs of sepsis
8 between the first and second surgeries?

9 A She did not.

10 Q Did she ever have any life-threatening infections
11 between the first and second surgeries?

12 A She did not.

13 Q Dr. Kohler, did you ever see any clinical evidence
14 that this patient had an entero-cutaneous fistula or
15 anything more serious than a relatively minor soft tissue
16 infection in the subcutaneous tissue?

17 A No.

18 Q Doctor, you're going to be asked about what's in
19 the medical records related to tachycardia. Did she have a
20 tachycardia?

21 A She did have a low level tachycardia.

22 Q And when you say low level, what do you mean by
23 that?

24 A When I took the time to review the nurses' notes
25 and the vital signs charts and, for example, on post-op day

Matthew Kohler - Direct Examination by Mr. McDow

1 number one, she was as high as 132. On post-op day number
2 three, she was 129. But truthfully, beyond, gosh, about
3 May the 2nd, which if I'm doing the math, it'd be about
4 post-op day 6 or 7, her pulse rate was in the low, sort of,
5 106 to one-teen range. Nothing terribly traumatic,
6 truthfully.

7 Q Is the mild low-level tachycardia nonspecific?

8 A Completely nonspecific. It can reflect volume
9 status and dehydration, to be expected in a patient that
10 has an ileus, involving ileus. The fluid is shifting from
11 the intravascular compartment into the lumen of the gut and
12 so patients are relatively intravascularly depleted, so
13 their heart rate goes up in response to that. Their system
14 in other words, heals the loss of fluid within the blood
15 vessels in response to that by increasing heart rate to
16 maintain blood flow to the organs.

17 It can also -- it is a normal response to pain.
18 It's a normal response to the anxiety of just having
19 surgery. It can be a secondary or a reflex response to
20 low-grade temperatures, which the patient was having. It
21 can be a sign of thyroid disease and so forth and so on.
22 It's completely nonspecific.

23 Q Doctor, can you address to the jury, please,
24 Plaintiff's Exhibit 4, nausea, vomiting between the first
25 and the second surgery. Does that cause you any concern?

Matthew Kohler - Direct Examination by Mr. McDow

1 A Well, I think Dr. Williams correctly interpreted
2 over time that nausea and vomiting along with the
3 appropriately radiographic studies to be indicative of an
4 ileus, which is to say, the bowel essentially goes to sleep
5 because of the manipulation at the time of the first
6 surgery.

7 Obviously, other things can cause nausea, too. For
8 example, narcotic pain medications are notorious for
9 causing nausea and whatnot. But over time, when the
10 symptoms persisted and so forth, it was correctly diagnosed
11 as an ileus versus a partial small bowel obstruction.

12 Q Now, you talked about the tachycardia, you talked
13 about the nausea and vomiting, let me ask you about
14 Plaintiff's Exhibit No. 5, abdominal distention. Is there
15 anything in the records to indicate to you that Dr.
16 Williams failed to appropriately evaluate the abdominal
17 distention between the first and the second surgeries?

18 A Quite the contrary. I thought that he was normal
19 at evaluating the abdominal distention. The thing that I
20 was most impressed about, truthfully, when reviewing this
21 chart last night is his meticulousness of the care that Dr.
22 Williams provided. I mean there was an attending note -- a
23 progress note in this patient's hospital chart virtually
24 every single day. There's a physician note every day. And
25 Dr. Williams' name is all over the chart. Virtually every

Matthew Kohler - Direct Examination by Mr. McDow

1 day, he or his partner were rallying this patient; he had
2 senior level attending physicians that were evaluating this
3 patient each and every day.

4 It's not like the care was delegated to resident
5 physicians or medical students. He had the attending
6 physician who operated on this patient seeing and examining
7 and documenting that exam each and every day in this
8 medical record.

9 Q Doctor, do you have an opinion to a reasonable
10 degree of medical certainty that Ms. Atkinson had a partial
11 small bowel obstruction?

12 A I believe that she did.

13 Q Now, what do you base that opinion on?

14 A I base that opinion on the clinical impression of
15 the attending physicians, multiple who examined her and
16 that includes Dr. Williams, Dr. Smith, Dr. Parker who saw
17 her in consult; I base that on multiple x-rays studies that
18 she had done over time, the KUB's. I base that on the
19 Upper GI of the small bowel follow through that she had
20 done which clearly demonstrated a bad ileus versus a
21 partial SBO and I base that on the fact that over a
22 prolonged period of conservative management, which would
23 have been expected to resolve an ileus was unsuccessful and
24 so after 33 days, it was clear that this patient had a
25 partial small bowel obstruction that was not responding to

Matthew Kohler - Direct Examination by Mr. McDow

1 conservative therapy.

2 Q Doctor, when you talk about not responding to
3 conservative therapy, what would that conservative therapy
4 have been?

5 A Conservative therapy -- conservative therapy would
6 have been bowel rest for some period of time until the
7 patient showed evidence that she could tolerate oral
8 intake. It would have been IV hydration; it would have
9 been the initiation of peripheral hyperalimentation, which
10 is to say nutritional support through the vein or TPN,
11 which is what she got. It would have been a concurrent
12 evaluation to make sure that she wasn't developing any
13 secondary or downstream complications of a bowel
14 obstruction, such as perforation of the bowel, or ischemia
15 of the bowel, or strangulation of the bowel, or gangrene of
16 the bowel, none of which she had any clinical sign of. And
17 ultimately, it would have to be -- reaching a stopping
18 point where we're getting stopped at further attempts of
19 conservative management more likely to be futile, and that
20 something of more invasive would have to be done to correct
21 the problem.

22 Q Doctor, was the second surgery performed by Dr.
23 Williams outside the purview of gynecologist-oncologists?

24 A Not at all.

25 Q Dr. Kohler, Dr. Williams has been criticized for

Matthew Kohler - Direct Examination by Mr. McDow

1 not obtaining a CT scan in this case. Are you critical of
2 Dr. Williams for not obtaining a CT scan in this case?

3 A I am not.

4 Q Why not?

5 A Because this patient had the appropriate diagnostic
6 and radiographic and laboratory tests done to evaluate the
7 diagnosis of ileus versus small bowel obstruction. She had
8 appropriate clinical management. She had a contrast study
9 to more further precisely define the nature of the ileus
10 versus obstruction and there was no clinical evidence of
11 overwhelming infection or sepsis that would have triggered
12 the necessity of a CT scan.

13 Q Dr. Kohler, stated no way --

14 **MR. CORBIN:** Objection, Your Honor, please.

15 Leading the witness. The attorney stating another
16 way of what he just said.

17 **THE COURT:** Overruled.

18 **BY MR. MCDOW:**

19 Q Doctor, do you have an opinion to a reasonable
20 degree of medical certainty as to whether or not Dr.
21 Williams violated any standards of care by not ordering a
22 CT scan in this case?

23 A By not ordering the scan, he did not violate the
24 standard of care.

25 Q Doctor, you mentioned the small bowel follow

Matthew Kohler - Direct Examination by Mr. McDow

1 through. Did you know there is criticism related to the
2 use of barium? Did you review the physician's order for
3 Upper GI, small bowel follow through for this case?

4 A I did.

5 Q Who ordered the use of the barium? Who's choice
6 would that be?

7 A It's my understanding looking at the record, I can
8 find no evidence that Dr. Williams made that decision. I
9 believe that decision to have been made by the radiologist
10 that did that procedure.

11 Q Was there any clinical indication of a small bowel
12 perforation on May the 2nd, 2007, at the time of the small
13 bowel follow through with barium was performed?

14 A There was not.

15 Q Do you have any criticisms of the use of barium at
16 the point?

17 A I do not. Might I -- Might I be indulged for a
18 minute.

19 Q You might. Go right ahead?

20 A There is a proper series of guidelines for managing
21 small bowel obstruction that is put out and is available
22 and published online called the East. That's spelled
23 E-A-S-T Practice Parameter Work Group. And in that -- in
24 that recommendation summary on page 3, it states that
25 during the diagnostic phase, the workup of small bowel

Matthew Kohler - Direct Examination by Mr. McDow

1 obstruction, number six. That nonionic, low osmolar weight
2 contrast, gastrografin, water-soluble dye, is an
3 alternative to barium for contrast studies to evaluate for
4 SBO for diagnostic purposes. This series of guidelines was
5 published in 2007 when it would have been entirely relevant
6 to this patient's management. It does not say, in this
7 summary of recommendations, that gastrografin, or
8 water-soluble contrast must be used. It says, it's a
9 viable alternative to barium. Which is to say that barium
10 is the implication here and barium is perfectly acceptable.

11 Q Doctor, you said that conservative management was
12 to be NPO, nothing by mouth, and the TPN given
13 appropriately in this case?

14 A I believe it was.

15 Q Did the small bowel follow through and the
16 subsequent KUB provide you reassurance that there was not a
17 clinical leak?

18 A They did.

19 Q How so?

20 A Well, for example, on post-operative day number 9,
21 or May the 4th, it states, a follow-up KUB after the Upper
22 GI series showed, quote, barium in colon; finding
23 consistent with partial or incomplete mechanical small
24 bowel obstruction, end quote. There was no mention of leak
25 at that time. On postoperative day number 17, or eight

Matthew Kohler - Direct Examination by Mr. McDow

1 days later on the 12th, the flat plate says, quote, marked
2 delay of GI transit; angular contrast collection, can't
3 exclude extra-luminal contrast, but unlikely. And I
4 emphasize but unlikely.

5 Again, on post-operative day number 26 or May the
6 21st, the flat plate showed findings worrisome for small
7 bowel obstruction. And again on post-operative day number
8 28, which was just a few days before the second operation,
9 the flat plate showed partial clearance of contrast barium,
10 end quote. At no point in my reading of the medical record
11 was there alarms radiologists' language to suggest that
12 contrast leak or anything of that nature.

13 Q All right.

14 A I want to make one point. My institution and I'm
15 sure that Dr. Williams' is as well; if a radiologist
16 encounters a potentially alarming or emergency or dangerous
17 finding on a radiograph, they invariably will personally
18 page and personally contact the attending physicians who's
19 taking care of that patient. For example, if they do a CT
20 and they find a blood clot, certainly what they have found
21 contrast leak or findings that were worrisome of a contrast
22 leak, almost by definition they would have personally
23 immediately contacted Dr. Williams, which, to my knowledge,
24 was never done.

25 Q Doctor, in your opinion, did Ms. Atkinson have an

Matthew Kohler - Direct Examination by Mr. McDow

1 abscess?

2 A She did not.

3 Q What do you base that opinion on?

4 A There was no clinical evidence of an abscess, in my
5 opinion, ever.

6 Q What would you have expected to have seen if she
7 did have an abscess?

8 A I would have seen a patient that was persistently
9 febrile. This patient did have a few low grade
10 temperatures early on in her post-operative course, but
11 those quickly resolved. For example, it's my opinion of
12 the medical record that after post-operative day number
13 five, she had no more fevers. Remember that when abscesses
14 form, they don't form on post-op day one or two, they form,
15 gosh, day five, day seven, day ten. So if anything, if
16 this patient were forming an abscess, we would have
17 expected her fevers to start kicking in about five to seven
18 days post-op, which they never did.

19 Almost an invariable finding in a pelvic abscess or
20 an abdominal abscess is the progressively rising white
21 count. I'm talking about into the 20, 25, 30, 40 thousand
22 range with a left shift, which is to say that immature
23 cells were there. Patient never had that. We'd accept
24 that -- we'd expect that untreated abscess, the only
25 effective treatment by large is surgical or pigtail

Matthew Kohler - Direct Examination by Mr. McDow

1 catheter drainage. If that isn't accomplished, the patient
2 quickly gets very, very ill and will get profoundly
3 tachycardic. We're talking about pulse rates in the 140,
4 150; high grade fever, she starts looking sick. And then
5 the metabolic parameters start to deteriorate. Patients
6 will start to shut down their kidneys. They'll start to
7 have a build up of acid in their blood, they will lower
8 their bicarbonate in their blood, the bicarbonate being the
9 buffering agent in the blood. This patient's bicarbonate
10 levels were almost normal. Her kidney function remained
11 normal. The kidneys are the first things to go if
12 somebody's clinically septic and sick. This patient's
13 kidney function was normal throughout. It's my -- it's my
14 unabashed clinical opinion that this patient was never
15 septic and she had no clinical signs of an abscess.

16 And I would add one more thing and that is that had
17 this patient had a smoldering intraabdominal abscess, that
18 would have been the first thing that Dr. Williams
19 encountered in his second surgery. He would have opened up
20 the abdomen and there would have been brown or green, white
21 cream pus just pouring out in copious amounts. The nurses
22 would have had to break out the Wintergreen for the OR
23 staff and the circulating nurses. It's really an awful
24 thing when you encounter that and, you know, once a month
25 or every month or two, I'm in a case like that, bacteremia,

Matthew Kohler - Direct Examination by Mr. McDow

1 infection, or whatever. It's not a subtle finding.

2 There's a lot of talk in this case about the possibility of
3 gold-colored dye that was found at the second surgery.

4 There was never any talk of pus in the abdomen. I --
5 there's no clinical evidence that there was an abscess in
6 this patient whatsoever, in my opinion.

7 Q Doctor, speaking of the second surgery, do you
8 have an opinion to a reasonable degree of medical
9 certainty, whether or not Dr. Williams performed the second
10 surgery within the applicable generally accepted standards
11 of care?

12 A I believe that he did.

13 Q What do you base that opinion on?

14 A I base that opinion on the fact that this patient
15 was clearly not responding to an extended course of
16 conservative therapy. This patient was post-operative day
17 number 33 and she wasn't getting better. A Board certified
18 general surgeon had been involved and declared that this
19 patient wasn't responding and would almost certainly need
20 to be re-explored or likely need to be re-explored, but
21 because of the patient's understandable wishes to avoid a
22 second operation for at least a while. You know, Dr.
23 Williams pursued an additional, I think wisely, additional
24 conservative measures. But when it was clear that those
25 weren't working, I don't know that he had a choice. Dr.

Matthew Kohler - Direct Examination by Mr. McDow

1 Williams is clearly qualified to perform all manner of
2 bowel surgery.

3 I've referred previously to the published
4 guidelines put out by the American Board of OB-GYN that
5 referred to the scope of surgical training and practice
6 that's applicable to gynecologic-oncologist and in that
7 published scope of practice guidelines, in fact, I would
8 refer to page 67, it talks about gastrointestinal upper
9 abdominal procedures. This is the so-called guide to
10 learning in gynecologic-oncology published by the American
11 Board of OB-GYN in the year 2006 and in that series of
12 published guidelines, I would refer to item two resections
13 and reanastomosis of the small bowel; number three, bypass
14 procedure to the small bowel, mucus fistula formations of
15 the small bowel, ileostomies, repair of fistulas, resection
16 reanastomosis of large bowel.

17 There is no question that Dr. Williams was both
18 trained, qualified, and indeed credentialed to perform this
19 surgery.

20 Q Dr. Kohler, these criticisms for the time frame in
21 taking Ms. Atkinson back to surgery, between the first
22 surgery and the second surgery, would you sit on this
23 patient like Dr. Williams did between the two surgeries?

24 A Absolutely.

25 Q All right. There's been criticism for not placing

Matthew Kohler - Direct Examination by Mr. McDow

1 an NG tube in between the first two surgeries until the day
2 before, May the 27th, would Ms. Atkinson have benefited
3 from an NG tube between those two times?

4 A Hard to say. Maybe, maybe not. You know, patients
5 hate them; they're uncomfortable; they have a number of
6 known complications. They can cause erosions of the
7 stomach, they can cause erosions in the nasal septum, they
8 can cause microscopic or even gross bleeding from the
9 lining of the stomach. They tend to decrease a patient's
10 incentive to take deep breaths and to get up and move
11 around. So as I believe Dr. Parker pointed out, they can
12 be contributory to patients remaining bedridden and getting
13 pneumonia, atelectasis, things of that nature. And
14 patients just hate them.

15 Moreover, I had one of my associates to a
16 comprehensive literature search this morning to see if any
17 randomized trials, which are really the gold standard in
18 the medical literature when you compare one treatment to
19 another to see if there were any published randomized
20 trials that we could find in the medical literature of
21 nasogastric suction versus no nasogastric suction in the
22 treatment of post-operative small bowel obstruction. We
23 were unable to find any randomized trials that indicate
24 that there's definite proof that nasogastric tubes benefit
25 patients.

Matthew Kohler - Direct Examination by Mr. McDow

1 There's a lot of things that we do in medicine
2 where we just do them because that's how we were taught.
3 But it -- but really, I didn't come across any level of
4 evidence that would have supported it. That would -- that
5 would say that not using an invasive nasogastric tube has
6 been proven to be detrimental to patients.

7 Q Doctor, do you have an opinion to a reasonable
8 degree of medical certainty as to whether or not Dr.
9 Williams complied with standard of care by taking Ms.
10 Atkinson back to surgery on May the 28th, 2007?

11 A I believe that he did comply with the standard of
12 care.

13 Q Doctor, as a gynecology-oncologist, would Dr.
14 Williams have the right to rely upon the second opinion of
15 Dr. Parker?

16 A Yes.

17 Q You mentioned the term, bandemia; what is
18 bandemia?

19 A Bandemia is the -- is the appearance in the
20 peripheral blood of immature neutrophils, or immature
21 granulocytes, which are called bands. And one of the
22 things that I've been taught in my training is actually,
23 while the total white count is significant, the presence or
24 absence of bands is arguably just as significant, okay. So
25 the sickest patients you'll ever see are those that are all

Matthew Kohler - Direct Examination by Mr. McDow

1 of a sudden looking sick and they're kicking out an
2 abnormally high level of immature neutrophils.

3 For example, a normal band count is under five
4 percent in our lab. You start to show me a patient who has
5 a 30 or 40 percent band count, that's a patient who's
6 fixing to fall off the cliff clinically. Look out.

7 Q All right. Doctor, let me show you -- show you my
8 copy, I know it's in evidence. Page 990 in the labs there
9 is -- is that what you're referring to when you talk about
10 bands?

11 A Yes.

12 Q Okay. First off, what's the range for -- the
13 reference range for having that?

14 A Evidently, in y'all's lab, it's zero to ten
15 percent.

16 Q And what was the reading on this occasion?

17 A Well, I think --

18 Q Well -- Yeah, what's the date and time?

19 A Let me summarize it by my -- on 5/28, which of
20 course was the day of the patient's second surgery, the
21 band count had gone to 42 percent, okay. Forty-two
22 percent, which is to say four times the normal range in
23 that lab. And of course this is -- this is the day of the
24 second surgery.

25 Q And what is the time that that lab was taken?

Matthew Kohler - Direct Examination by Mr. McDow

1 A About six o'clock in the afternoon.

2 Q Would that be after she came out of surgery that
3 day?

4 A That is correct. It's a stress response.

5 Q No indication based on that particular band that
6 there was any type of abscess, small bowel leak,
7 perforation, or infection; is that correct?

8 A I believe in that circumstance it would have been a
9 stress response. Because again, at the time of that second
10 surgery, there was no evidence of abscess. Specifically no
11 evidence of abscess.

12 Q Dr. Kohler I got a little bit ahead of myself.
13 Let me back up. Tell the jury what a week in the life of
14 Dr. Kohler is like. What do you do on Mondays? How many
15 patients do you see? What do you do with your residents?
16 How many operations are you doing and so forth?

17 A Well, I joke that it's sort of reverse form of job
18 security because nobody wants my job. There are long days.
19 So, for example, when I come to work, I'll typically on
20 Monday have an all day clinic. I'll see 30 or 35 patients
21 over the course of the day.

22 On Tuesdays, it's our academic morning, we have
23 grand rounds. And like most Tuesdays, I operate in the
24 afternoon. I operate all days on Wednesdays. On Thursday
25 mornings, it's back in clinic for a half-day, typically

Matthew Kohler - Direct Examination by Mr. McDow

1 seeing 15 to 20 patients and then it's back to the
2 operating room Thursday afternoon. And then on Friday, I
3 either have clinic up in one of our satellite facilities in
4 the Grand Strand or many times, I operate on that day as
5 well.

6 So there -- and then on top of that, I'm in a
7 three-person practice and so we're on call for one out of
8 every three weeks, which is to say the pager is on our
9 person 24/7 for all of the calls that come in two o'clock
10 in the morning, three o'clock in the morning. I think it's
11 important to understand that in this day and age, a
12 gynecologic oncologist not only has his or her clinical
13 practice of cancer patients or whatnot, but we've become
14 the de facto advanced pelvic surgeons for the field of
15 obstetrics and gynecology.

16 So for example, we're the -- we're the folks
17 that -- we're the beneficiaries of all the surgical
18 training and complex cases so we'll get the calls for labor
19 and delivery for example and a young mother is trying to
20 bleed to death after a delivery or after a c-section and we
21 get those calls increasingly often now-a-days. And they're
22 hair-raising, when the pager goes off at two o'clock and
23 some 26 year old young mother is trying to bleed to death
24 on labor and delivery and we're the backstop and so we get
25 called in to do that. So there are long days.

Matthew Kohler - Direct Examination by Mr. McDow

1 Q Doctor, based on your education and training and
2 experience, your review of the various medical records and
3 depositions you've read in this case, the medical
4 literature, have you formed an opinion to a reasonable
5 degree of medical certainty as to whether or not Dr. James
6 Williams complied with the generally accepted standards of
7 care in the care that he rendered to Ms. Atkinson that we
8 discussed?

9 A I have.

10 Q What is that opinion?

11 A I believe without question that Dr. Williams
12 adhered to the standard of care. Could I ask a favor and
13 get a refill.

14 Q I'll get a refill on that. I do have one more
15 question?

16 A Yeah.

17 Q How many times have you testified in court as an
18 expert?

19 A In court, this is my first time.

20 Q I have no further questions.

21 THE COURT: All right. Mr. Corbin, Mr. McDow,
22 would y'all come up for just a moment.

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

25 THE COURT: Ladies and gentlemen, you may go to

Matthew Kohler - Direct Examination by Mr. McDow

1 your jury room, please. Do not discuss the case and I'll
2 have you back out in just a few minutes.

3 (WHEREUPON the jury left the courtroom at 4:12
4 p.m.)

5 THE COURT: Dr. Kohler, you may step down. You may
6 not discuss your testimony or opinion. All right.

7 THE WITNESS: All right. Thank you.

8 (WHEREUPON there was a recess observed.)

9 THE COURT: Okay. Mr. McDow, are you ready for the
10 jury?

11 MR. MCDOW: I am ready for the jury, yes.

12 THE COURT: Okay. Mr. Corbin?

13 MR. CORBIN: Yes, sir.

14 THE COURT: Dr. Kohler's up here and we're not
15 going to get them quite yet. Wait till he finishes talking
16 to the gentlemen and then we'll start.

17 MR. CORBIN: Your Honor, may I -- may I ask the
18 witness. I'm going to use his exhibits to his deposition,
19 does he have his handwritten notes? If not --

20 THE WITNESS: I do. Let me just verify --

21 THE CLERK: I can make copies.

22 THE COURT: Who said that? Oh that was you. Okay.
23 No, I thought someone out there answered and I didn't know.

24 THE WITNESS: Mr. Corbin, let me verify that that's
25 what you're referring to right there.

Matthew Kohler - Direct Examination by Mr. McDow

1 MR. CORBIN: May I -- May I look at it Your Honor
2 to make sure we're talking about the same thing.

3 THE COURT: Yes, sir. You can do that. I wasn't
4 telling you to be quiet, I just thought that somebody was
5 talking to me.

6 Now, you did --

7 MR. CORBIN: Yes, sir.

8 THE COURT: -- not use Dr. Strickland's deposition;
9 is that correct? In questioning him.

10 MR. MCDOW: I don't think we did. I don't think we
11 did.

12 THE COURT: Do you want to mark it as an exhibit
13 in --

14 MR. MCDOW: Yes, sir.

15 THE COURT: Is it in yet?

16 Okay. Now you ready?

17 MR. CORBIN: Yes, sir.

18 THE COURT: Where did --

19 MR. MCDOW: I'm down here.

20 THE COURT: Okay. All right. Bring in the jury.

21 (WHEREUPON the jury entered the courtroom.)

22 THE BAILIFF: Jury's seated, Your Honor.

23 THE COURT: All right, sir. Yeah.

24 ///

25 ///

Matthew Kohler - Cross-Examination by Mr. Corbin

CROSS-EXAMINATION

BY MR. CORBIN:

Q Good afternoon, Dr. Kohler.

A Good afternoon.

Q Yes, sir. Were you aware that by the time Dr. Williams surgically fixed Faye after her second surgery, she had about two and a half feet of small bowel left. Were you aware of that?

A I -- as the politicians say, I can neither confirm or deny it. I just --

Q Yes, sir.

A I don't have specific knowledge in that regard.

Q A normal female, 5 foot 2 or so, it's been in testimony, on average, 16 to 18 feet of small intestines. Is that a fair average?

A It is. I want to qualify that that would be an individual who's had no prior bowel surgery. Ms. Atkinson clearly having had prior bowel surgery...

Q Do you believe that the prior bowel surgeries in Hartsville in 1995 caused Ms. Atkinson to have short bowel syndrome?

A I have no evidence that that's true.

Q Do you believe or have any evidence that the surgeries she had in 1995 in Hartsville caused her to have some kind of abnormally shortened bowel?

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A I believe that her bowel would have been shorter
2 than the 16 to 18 feet that has been referred to, but I
3 haven't reviewed those notes from 1995, so I couldn't
4 speculate by how much her bowel length had been shortened
5 previously.

6 Q Assume Faye does in fact have about 2 and half
7 feet of small bowel left.

8 A At the present time?

9 Q Yes, sir. How about 20 -- let's be more precise.
10 About 2 and a half feet of small bowel left. That
11 certainly falls in the range of short bowel syndrome?

12 A I would agree.

13 Q Anything less than 6 or 8 feet would fall within
14 bounds of short bowel syndrome; correct?

15 A Two and half meters, 6 feet on average.

16 Q So whatever caused it, when Dr. Williams fixed
17 Faye with the second operation, by definition, 2 and a half
18 feet is a lot less than 6 feet. She had short bowel
19 syndrome; correct?

20 A Again, 2 and a half -- 2 and a half feet currently;
21 yes, that is correct.

22 Q Barium causes chemical peritonitis, right?

23 A I -- anecdotally, I have heard that to be true; I'm
24 not an expert in that area.

25 Q And, you were very frank in your deposition. The

Matthew Kohler - Cross-Examination by Mr. Corbin

1 first part of your deposition was -- you saw no evidence at
2 all of a bowel perforation between the first and second
3 operations. That's what you initially said in the
4 depositions; right?

5 A Correct.

6 Q Later on towards the end of the deposition, you
7 stood corrected and honestly told me that; fair enough?

8 A I reread my deposition last night and what I said
9 is that I was willing in that -- in the latter part of the
10 deposition to entertain the possibility and I still think
11 there's a lot of ambiguity in the medical record as whether
12 she might have had an occult or micro-leak in retrospect
13 given the presence of the possible versus probable
14 gold-colored dye in the abdomen.

15 Q Fair enough. And you know exactly what I'm
16 talking about in the second operative report, correct?

17 A Correct.

18 Q And the issue is whether or not we accept the
19 first two sentences as true and accurate, correct?

20 A The first two sentences of the operative note?

21 Q Yes, sir.

22 A Let me just take one minute, if I may, to pull that
23 up.

24 Q Do you have it, Doctor?

25 A Let's see.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Okay, I've got it.

2 Q Yes, sir. The findings are supposed to be
3 accurate and correct. Fair enough?

4 A Correct.

5 Q Assume that in fact the second sentence is true?

6 A Which is -- the pocket of probable --

7 Q Quote, pocket of probable extravasated bowel.
8 That means leak. Fair?

9 A Extravasated dye would refer to contrast material
10 that was outside of the lumen of the bowel.

11 Q And if a person sips it and it goes to the
12 intestines and it gets outside the intestine, there was a
13 hole?

14 A That is correct; that is true.

15 Q You were talking a while ago, you know, about
16 sitting on patients and that kind of stuff?

17 A Right.

18 Q And we discussed that in deposition and Faye
19 Atkinson was a very complex, difficult patient. Especially
20 after the first surgical procedure, the resection, a couple
21 of perforations, and 32 post-operative days. She was
22 complex and difficult to operate on, wasn't she?

23 A I just would have to look back. Did she have a
24 couple -- as you say, a couple of perforations; I only
25 recall one enterotomy in the first surgery that

Matthew Kohler - Cross-Examination by Mr. Corbin

1 necessitated the small bowel resection and reanastomosis.

2 I don't --

3 Q We'll go with one.

4 A Okay.

5 Q It was a still a difficult surgical procedure
6 whether one or two and there was a resection?

7 A Correct.

8 Q How much bowel was taken out in the first surgical
9 procedure?

10 A I have -- I don't know.

11 Q You do know that after the first surgery, that she
12 was at a high risk for certain post-surgical complications;
13 fair enough?

14 A She was at increased risk for post-operative
15 complications. Both by virtue of the fact that she was
16 complex from the get go having had prior bowel resections,
17 having had a bowel resection at the time of first surgery.
18 So she was increased peri-operative risk.

19 Q Peri-operative risks such as a perforation or hole
20 in the bowel; correct?

21 A Well, actually, her risks would have been increased
22 across the board. Whether you want to talk about wound
23 infection; whether you want to talk about atelectasis,
24 pneumonia, blood clots. Actually, bowel leak, or
25 perforation -- as you say, perforation, would have been

Matthew Kohler - Cross-Examination by Mr. Corbin

1 relatively low. I mean, on a percentage basis, it may have
2 been relatively increased but the absolute number would
3 have still been a very low number.

4 Q It would make the list?

5 A If one was going to be exhaustive and encyclopedic
6 in listing the possible risks; then it would be somewhere,
7 but it would be very low if not at the bottom of the list.

8 Q So if Faye is your patient, the risk of a bowel
9 leak with respect to your treatment, it might not even make
10 the list, but it'd certainly be way down on the bottom of
11 the list; correct?

12 A I agree with that.

13 Q You told the jury that you were impressed with the
14 care that Dr. Williams provided to Faye; true?

15 A True.

16 Q Very meticulous; true?

17 A True.

18 Q Do you recall in your deposition when I had
19 subpoenaed you to bring any handwritten notes that you
20 might have prepared in your review?

21 A Yes.

22 Q Do you have those particular handwritten notes
23 with you on the witness stand?

24 A Yes, give me just a minute. I've got them.

25 Q Were you careful when you reviewed the materials?

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A Could you be more specific.

2 Q Did you consider yourself to be careful in doing a
3 thorough job when you reviewed Faye's medical records?

4 A Yes.

5 Q Go to your handwritten notes. You were hired by
6 the defense in this case; correct?

7 A Correct.

8 Q And you were instructed, do not prepare a written
9 report; weren't you?

10 A Mr. Corbin, honestly, my involvement in this case
11 began almost 2 and a half years ago and I cannot in good
12 conscience state what the instructions would have been 2
13 and a half years ago. I honestly can't, for the record,
14 state that.

15 Q If you would have been told four separate times in
16 writing in this particular case, from the defense, asking
17 for, I do not underscore, need a written report, as before,
18 I do not need a written report?

19 A Yes. I had -- I had seen those -- I had seen that
20 appearing in cover letters subsequently, but again, we're
21 referring to the initial contact 2 and a half years ago,
22 and at that time, I don't remember if there were
23 instructions, truthfully.

24 Q These are four letters, starting June 20, 2011;
25 November 4, 2001; February 1, 2012. Would you identify

Matthew Kohler - Cross-Examination by Mr. Corbin

1 those as letters that you got --

2 A Yes.

3 Q With your instructions in this case?

4 A Yes, I would. And I would also comment that they
5 were -- the first one that you gave me, which is to say the
6 oldest one, is almost a year after the date of the cover
7 letter that Mr. McDow sent to me, sending me back my
8 handwritten notes. So for example, I've got a letter from
9 Mr. McDow returning to me my handwritten notes from July
10 20th, 2010. The earliest letter that you -- or the oldest
11 letter that you just gave me is dated almost a year later
12 in June 2011.

13 Q Dr. Kohler, please, I'm not saying that you did
14 anything inappropriate?

15 A Yeah.

16 Q I'm just saying that at one time, for whatever
17 reason, you were instructed not to prepare anything in
18 writing; correct?

19 A I would agree with that statement.

20 Q And you were instructed four times, okay?

21 A I'll take your word for it.

22 Q You prepared your handwritten notes before you got
23 those four instructions, do not put anything in writing;
24 correct?

25 A Again, I want to be clear. I cannot honestly

Matthew Kohler - Cross-Examination by Mr. Corbin

1 remember what the instructions would have been or would not
2 have been when I got involved in the case initially in the
3 Summer of 2010. I would stipulate that as you've pointed
4 out, in June of 2011, there was a series of cover letters
5 from Mr. McDow instructing me not to report written reports
6 after then.

7 Q Please turn to your handwritten notes; the one
8 that has issues on it. On the left hand side?

9 A Okay.

10 Q And this entire note is in your handwriting;
11 correct?

12 A That is correct.

13 Q Nobody else wrote anything on this document except
14 you; correct?

15 A Nobody can impersonate my sloppy handwriting.

16 Q Yes, sir. And not many people could probably read
17 it either; true?

18 A No.

19 Q And if I may, when I ask you to read this, I might
20 ask you about the underscoring, because sometimes you have
21 one underscore, sometimes two underscores; sometimes you
22 have as many as four or five stars next to these issues;
23 correct?

24 A Fair enough.

25 Q Would you please read verbatim starting with the

Matthew Kohler - Cross-Examination by Mr. Corbin

1 first issue that you had in this case?

2 A Okay. Number one, review of consents, particularly
3 pertaining to surgeries, number one and number two,
4 parenthesis, i.e., Williams end parenthesis. And number
5 two, what happened to the bowel resected in surgery number
6 one? It never appears on the Path Report and Williams
7 doesn't mention reanastomosis per se.

8 Q If I may, please. And you had underlined, what
9 happened to the bowel. Or did you underlined something
10 later? This is just a...that you crossed off?

11 A I have --

12 Q Oh, I'm sorry. The part of the message that's
13 underlined. Please continue.

14 A Yeah. It says, nightmare scenario, underlined. He
15 got distracted and didn't finish the resection of the
16 reanastomosis. I'll -- we'll come back to that if I get an
17 opportunity.

18 Q Yes, sir. I want you to read it first, please.

19 A Okay. Need to pin Williams down on this and/or use
20 CT scans to look for staple lines.

21 Q Okay. I'm going to ask you a question?

22 A Uh-huh.

23 Q When you went looking for the CT scans, did you
24 find any?

25 A I did not.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Q Did you pin him down?

2 A I have never spoke -- I actually looked forward to
3 this court date. I've never met or spoken to Dr. Williams
4 in my life.

5 Q When you put on here, potential nightmare
6 scenario --

7 A Uh-huh.

8 Q And you needed to pin Dr. Williams -- or you said
9 pin Williams down. What happened to the bowel? Did you
10 ever find out?

11 A No.

12 Q What's the next -- oh, I'm sorry. What's the next
13 issue with the case? Number three?

14 A Number three, what was conversation between
15 Williams and patient and --

16 Q What --

17 A -- and A Williams and patient and B Williams and
18 Harris parenthesis, general surgeon, end parenthesis, prior
19 to Williams second surgery. And then underlined, why
20 didn't general surgeon do the case? Need to find out what
21 Harris' testimony is going to be in this regard.

22 Q And you've got that underscored twice?

23 A Correct.

24 Q Why did you have an issue, why didn't general
25 surgeon do the case; we need to find out what Dr. Harris'

Matthew Kohler - Cross-Examination by Mr. Corbin

1 testimony is going to be? Why was that important to you?

2 A I think it, admittedly and arguably, it was a -- it
3 was a difficult case and Dr. Harris had consulted to get
4 involved in providing a second opinion and in some
5 circumstances, that might have led to his participation in
6 the second surgery.

7 Q The fourth issue you have after review of the
8 records was what, please?

9 A What was patient's nutritional status just before
10 second surgery? Albumin, pre-albumin. Was she on TPN?
11 Was thought given to prolong TPN instead of, underlined,
12 pre-operation, question mark.

13 Q If I may, please?

14 A Uh-huh.

15 Q Before the second surgery --

16 A Right.

17 Q -- you had a question when you reviewed the
18 medical records?

19 A Uh-huh.

20 Q When you prepared this handwritten note. Your
21 question was, was thought given to prolong TPN instead of,
22 underscored, preoperation; did you ever find the answer out
23 to that question?

24 A I did not.

25 Q Please continue.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A I might ask you or the Court, can I ask one
2 question.

3 THE COURT: You can't ask me anything, but you can
4 respond to the questions that Mr. Corbin --

5 MR. CORBIN: I think --

6 THE COURT: -- if you need guidance from me, you
7 can --

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

9 THE COURT: You can ask Mr. Corbin.

10 BY MR. CORBIN:

11 Q Under the rules, Doctor -- and we all have rules?

12 A Uh-huh.

13 Q Doctors have rules too, correct?

14 A Most days.

15 Q Yes, sir. Attorneys have rules. And the rules
16 are, I ask you the questions --

17 A Fair enough.

18 Q And please, you're under oath, please answer the
19 questions under oath. Will you get that please?

20 The fourth issue that you had with Dr. Williams'
21 care was what?

22 A I think that's --

23 Q I'm sorry --

24 A Number five.

25 Q Yes, sir. Number five.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A Okay.

2 Q What was the fifth issue you had with his care,
3 please, sir?

4 A How many -- I'm just, literally, trying to read my
5 own handwriting. How many extensive bowel surgeries had
6 Williams done previously as determining the surgeon, who he
7 consulted as such.

8 Q Did you ever find out the issue of that? Did you
9 pin anybody down on that issue?

10 A My presumption was that Dr. Williams has done many,
11 many of those types of surgeries. But I don't believe he's
12 out of his league.

13 Q And if we could, go back. We have another
14 handwritten note which you entitled at the top Op Notes of
15 4/25/2007. Can you please go to that page?

16 A Yeah. Got it.

17 Q Okay. Here you have a couple of problems listed?
18 The first one has four stars next to it. Four stars
19 following number one. Read to the jury what that four
20 stars problem was?

21 A Further description of bowel reanastomosis.

22 Q Why is that important, please?

23 A Well, it would potentially be important because if
24 the bowel was resected and not re-hooked back up then it
25 would lead to a high-grade bowel obstruction.

Matthew Kohler - Cross-Examination by Mr. Corbin

1 Q High-grade bowel obstruction. What is the medical
2 significance of that? If you don't properly do the
3 resection, get a high-grade obstruction, what is the
4 medical significance, please?

5 A Well, the patient would end up with a bowel
6 obstruction; of course, she never had a -- that. She had
7 documentation of barium all the way through her intestine
8 on subsequent studies. There's also -- when you re-read
9 that post-operative note, Dr. Williams, there is, in
10 fact -- when I re-reviewed it, specific reference to the
11 bowel reanastomosis.

12 Q If we can doctor -- I mean, if you want to pull
13 that aside --

14 A Sure.

15 Q If you want to fully discuss these problem
16 areas -- I'd rather go through the problems and then you
17 can fully explain --

18 A Fair enough.

19 Q -- your position.

20 A Sure.

21 Q So we can make some sense of it.

22 A Sure.

23 Q Now that problem, it didn't have one but it had
24 four stars. Is that a big problem?

25 A When I -- then, this was my first pass through of

Matthew Kohler - Cross-Examination by Mr. Corbin

1 the medical record. This was literally my first pass, a
2 cursory perusal of the records. It might have seemed to be
3 a problem initially, but again, when one looks at the
4 options and Dr. Williams states excellent attention
5 reanastomosis was accomplished, that completely alleviates
6 my fears along with the fact that the subsequent barium
7 study showed the contrast went right through. So he -- he
8 most definitely reanastomosed that bowel. That's not, in
9 my mind, an issue.

10 Q That -- I'm sorry, Doctor, that relieved your
11 fears about any high-grade post-operative --

12 A It relieved my fears about the possibility that the
13 bowel could not have been reanastomosed at the first
14 surgery once it had been resected, there's no question that
15 it was --

16 Q I --

17 A -- reanastomosed.

18 Q A high-grade or complete obstruction would have
19 been resolved and improper reanastomosis?

20 A Well, if the surgeon was having a really bad day
21 and resected a piece of bowel and literally left both ends
22 stapled but not reconnected, that patient would have
23 immediately developed a complete bowel obstruction. For
24 example, the Upper GI that this patient had would show the
25 contrast coming down and stopping at a right angle. Of

Matthew Kohler - Cross-Examination by Mr. Corbin

1 course, that didn't happen.

2 Q Yes, sir.

3 A So --

4 Q Based on your review of the medical records, did
5 Faye ever have at least a high-grade partial obstruction?

6 A I think we're getting into confusing terminology.
7 I didn't come across in any of the studies that she had a
8 high-grade obstruction or a complete obstruction. She had
9 a persistent, what was initially thought to be an ileus
10 versus a partial obstruction, but with the passage of
11 barium at the time, the correct diagnosis ultimately was
12 that she had a refractory, partial small bowel obstruction
13 that was not responding to conservative therapy.

14 Q Fair enough. A complete obstruction would change
15 the course of treatment; is that fair?

16 A I believe that to be true.

17 Q Yes, sir?

18 A Uh-huh.

19 Q A high-grade obstruction would change the course
20 of treatment; fair?

21 A Correct.

22 Q Dr. Williams' progress notes dated 5/21/2007 and
23 you probably -- did you review the progress notes?

24 A I did.

25 Q Did you read through them carefully?

Matthew Kohler - Cross-Examination by Mr. Corbin

1 A I did.

2 Q You were looking for high-grade obstructions;
3 correct?

4 A Well, again, a high-grade obstruction is a -- is --
5 it's a combination of a -- it's primarily a radiographic
6 dissection; so the distinction that's made on the x-ray
7 studies and it could be supported by clinical findings as
8 well.

9 Q You indicated complete obstruction or high grade
10 partial obstruction would change the course of treatment.
11 So I need to read to you this particular progress report by
12 Williams 5/21/2007. Quote, x-ray reviewed, reveals no
13 change in barium distribution supporting at least
14 high-grade partial versus complete obstruction; would that
15 make your index of suspicion go up?

16 A Well, allow me, if I could -- because I have the --
17 and I'd be happy to review anything that you have to the
18 contrary, but I have the x-ray report from that day which
19 is the same, 5/21, and it to me as quoted as findings
20 worrisome for small bowel obstruction, end quote. I don't
21 recall the x-ray talking about high-grade partial versus
22 complete obstruction. Do you have any information there?
23 Because I don't; I didn't see an x-ray report that stated
24 that.

25 Q And you certainly weren't there treating the

Matthew Kohler - Cross-Examination by Mr. Corbin

1 patient either; is that correct?

2 A That is correct.

3 Q So if Dr. Williams, based on the information he
4 had on 5/21, he came to the conclusion that the barium
5 distribution supported at least high-grade partial versus
6 complete obstruction. Can you quibble with that?

7 A Let's -- let's play it theoretic through the card
8 that you're dealing and say that Dr. Williams' clinical
9 impression trumped the radiographic impression. It was not
10 a complete obstruct, let's just go down that path for a
11 minute. This actually was the day that Dr. Williams
12 obtained expert second opinion consultation with Dr. Parker
13 and Dr. Parker came by and assessed this patient. We just
14 heard his testimony, and his conclusion, again, as the
15 Board certified expert general surgeon, was that this
16 patient had partial small bowel obstruction. And actually
17 could be effectively and safely and appropriately treated
18 with medical management, which was to say that catharsis
19 above.

20 If the expert general surgeon had thought that the
21 patient would have had a complete bowel obstruction, he
22 would not have described catharsis for above -- from above.
23 So it was the opinion of the expert general surgeon, second
24 opinion that this patient did not have a complete bowel
25 obstruction.