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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM HORRY COUNTY
Steven H. John, Circuit Court Judge

Case No. 2011-CP-26-7403

Randall M. Green and Ann Green, ... Respondents/Appellants,

v.

Wayne B. Bauerle, M.D. and
Wayne B. Bauerle, M.D., P.C., ... Appellants/Respondents.

RECORD ON APPEAL

Andrew F. Lindemann
DAVIDSON & LINDEMANN, P.A.
Post Office Box 8568
Columbia, South Carolina 29202
(803) 806-8222

Counsel for Appellants/Respondents
Wayne B. Bauerle, M.D. and
Wayne B. Bauerle, M.D., P.C.

O. Grady Query
E. Brooke Hurt
QUERY SAUTTER FORSYTHE, LLC
The Wappoo Centre
147 Wappoo Creek Drive - Suite 202
Charleston, South Carolina 29412
(843) 795-9500

Counsel for Respondents/Appellants
Randall M. Green and Ann Green

John B. McCutcheon, Jr.
Lisa A. Thomas
THOMPSON & HENRY, P.A.
Post Office Box 1740
Conway, South Carolina 29528
(843) 248-5741

Counsel for Appellants/Respondents
Wayne B. Bauerle, M.D. and
Wayne B. Bauerle, M.D., P.C.

L. Morgan Martin
LAW OFFICES OF
L. MORGAN MARTIN, P.A.
1121 Third Avenue
Conway, South Carolina 29526
(843) 248-3177

Cristin A. Uricchio
URICCHIO LAW FIRM
147 Wappoo Creek Drive - Suite 205
Charleston, South Carolina 29412
(843) 795-9300

Counsel for Respondents/Appellants
Randall M. Green and Ann Green

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STATE OF SOUTH CAROLINA
COUNTY OF HORRY

Randall M. Green and Ann Green,
Plaintiffs,

vs.

Wayne B. Bauerle, M.D., Wayne B.
Bauerle, M.D., P.C., and Grand Strand
Regional Medical Center, LLC,
Defendants.

IN THE COURT OF COMMON PLEAS

Civil Action No. 2011-CP-26-07403

**ORDER GRANTING
DEFENDANT GRAND STRAND
REGIONAL MEDICAL CENTER, LLC
MOTION FOR PARTIAL
SUMMARY JUDGMENT**

HORRY COUNTY
CLERK OF COURT
JULIE HUGGINS-WARD
MAY - 1 PM 4: 57

This matter came before me on February 11, 2013, for a hearing on a Motion for Partial Summary Judgment filed by Defendant Grand Strand Regional Medical Center, LLC (referred to herein as "Grand Strand"). The motion seeks summary judgment on the Fourth Amended Complaint's causes of action for vicarious liability and negligent hiring, supervision, and retention. After carefully reviewing the record, the memoranda submitted by the parties, and the applicable law, and after considering the arguments of counsel, I hereby grant Grand Strand's motion.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of the allegedly negligent treatment of Plaintiff Randall Green by various medical professionals for injuries Mr. Green suffered in an automobile accident on April 17, 2004, in Horry County. The first Complaint was filed only against Defendant Bauerle on June 3, 2005, by the Plaintiffs' original attorney. Grand Strand was added as a Defendant via the Amended Complaint, which was filed on January 17, 2007.¹ The Plaintiffs' most recent

¹ The Complaint and Amended Complaint (as well as the Second Amended Complaint and the Third Amended Complaint) were filed under civil action no. 2005-CP-26-02805.

pleading is the Fourth Amended Complaint, filed on October 15, 2012, which added new causes of action against Grand Strand for vicarious liability and negligent hiring, supervision, and training.

STANDARD OF REVIEW

Summary judgment shall be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Rule 56(c), SCRPC. "Once the party moving for summary judgment meets the initial burden of showing an absence of evidentiary support for the opponent's case, the opponent cannot simply rest on mere allegations or denials contained in the pleadings" but "must present specific facts showing a genuine issue for trial." Gauld v. O'Shaughnessy Realty Co., 380 S.C. 548, 558-59, 671 S.E.2d 79, 85 (Ct. App. 2008) (citations and quotations omitted). "[W]hen plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted." Miller v. Blumenthal Mills, Inc., 365 S.C. 204, 220, 616 S.E.2d 722, 729 (Ct. App. 2005).

FINDINGS AND CONCLUSIONS

I. THE PLAINTIFFS CANNOT ESTABLISH VICARIOUS LIABILITY ON THE PART OF GRAND STRAND.

The Fourth Amended Complaint alleges that the Plaintiffs "looked to [Grand Strand] to provide them with adequate care" and "relied on [Grand Strand] to provide them with caregivers who were competent and skilled in treating trauma patients." Fourth Amended Complaint ¶ 33. This evinces an intent to hold Grand Strand vicariously liable for the alleged negligence of its independent contractor physicians pursuant to the nondelegable duty doctrine announced in Simmons v. Tuomey Regional Medical Center, 341 S.C. 32, 533 S.E.2d 312 (2000) ("Simmons

II"). However, Grand Strand cannot be held vicariously liable for the acts or omissions of its independent contractor physicians—or any of its other independent contractors or employees for that matter—because both the statute of limitations and the statute of repose have expired as to Grand Strand's independent contractors and employees, none of whom have been named in any of the five versions of the Complaint.

S.C. Code § 15-3-545(A) establishes a three-year statute of limitations and a six-year statute of repose in medical malpractice actions. A plaintiff may bring a medical malpractice action within three years of the date he or she discovers (or ought to have discovered) the existence of the cause of action, but in no event may a plaintiff bring a medical malpractice action more than six years after the occurrence of the act or omission giving rise to the cause of action. In this case, all of the acts or omissions upon which the Plaintiffs' claims are based occurred on or about April 17, 2004. Therefore, any medical malpractice action by the Plaintiffs against Grand Strand's independent contractors or employees filed after April 17, 2010 would be subject to dismissal on its face pursuant to S.C. Code § 15-3-545(A).

Because the Plaintiffs are barred by the statute of limitations and the statute of repose from asserting a direct cause of action for medical malpractice against Grand Strand's independent contractors and employees, Grand Strand cannot be held vicariously liable for their acts or omissions. In Comer v. Risko, 833 N.E.2d 712 (Ohio 2005), the Supreme Court of Ohio confronted the question of whether a hospital could be held vicariously liable under "agency by estoppel"² principles pursuant to its holding in Clark v. Southview Hospital & Family Health

² "Agency by estoppel" is, for all intents and purposes, identical to the "nondelegable duty" doctrine adopted by the South Carolina Supreme Court in Simmons II. See Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994) ("A hospital may be held liable under the doctrine of agency by estoppel for the negligence of independent medical practitioners practicing in the hospital if it holds itself out to the public as a provider of medical services and in the absence of notice or knowledge to the contrary, the patient looks to the hospital, as opposed to the individual practitioner, to provide competent medical care."). Compare Simmons II, 341 S.C. at 51, 533 S.E.2d at 322 (holding that a hospital will be held vicariously liable for any negligent or wrongful

Center, 628 N.E.2d 46 (Ohio 1994),³ where the negligent independent-contractor physician could not be joined due to the expiration of the statute of limitations. The court found that “a direct claim against a hospital premised solely upon the negligence of an agent who cannot be found liable is contrary to basic agency law,” Comer, 833 N.E.2d at 717, and therefore that “if the independent contractor is not and cannot be liable because of the expiration of the statute of limitations, no potential liability exists to flow through to the secondary party, i.e., the hospital, under an agency theory.” Id. at 718. Accordingly, the court held: “[A]gency by estoppel is a derivative claim of vicarious liability whereby the liability of the hospital must flow through the independent-contractor physician. Consequently, there can be no viable claim for agency by estoppel if the statute of limitations against the independent-contractor physician has expired.” Id. See also Huber v. Marlow, 2008 WL 2199827 at *1 (Tenn. Ct. App. May 28, 2008) (“We hold that because the statute of repose extinguished the plaintiffs’ cause of action against the nonparty employee, the employer cannot be held liable for allegations of medical negligence based solely on the actions of the nonparty employee.”); Stephens v. Petrino, 86 S.W.3d 836, 843 (Ark. 2002) (affirming summary judgment for a hospital in a vicarious liability action because “[i]t is well-settled that when an employee has been released [from liability] or dismissed [from the litigation], and the employer has been sued solely on a theory of vicarious liability, any liability of the employer is likewise eliminated”); Greco v. Univ. of Del., 619 A.2d 900, 903 (Del. 1993) (“If an employee, who is a licensed health care provider, is not liable to the plaintiff for medical negligence, neither is the employer.”); Hewett v. Kennebec Valley Mental

acts committed by the treating physician if the plaintiff can establish “(1) the hospital held itself out to the public by offering to provide services; (2) the plaintiff looked to the hospital, rather than the individual physician, for care; and (3) a person in similar circumstances reasonably would have believed that the physician who treated him or her was a hospital employee”).

³ The South Carolina Supreme Court relied heavily on Ohio case law—and Clark in particular—in Simmons II. See Simmons II, 341 S.C. at 46-47, 533 S.E.2d at 320 (discussing Clark).

Health Ass'n, 557 A.2d 622, 624 (Me. 1989) (“[T]he [hospital’s] liability under Count II being vicarious to [its physician-employee’s] liability, the [hospital] had available the same statute of limitations defense that was available to [its physician-employee].”).

Numerous other courts, including those in South Carolina, have held outside the medical malpractice context that a principal may not be held vicariously liable if there is no liability on the part of the agent. See, e.g., E.A. Prince & Son, Inc. v. Selective Ins. Co. of Se., 818 F.Supp. 910, 915 (D.S.C. 1993) (“A judgment on the merits in favor of the agent is a bar to an action against the principal for the same cause, because the principal’s liability is predicated upon that of the agent.”) (quoting Rookard v. Atlanta & C. Air Line Ry. Co., 65 S.E. 1047, 1047 (S.C. 1909)). See also Jones Express, Inc. v. Jackson, 86 So.3d 298, 308 n.8 (Ala. 2010) (“If the agent is not liable for any tort, the principal is also absolved.”) (citations and quotations omitted); Creech v. Addington, 281 S.W.3d 363, 374 (Tenn. 2009) (“A principal may not be held vicariously liable under the doctrine of respondeat superior based upon the acts of its agent . . . when the right of action against the agent is extinguished by operation of law[.]”) (citations and quotations omitted); Faieta v. World Harvest Church, 891 N.E.2d 370, 400 (Ohio Com. Pl. 2008) (“Generally, a principal is vicariously liable for the acts of its agent only to the extent of the agent’s liability. As a result, where an agent is not liable, the principal is also not liable.”); H&S Homes, LLC v. McDonald, 978 So.2d 692, 694 (Ala. 2007) (“The adjudication on the merits in favor of the agents exonerated [the principal] from vicarious liability for the agents’ torts and entitled [the principal] to a judgment as a matter of law.”); Draughon v. Harnett County Bd. of Educ., 602 S.E.2d 721, 726 (N.C. Ct. App. 2004) (“[J]udgment on the merits in favor of the agent precludes any action against the principal where, as here, the principal’s liability is purely derivative.”); Molina v. Watkins, 824 So.2d 959, 963 (Fla. Dist. Ct. App. 2002) (“The law is

settled that where an agent or employee is found to have no liability, then a judgment cannot stand against the principal or employer on the basis of vicarious liability or respondeat superior.”); Hatcher v. Bellevue Volunteer Fire Dep’t, 628 N.W.2d 685, 695 (Neb. 2001) (“Under the doctrine of respondeat superior, the principal’s liability is derived solely from that of its agent. Unless the agent is liable, there can be no liability on the part of the principal.”) (citations omitted); Buettner v. Cellular One, Inc., 700 So.2d 48, 48 (Fla. Dist. Ct. App. 1997) (upholding summary judgment for the principals on the basis of the “well-settled doctrine that when a principal’s liability rests solely on the doctrine of respondeat superior, a principal cannot be held liable if the agent is exonerated”) (citations and quotations omitted); Burns v. Metz, 513 N.W.2d 505, 511 (Neb. 1994) (“[U]nless the servant or agent is liable in negligence, there can be no liability on the master or principal.”); Lincoln v. Gupta, 370 N.W.2d 312, 317 (Mich. Ct. App. 1985) (“A principal . . . cannot be held liable if the agent having primary responsibility is not liable.”); Reese v. Credit, 469 P.2d 467, 472 (Ariz. Ct. App. 1970) (“[T]he general rule is that the principal’s liability, derivative from the agent’s wrongdoing, is secondary and is extinguished when a verdict exonerates the agent.”); Barkett v. Brucato, 264 P.2d 978, 985-86 (Cal. Dist. Ct. App. 1953) (“It is undoubtedly the law that where the alleged negligent act of the agent was not directed or ratified by the principal and where the sole basis of the claimed responsibility of the principal is the doctrine of respondeat superior, the exoneration of the agent exonerates the principal.”).⁴

⁴ The U.S. Supreme Court has held that dismissal of an action due to the expiration of the statute of limitations is a “judgment on the merits.” See, e.g., Plaut v. Spendthrift Farm, Inc., 514 U.S. 211, 228 (1995) (“The rules of finality, both statutory and judge made, treat a dismissal on statute-of-limitations grounds the same way they treat a dismissal for failure to state a claim, for failure to prove substantive liability, or for failure to prosecute: as a judgment on the merits.”). See also Ex parte Capital U-Drive-It, Inc., 369 S.C. 1, 7, 630 S.E.2d 464, 467 (2006) (“An order ‘involves the merits,’ . . . when it finally determines some substantial matter forming the whole or part of some cause of action or defense.”); Foran v. USAA Cas. Ins. Co., 311 S.C. 189, 191, 427 S.E.2d 918, 919 (Ct. App. 1993) (“The general rule under the traditional terminology is that a judgment is on the merits if it completely disposes of the underlying cause of action.”) (citations and quotations omitted).

"[P]laintiffs should not be permitted to engage in an 'encircling movement' against the principal when they cannot pursue a 'frontal attack' on the agent." Abshire v. Methodist Healthcare-Memphis Hosps., 325 S.W.3d 98, 110 (Tenn. 2010). Because the statutes of limitations and repose have long since expired as to Grand Strand's independent contractors or employees, they cannot be held directly liable for medical malpractice.⁵ Accordingly, Grand Strand cannot be held vicariously liable for their acts or omissions because no potential liability exists to flow through to Grand Strand. Grand Strand is, therefore, entitled to judgment as a matter of law on the Plaintiffs' cause of action for vicarious liability.

II. THE PLAINTIFFS HAVE NOT PROPERLY ALLEGED AND CANNOT ESTABLISH NEGLIGENT HIRING, SUPERVISION, AND TRAINING ON THE PART OF GRAND STRAND.

In James v. Kelly Trucking Co., 377 S.C. 628, 661 S.E.2d 329 (2008), the South Carolina Supreme Court described the circumstances under which an employer may be held liable for negligent hiring, supervision, or training. The court stated:

In circumstances where an employer knew or should have known that its employment of a *specific person* created an undue risk of harm to the public, a plaintiff may claim that the employer was itself negligent in hiring, supervising, or training the employee, or that the employer acted negligently in entrusting its employee with a tool that created an unreasonable risk of harm to the public.

Id. at 631, 661 S.E.2d at 330 (emphasis added). Thus, in order to recover under this cause of action, the Plaintiffs must establish: (1) that a *specific employee* of Grand Strand had a propensity to cause harm; and (2) that Grand Strand knew or should have known of that

⁵ The Plaintiffs argue they were not required to name Grand Strand's independent contractors or employees as Defendants in order to state a cause of action for vicarious liability against Grand Strand. That is correct, but it reflects a misapprehension of the issue at hand. Though a plaintiff is not required to sue the agent in order to state a cause of action for vicarious liability against the principal, the cited cases stand for the proposition that he must be able to do so on the date he brings the claim. Due to the expiration of the statute of repose, the Plaintiffs could not have brought claims against Grand Strand's independent contractors and employees on the date they first asserted a vicarious liability claim against Grand Strand. Accordingly, no liability existed to flow through to Grand Strand on that date.

employee's propensity to cause harm.⁶ However, the Fourth Amended Complaint contains no allegations—and the Plaintiffs have submitted no record evidence—regarding the alleged propensity of a specific Grand Strand employee to cause harm, much less Grand Strand's knowledge of that propensity. The Fourth Amended Complaint does contain generic allegations regarding nurses, physicians, and other health care professionals allegedly utilized by Grand Strand in providing care,⁷ but such generic allegations are insufficient to state a claim for negligent hiring, supervision, and training in South Carolina. Because the Plaintiffs have not identified a specific Grand Strand employee or alleged any acts, behavior, or propensities of a specific employee, knowledge of which could be charged to Grand Strand, the Plaintiffs' cause of action for negligent hiring, supervision, and training fails as a matter of law and Grand Strand is entitled to summary judgment.

To the extent the Fourth Amended Complaint is generously read to contain a separate cause of action for negligent supervision, this cause of action fails for another reason. The South Carolina Supreme Court recognized this cause of action in Degenhart v. Knights of Columbus, 309 S.C. 114, 420 S.E.2d 495 (1992). In that case, the court held:

Under certain circumstances, an employer is under a duty to exercise reasonable care to control an employee *acting outside the scope of his employment*. An employer may be liable for negligent supervision *if the employee intentionally harms another* when he:

(i) is upon the premises in possession of the employer or upon which the employee is privileged to enter only as his employee, or

⁶ Whether an employer has sufficient knowledge of an employee's potential to cause harm turns on "whether the employer knew the offending employee was in the habit of misconducting himself in a manner dangerous to others." Doe v. ATC, Inc., 367 S.C. 199, 206, 624 S.E.2d 447, 450-51 (Ct. App. 2005) (citations and quotations omitted).

⁷ The Fourth Amended Complaint also alleges that "Defendant Bauerle treated [Mr. Green] as a result of a contractual relationship with Defendant Grand Strand," but Dr. Bauerle was not an employee of Grand Strand. Moreover, the Plaintiffs have not identified any record evidence tending to show that Grand Strand "knew or should have known that its [contracting with Dr. Bauerle] created an undue risk of harm to the public."

(ii) is using a chattel of the employer, and . . . the employer

(i) knows or has reason to know that he has the ability to control his employee;
and

(ii) knows or should know of the necessity and opportunity for exercising such control.

Id. at 116-17, 420 S.E.2d at 496 (quoting Restatement (2d) of Torts § 317 (1965)) (emphasis added). Not only have the Plaintiffs failed to allege any of these elements of negligent supervision, but there has never been, in almost eight years of litigation and through five drafts of the Complaint, any allegation that any medical care provider, whether or not an independent contractor or employee of Grand Strand, acted outside the scope of his or her employment or intentionally harmed the Plaintiffs. Thus, because the Supreme Court has only recognized the tort of negligent supervision in the context of injury inflicted intentionally and/or outside the scope of the employee's employment, this cause of action is not viable in this case.

III. THE RELATION BACK DOCTRINE IS INAPPLICABLE.

The Plaintiffs argue their vicarious liability and negligent hiring, supervision, and training claims are saved by Rule 15(c), SCRCP, and relate back to the date of the initial Complaint. I disagree for the reasons set forth below:

A. The applicability of the relation back doctrine to the vicarious liability claim is moot because the Plaintiffs cannot establish a critical element of the cause of action.

As discussed in Section I, *supra*, the principal's liability in vicarious liability cases is predicated upon the liability of the agent. Thus, in order to recover from a principal under the doctrine of *respondeat superior*, a plaintiff must establish that the agent is liable. Because the expiration of the statute of repose has rendered Grand Strand's independent contractors and employees not liable, the Plaintiffs cannot establish their liability, and thus an indispensable

element is missing from the Plaintiffs' vicarious liability claim against Grand Strand regardless of whether the relation back doctrine applies.

This exact scenario was confronted by the Court of Appeals of Tennessee in Huber. There, as here, the plaintiffs filed suit against various parties for medical malpractice and amended their complaint to allege vicarious liability against the employer of a nonparty physician only after the statute of repose had expired as to the nonparty physician. The employer moved for partial summary judgment on the vicarious liability claim, which the plaintiffs opposed on the basis of the relation back doctrine. The trial court granted the motion and was affirmed on appeal. The court of appeals wrote that the relation back doctrine "cannot be used to support an 'end run' around the statute of repose[.]" 2008 WL 2199827 at *5. The court continued: "[The plaintiffs] have, for all practical purposes and effect, tried to add a new party defendant more than three years after the alleged negligence and injury—[the employer], in its capacity as [the nonparty physician's] employer—based solely upon the actions of . . . a nonparty employee against whom the Plaintiffs' cause of action has been extinguished by the statute of repose. The relation back doctrine . . . does not contemplate nor permit such a result." Id.

The Huber court's reasoning was affirmed by the Supreme Court of Tennessee in Abshire. In that case, the court recognized that the law prohibits the assertion of a vicarious liability claim against a principal "after its right to assert a claim against the agent has become procedurally barred." 325 S.W.2d at 110. The court found this limitation "reflects one of the traditional policy reasons for refusing to permit a plaintiff to pursue a vicarious liability claim against a principal—plaintiffs should not be permitted to engage in an 'encircling movement' against the principal when they cannot pursue a 'frontal attack' on the agent." Id. In discussing Huber, the court wrote that in that case (as well as another similar case):

the plaintiffs initially sued the principals but did not assert vicarious liability claims against them. While the plaintiffs' claims against the principal were pending, they lost their opportunity to mount a 'frontal attack' on the agent or agents. In Huber v. Marlow, the statute of repose governing the claims against the agent ran. . . . Thus, the plaintiffs' belated efforts to amend their complaints against the principals to add a vicarious liability claim were found to be nothing more than the sort of 'encircling movement' prohibited by [precedent]."

Id. at 110-11 (citations omitted).

Accordingly, the Plaintiffs cannot establish an essential element of their vicarious liability claim against Grand Strand—the liability of Grand Strand's independent contractors and employees—due to the expiration of the statute of repose, and the question of whether the relation back doctrine applies is moot.

B. The applicability of the relation back doctrine to the negligent hiring, supervision, and training claim is moot because the Plaintiffs cannot establish a critical element of the cause of action.

As discussed in Section II, *supra*, a plaintiff in a negligent hiring, supervision, and training case must establish that the employer knew or should have known that a *specific employee* of the employer had a propensity to cause harm. Because the Fourth Amended Complaint contains no allegations—and the Plaintiffs have submitted no record evidence—regarding the alleged propensity of a specific Grand Strand employee to cause harm, much less Grand Strand's knowledge of that propensity, the Plaintiffs cannot establish an essential element of their negligent hiring, supervision, and training claim. The question of whether the relation back doctrine applies is, therefore, moot. This is so even if the Fourth Amended Complaint is interpreted to assert a separate cause of action for negligent supervision because it does not allege that any independent contractor or employee of Grand Strand acted outside the scope of his or her employment or intentionally harmed the Plaintiffs.

C. Grand Strand was never on notice that the Plaintiffs would assert a vicarious liability claim against it based on the nondelegable duty doctrine.

Even though the applicability of the relation back doctrine is moot, I further find that it is inapplicable to the Plaintiffs' vicarious liability claim. The "central requirement" for application of the relation back doctrine is that "the party defending against the new claim have sufficient notice of it[.]" Whitfield Const. Co. v. Bank of Tokyo Trust Co., 338 S.C. 207, 222, 525 S.E.2d 888, 897 (Ct. App. 1999). However, Grand Strand did not have notice that the Plaintiffs would assert a vicarious liability claim against it based on the nondelegable duty doctrine. The following timeline is illustrative.

April 17, 2004	Mr. Green is involved in an automobile accident in Horry County and receives the treatment upon which this lawsuit is based.
June 3, 2005	The Plaintiffs' initial Complaint is filed against Dr. Bauerle only.
January 17, 2007	The Plaintiffs' Amended Complaint is filed adding Grand Strand as a Defendant. It asserts two causes of action against Grand Strand: negligence and loss of consortium. It does not name Grand Strand's independent contractors or employees as Defendants or allege that Grand Strand is vicariously liable for their conduct.
March 19, 2007	The Plaintiffs' Second Amended Complaint is filed. Like the Amended Complaint, it asserts negligence and loss of consortium claims against Grand Strand but does not name Grand Strand's independent contractors or employees as Defendants or allege that Grand Strand is vicariously liable for their conduct.
August 20, 2007	The Plaintiffs' Third Amended Complaint is filed. Like its predecessors, it asserts negligence and loss of consortium claims against Grand Strand but does not name Grand Strand's independent contractors or employees as Defendants or allege that Grand Strand is vicariously liable for their conduct.

April 17, 2010

The statute of repose (S.C. Code § 15-3-545(A)) expires as against Grand Strand's independent contractors and employees.

May 18, 2010

The Plaintiffs move for leave to file their Fourth Amended Complaint. Their motion states: "There exist *additional claims* against Defendant [Grand Strand] for vicarious liability for the negligence of physicians and nurses employed by and/or caring for Mr. Green during his hospitalization at Grand Strand" (emphasis added).

October 15, 2012

The Plaintiffs file their Fourth Amended Complaint, alleging two new causes of action against Grand Strand: vicarious liability and negligent hiring, supervision, and training.

The Plaintiffs argue Grand Strand has been on notice since the early stages of this litigation that they would rely on the nondelegable duty doctrine as against Grand Strand, but that argument is belied by the text of the pleadings and motions they have filed in this case. For example, the Third Amended Complaint contains the following allegations specifically asserting the vicarious liability of other Defendants:

- "Any and all acts of negligence of Defendant Wayne B. Bauerle, M.D. are imputed to Defendant Wayne B. Bauerle, M.D., P.C. and Defendant Strand Orthopaedic Consultants, LLC" (paragraph 6); and
- "Defendant Bauerle's negligent and reckless actions, complained of herein are attributed to Defendants Wayne B. Bauerle, M.D., PC and Strand Orthopaedic Consultants, LLC" (paragraph 25).

Yet the Third Amended Complaint contains no similar allegations concerning vicarious liability on the part of Grand Strand. Furthermore, the Plaintiffs wrote in paragraph 2 of their Motion to Amend Complaint: "There exist *additional claims* against Defendant [Grand Strand] for vicarious liability for the negligence of physicians and nurses employed by and/or caring for Mr. Green during his hospitalization at Grand Strand" (emphasis added). See also Motion to Amend ¶ 3 ("The *addition* of these claims") (emphasis added). Thus, because none of the first four

iterations of the Complaint put Grand Strand on sufficient notice of a nondelegable duty claim, the relation back doctrine does not apply to that claim.

D. Grand Strand was never on notice that the Plaintiffs would assert a negligent hiring, supervision, and training claim against it.

For much the same reasons set forth in in Section III(C), *supra*, I find the relation back doctrine would be inapplicable to the Plaintiffs' negligent hiring, supervision, and training claim even if the question were not moot. None of the first four versions of the Complaint gave sufficient notice to Grand Strand of such a claim. *See, e.g.*, Third Amended Complaint (specifically alleging in paragraph 23(n) that Strand Orthopaedic Consultants, LLC, Wayne B. Bauerle, M.D. and Wayne B. Bauerle, M.D., P.C. were negligent in "failing to adequately train and supervise Dr. Bauerle" but containing no similar allegations as against Grand Strand). *See also* Motion to Amend ¶¶ 2 ("There exist *additional claims* against Defendant [Grand Strand] for vicarious liability for the negligence of physicians and nurses employed by and/or caring for Mr. Green during his hospitalization at Grand Strand.") and 3 ("The *addition* of these claims . . .") (emphasis added).

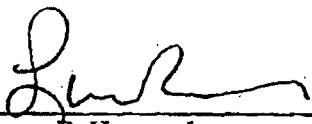
E. The relation back doctrine does not apply to statutes of repose.

Finally, I find in the alternative that the relation back doctrine does not apply to statutes of repose. "A statute of repose creates a *substantive right* in those protected to be free from liability after a legislatively-determined period of time[.]" Florence County Sch. Dist. No. 2 v. Interkal, Inc., 348 S.C. 446, 453, 559 S.E.2d 866, 869 (Ct. App. 2002) (emphasis added) (quoting Langley v. Pierce, 313 S.C. 401, 438 S.E.2d 242 (1993)). Once April 17, 2010, passed without a vicarious liability claim having been asserted against it, Grand Strand gained the substantive right to be free from vicarious liability in this case. "Relation back under Rule 15 does not apply when the statute at issue defines substantive rights rather than merely limiting

procedural remedies." Resolution Trust Corp. v. Olson, 768 F.Supp. 283, 285 (D. Ariz. 1991).⁸ See also In re Lehman Bros. Sec. & Erisa Litig., 800 F.Supp.2d 477, 483 (S.D. N.Y. 2011) (collecting cases for the proposition that "the Rule 15(c) relation back doctrine does not apply to statutes of repose"); Tindol v. Boston Hous. Auth., 487 N.E.2d 488, 491 (Mass. 1986) ("[A]n application of the 'relation back' doctrine would have the effect of reactivating a cause of action that the Legislature obviously intended to eliminate.") (citations and quotations omitted). Accordingly, the Plaintiffs' vicarious liability claim is not saved by the relation back doctrine.

IT IS, THEREFORE, ORDERED that Grand Strand's Motion for Partial Summary Judgment is **GRANTED**. Judgment shall be entered in Grand Strand's favor on the Fourth Amended Complaint's causes of action for vicarious liability and negligent hiring, supervision, and training.

AND IT IS SO ORDERED.



Larry B. Hyman, Jr.
Judge, Fifteenth Judicial Circuit

April 18, 2013
Conway, South Carolina

⁸ Since the South Carolina Rules of Civil Procedure are based on the Federal Rules of Civil Procedure, our courts may look to the construction given to the federal rules. See Gardner v. Newsome Chevrolet-Buick, Inc., 304 S.C. 328, 330, 404 S.E.2d 200, 201 (1991). See also Dalon v. Golden Lanes, Inc., 320 S.C. 534, 541, 466 S.E.2d 368, 372 (Ct. App. 1996) ("[T]his court has resorted to treatment of the federal rules for guidance in interpreting our rules.").

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS

Randall M. Green and Ann Green,

Docket No.: 2011-CP-26-7403

Plaintiffs,

v.

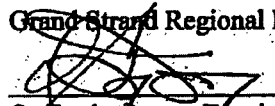
Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC, and Grand Strand
Regional Medical Center, LLC,

**STIPULATION OF DISMISSAL
WITH PREJUDICE AS TO GRAND
STRAND REGIONAL MEDICAL
CENTER ONLY**

Defendants.

Pursuant to the provisions of South Carolina Rule of Civil Procedure 41, the parties hereby stipulate that this action is dismissed with prejudice as to the Defendant,

Grand Strand Regional Medical Center, LLC only,


O. Grady Query, Esquire

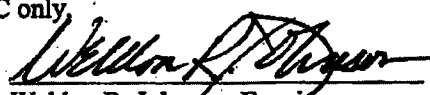
Query Sauter Forsythe

The Wappoo Centre

147 Wappoo Creek Drive, Suite 202

Charleston, South Carolina 29412

Attorney for the Plaintiffs


Weldon R. Johnson, Esquire

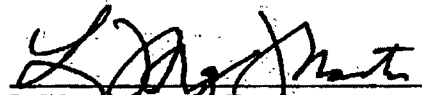
Barnes, Alford, Stork & Johnson, LLP

1613 Main Street

Post Office Box 8448

Columbia, South Carolina 29202

Attorney for the Defendant Grand Strand
Regional Medical Center, LLC

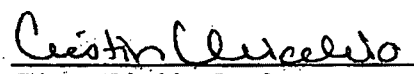

L. Morgan Martin, Esquire

L. Morgan Martin, PA

1121 Third Avenue

Conway, South Carolina 29526

Attorney for the Plaintiffs


Cristen Uricchio, Esquire

Uricchio Law Firm

147 Wappoo Creek Drive, Suite 205

Charleston, South Carolina 29412

Attorney for the Plaintiffs

see attached

John B. McCutcheon, Jr., Esquire

Thompson & Henry, PA

1300 Second Avenue, Third Floor

Post Office Box 1740

Conway, SC 29528

Attorney for Wayne B. Bauerle, MD
and Wayne B. Bauerle, MD, PC

HORRY COUNTY
13 JUN 11 PM 1:55
MELANIE HUGGINS, WARE
CLERK OF COURT

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS

Randall M. Green and Ann Green,

Plaintiffs,

v.

Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC, and Grand Strand
Regional Medical Center, LLC,

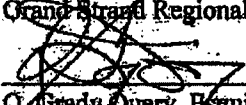
Defendants.

Docket No.: 2011-CP-26-7403

**STIPULATION OF DISMISSAL
WITH PREJUDICE AS TO GRAND
STRAND REGIONAL MEDICAL
CENTER ONLY**

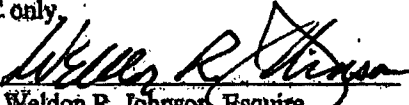
Pursuant to the provisions of South Carolina Rule of Civil Procedure 41, the
parties hereby stipulate that this action is dismissed with prejudice as to the Defendant,

Grand Strand Regional Medical Center, LLC only.


O. Grady Query, Esquire
Query Saunder Forsythe
The Wappoo Centre
147 Wappoo Creek Drive, Suite 202
Charleston, South Carolina 29412
Attorney for the Plaintiffs


L. Morgan Martin, Esquire
L. Morgan Martin, PA
1121 Third Avenue
Conway, South Carolina 29526
Attorney for the Plaintiffs


John R. McCutcheon, Jr., Esquire
Thompson & Henry, PA
1300 Second Avenue, Third Floor
Post Office Box 1740
Conway, SC 29528
Attorney for Wayne B. Bauerle, MD
and Wayne B. Bauerle, MD, PC


Weldon R. Johnson, Esquire
Barnes, Alford, Stark & Johnson, LLP
1613 Main Street
Post Office Box 8448
Columbia, South Carolina 29202
Attorney for the Defendant Grand Strand
Regional Medical Center, LLC


Cristen Uricechio, Esquire
Uricechio Law Firm
147 Wappoo Creek Drive, Suite 205
Charleston, South Carolina 29412
Attorney for the Plaintiffs

HORRY COUNTY
13 JUN 11 PM 1:55
MELANIE HUGHES-HARD
CLERK OF COURT

FILED
STATE OF SOUTH CAROLINA
COUNTY OF HORRY
2013 OCT 17 AM 10:35

2011CP2607403
IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

MELANIE HUGGINS-WARD
CLERK OF COURT
Randall M. Green and Ann Green

Plaintiffs,

vs.

Wayne B. Bauerle, M.D., and Wayne B.
Bauerle, M.D., P.C.,

Defendants.

**ORDER GRANTING IN PART AND
DENYING IN PART DEFENDANTS
WAYNE B. BAUERLE, MD, AND
WAYNE B. BAUERLE, MD, PC'S
MOTION FOR SET OFF**

FACTS

This medical malpractice case was tried before a jury during the week of September 9, 2013, with the Honorable Steven H. John presiding. The jury found for Randall M. Green, under a medical malpractice theory, in the amount of \$2.3 million and Ann Green, under a loss of consortium theory, in the amount of \$550,000.

Prior to trial, Defendant Grand Strand Regional Medical Center, LLC ("Grand Strand") settled with the Plaintiffs for \$2 million. The ambulance company, Carolinas Medical Response, Inc., settled with the Plaintiffs for \$25,000.00. In addition, Mr. Green settled with the at-fault driver for \$100,000.00, and he received \$150,000.00 in settlement of his underinsured motorist claim. Likewise, Mrs. Green received \$100,000.00 in settlement with the at-fault driver and an additional \$75,000.00 in settlement of her underinsured motorist claim. Finally, the Medical University of South Carolina (MUSC) settled with the Plaintiffs for \$160,000 for medical negligence stemming from allegations that a sponge was left in Mr. Green's leg by staff at MUSC.

10/6
J.H.J.

Following the trial, the Defendants moved to off set the verdict with the amounts paid in settlement on behalf of Grand Strand, Carolinas Medical Response, the at-fault driver (including the underinsured motorist payments), and MUSC.

For the below reasons, the Defendants' Motion for Set Off is granted in part and denied in part. The Court grants a set-off for the amounts paid in settlement on behalf of Grand Strand and Carolina Medical Response, and denies a set-off for the amounts paid in settlement on behalf of the Medical University of South Carolina and the at-fault driver including the underinsured motorist payments.

LAW AND ANALYSIS

I. SET-OFF

"When a release or a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death: (1) it does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide, but it reduces the claim against the others to the extent of any amount stipulated by the release or the covenant, or in the amount of the consideration paid for it, whichever is the greater." S.C. Code Ann. § 15-38-50.

"A nonsettling defendant is entitled to credit for the amount paid by another defendant who settles." Hawkins v. Pathology Associates of Greenville, P.A., 330 S.C. 92, 113, 498 S.E.2d 395, 406 (Ct. App. 1998) (citing Powers v. Temple, 250 S.C. 149, 156 S.E.2d 759 (1967); Vaughn v. City of Anderson, 300 S.C. 55, 386 S.E.2d 297 (Ct. App. 1989). "Therefore, before entering judgment on a jury verdict, the court must reduce the amount of the verdict to account for any funds previously paid by a settling defendant, so long as the settlement funds were paid to compensate the same plaintiff on a claim for the same injury." Smith v. Widener, 397 S.C. 468,

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A.M.

471-72, 724 S.E.2d 188, 190 (Ct. App. 2012) (citing Hawkins v. Pathology Associates of Greenville, PA, 330 S.C. 92, 113, 498 S.E.2d 395, 406 (Ct. App. 1998)). "When the settlement is for the same injury, the nonsettling defendant's right to a setoff arises by operation of law." Smith, 397 S.C. at 472, 724 S.E.2d at 190 (citing Ellis v. Oliver, 335 S.C. 106, 113, 515 S.E.2d 268, 271-72 (Ct. App. 1999)). "Therefore, a plaintiff's claim for actual and punitive damages arising from the same injury is the same claim for purposes of setoff under section 15-38-50(1)." Smith v. Widener, 397 S.C. 468, 473, 724 S.E.2d 188, 191 (Ct. App. 2012).

In Ellis v. Oliver, 335 S.C. 106, 515 S.E.2d 268 (Ct. App. 1999), the Court of Appeals explained that "[a]pplication of the settlement credit was statutorily mandated in this case. Section 15-38-50 grants the court no discretion in determining the equities involved in applying a set-off once a release has been executed in good faith between a plaintiff and one of several joint tortfeasors." Ellis, 335 S.C. at 113, 515 S.E.2d at 272.

In the case at bar, this Court finds that the Plaintiffs' settlements with Grand Strand and Carolinas Medical Response were for the same injury, that being Mr. Green's paralysis and the loss of consortium by Mrs. Green, as was litigated against Dr. Bauerle and for which the jury returned its verdict against Dr. Bauerle.¹ The Court disagrees with the Plaintiffs' claim that they suffered different injuries. Likewise, the Court rejects the Plaintiffs' argument that their settlements were for different causes of action.² In accordance with Ellis v. Oliver and Smith v.

¹ For ease of discussion, the Defendants Wayne B. Bauerle, M.D., and Wayne B. Bauerle, M.D., P.C. shall be referred to collectively as "Dr. Bauerle."

² In opposing the Defendants' Motion for Set Off, the Plaintiffs argue that their settlement with Grand Strand and the verdict against Dr. Bauerle resulted from different causes of action. This Court disagrees. In making this argument, the Plaintiffs cite to the Order filed May 1, 2013, where Judge Larry Hyman granted partial summary judgment to Grand Strand on the causes of action for vicarious liability and negligent hiring, supervision and training. Nonetheless, Judge Hyman did not dismiss the Plaintiffs' negligence cause of action which was the

Widener, supra, the settlements from Grand Strand and Carolinas Medical Response shall be set-off because they concerned the same injury as the jury verdict against Dr. Bauerle.

However, the Court further concludes that the settlements on behalf of the at-fault driver (including the underinsured motorist payments) and MUSC concerned different injuries than the injury for which the jury found Dr. Bauerle liable. Specifically, the settlement with MUSC concerned an injury to Mr. Green's leg, which the Court finds to be a separate injury from Mr. Green's paralysis. In addition, the Court finds that the settlement with the at-fault driver concerning events occurring prior to Mr. Green's paralysis do not concern the same injury. Because those settlements involved different injuries, this Court rules those settlements are not subject to a set-off.

II. APPORTIONMENT OF THE SET-OFF

At trial, the jury found for Randall M. Green in the amount of \$2.3 million and Ann Green in the amount of \$550,000. Grand Strand settled with the Plaintiffs for \$2 million and Carolinas Medical Response settled for \$25,000 prior to trial. Those settlements did not provide for a specific allocation of the settlement amounts between Mr. Green and Mrs. Green. In making an equitable allocation of those settlement amounts between Mr. Green and Mrs. Green, the Court finds that it is reasonable, fair, and just to utilize the jury's verdict as to the Plaintiffs' claims. As a result, this Court will apply the percentage of the total verdict given to each Plaintiff by the jury to apportion the settlements between Mr. Green's claim for medical malpractice and Mrs. Green's claim for loss of consortium.

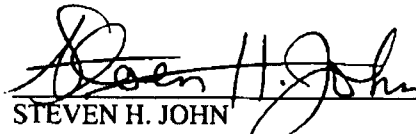
first cause of action in the Fourth Amended Complaint where the very same allegations of negligence were alleged against all Defendants including Grand Strand and Dr. Bauerle. Moreover, the settlement with Grand Strand occurred before any appeal rights were extinguished. The Plaintiffs still had the right until thirty days after final judgment was entered to appeal the grant of partial summary judgment by Judge Hyman, and the Plaintiffs' settlement with Grand Strand was intended to and did extinguish all claims against Grand Strand.

The South Carolina Supreme Court has specifically authorized the equitable *reallocation* of settlements in cases where the settling parties had agreed to a certain allocation between claims. See e.g., Rutland v. South Carolina Department of Transportation, 400 S.C. 209, 734 S.E.2d 142 (2012). Therefore, it logically follows that a court may make an equitable *allocation* in a case where the settling parties did not even agree to any particular allocation between claims.

In the case at bar, the jury found for Mr. and Mrs. Green for a combined verdict of \$2.85 million against the Defendants. The jury awarded Mr. Green \$2.3 million of the total \$2.85 million verdict, or 80.70% of the total verdict. The jury awarded Mrs. Green \$550,000 or 19.30% of the total verdict. Using that allocation, this Court rules that the \$2 million settlement with Grand Strand shall off set the verdict for Mr. Green in the amount of \$1,614,035.09 and the verdict for Mrs. Green in the amount of \$385,694.91. Likewise, the settlement between Plaintiffs and Carolinas Medical Response shall off set the verdict for Mr. Green in the amount of \$20,175.44 and the verdict for Mrs. Green in the amount of \$4,824.56.

The total amount to be set off is \$1,634,210.53 for Mr. Green's medical malpractice claim and \$390,519.47 for Mrs. Green's loss of consortium claim. Therefore, after applying these set-offs, the judgment against Defendants shall be reduced to \$665,789.47 for Mr. Green and \$159,480.53 for Mrs. Green. It is therefore

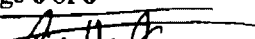
ORDERED that the Defendants' Motion for Set Off is granted in part and denied in part as set forth above. The Clerk of Court is directed to enter judgment in the amount of \$665,789.47 in favor of the Plaintiff Randall M. Green against the Defendants and to enter judgment in the amount of \$159,480.53 in favor of the Plaintiff Ann Green against the Defendants.


STEVEN H. JOHN
Resident Circuit Court Judge
Fifteenth Judicial Circuit

October 16, 2013
Conway, SC

DLSCN 10/29/13

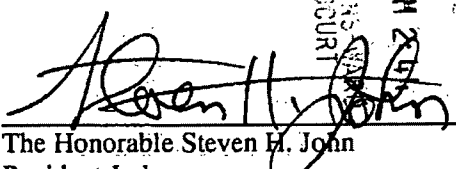
Page 6 of 6



STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
RANDALL M. GREEN AND ANN GREEN,	)	C/A # 2011-CP-26-7403
Plaintiff,	)	
v.	)	ORDER DENYING DEFENDANT'S
WAYNE B. BAUERLE, MD, and WAYNE B.	)	MOTION TO ALTER OR AMEND
BAUERLE, MD, PC,	)	ORDER GRANTING PARTIAL
Defendants.	)	SET-OFF

This matter came before the Court on Defendant's Motion dated November 7, 2013, to Alter or Amend the Court's Order Granting Partial Set-Off. The Court has considered Defendant's Motion and all other matters in the Clerk of Court's file. The Court believes it addressed the matters in its previous Order. The Court finds that oral arguments would not assist it in this matter and that any additional arguments would be redundant and unnecessary. It is therefore

ORDERED that Defendant's Motion to Alter or Amend the Court's Order Granting Partial Set-Off is denied and the previous Order is reaffirmed in toto.


 The Honorable Steven H. John
 Resident Judge
 Fifteenth Judicial Circuit

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 CLERK OF COURT

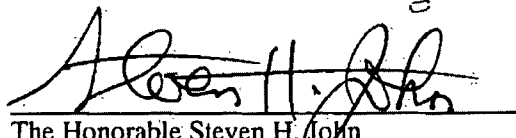
February 13, 2014
 Conway, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
RANDALL M. GREEN AND ANN GREEN,	)	C/A # 2011-CP-26-7403
Plaintiff,	)	
v.	)	ORDER DENYING PLAINTIFF'S
WAYNE B. BAUERLE, MD, and WAYNE B.	)	MOTION TO ALTER OR AMEND
BAUERLE, MD, PC,	)	ORDER GRANTING PARTIAL
Defendants.	)	SET-OFF

This matter came before the Court on Plaintiff's Motion dated October 25, 2013, to Alter or Amend the Court's Order Granting Partial Set-Off. The Court has considered Plaintiff's Motion and all other matters in the Clerk of Court's file. The Court finds that oral arguments would not assist it in this matter and that any additional arguments would be redundant and unnecessary. It is therefore

ORDERED that Plaintiff's Motion to Alter or Amend the Court's Order Granting Partial Set-Off is denied and the previous Order is reaffirmed in toto.

FEB 13 PM 2:44
 CLERK OF COURT


 The Honorable Steven H. John
 Resident Judge
 Fifteenth Judicial Circuit

February 13, 2014
 Conway, South Carolina

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

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO. 2011 CP-26-07403

RANDALL M. GREEN, AND ANN GREEN

WAYNE B. BAUERLE, M.D. AND WAYNE B. BAUERLE,
M.D. PC

PLAINTIFF(S)

DEFENDANT(S)

Submitted by:

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

DISPOSITION TYPE (CHECK ONE)

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

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

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk:

WE THE JURY, FIND FOR THE PLAINTIFF, RANDALL M. GREEN IN THE AMOUNT OF \$2,300,000.00 ACTUAL DAMAGES. WE FIND FOR THE PLAINTIFF, ANN GREEN IN THE AMOUNT OF \$550,000.00 ACTUAL DAMAGES AS TO LOSS OF CONSORTIUM.

INFORMATION FOR THE PUBLIC INDEX

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

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
RANDALL M. GREEN	WAYNE B. BAUERLE, MD AND WAYNE B. BAUERLE, MD PC	\$2,300,000.00
ANN GREEN	WAYNE B. BAUERLE, MD AND WAYNE B. BAUERLE MD, PC	\$550,000.00
		\$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest

A.H.R.

or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Steven H. John
Circuit Court Judge

129
Judge Code

9/13/13
Date

For Clerk of Court Office Use Only

This judgment was entered on the 16th day of Sept, 2013 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

M. MORGAN MARTIN

O. GRADY QUERY

ATTORNEY(S) FOR THE PLAINTIFF(S)

JOHN B. MCCUTCHEON

LISA ARLENE THOMAS

ATTORNEY(S) FOR THE DEFENDANT(S)

Melanie Huggins-Ward
CLERK OF COURT

Court Reporter: HENRY YOUNG

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

Instructions: Mark the appropriate response to the following questions. Each response must be unanimous.

1. DO YOU FIND THAT DEFENDANTS WAYNE B. BAEURLE, M.D. AND WAYNE B. BAEURLE, M.D., PC NEGLIGENTLY DEPARTED FROM THE STANDARD OF CARE IN TREATING PLAINTIFF RANDALL M. GREEN AND THAT THIS NEGLIGENT DEPARTURE FROM THE STANDARD OF CARE PROXIMATELY CAUSED PLAINTIFF RANDALL M. GREEN'S INJURIES?

[Signature]

✓ YES: IF YES, GO TO QUESTION 2.

— NO: IF YOU ANSWER NO, STOP AND DELIBERATE NO FURTHER.

FILED
HORRY COUNTY
3 SEP 16 AM 8:04
KELAN J. JENNIS-WARD
CLERK OF COURT

NOTE: If you answered "Yes" to Question 1, please continue to Page 2 for a determination of damages. If you answered "No" to Question 1, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

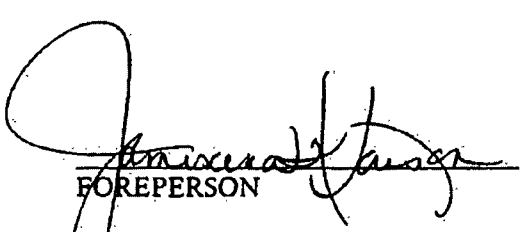
2. PLEASE STATE THE TOTAL AMOUNT OF DAMAGES, IF ANY, SUSTAINED BY
PLAINTIFF RANDALL M. GREEN

\$ 2,300,000.00 Actual Damages
Two Million, three hundred thousand dollars and 00/100

OR

For the Defendants.

September 13, 2013
Conway, South Carolina


FOREPERSON

NOTE: If you awarded actual damages, please continue to Question 3 on Page 3. If you did not award actual damages, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

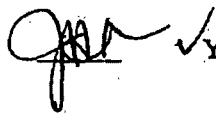
v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

3. DO YOU FIND THAT DEFENDANTS WAYNE B. BAUERLE, M.D. AND WAYNE B. BAEURLE, M.D., PC WERE NEGLIGENT AND THAT SUCH NEGLIGENCE PROXIMATELY CAUSED THE PLAINTIFF ANN GREEN'S LOSS OF CONSORTIUM?



YES: IF YES, GO TO QUESTION 4.

NO: IF YOU ANSWER NO, STOP AND DELIBERATE NO FURTHER.

NOTE: If you answered "Yes" to Question 3, please continue to Page 4 for a determination of damages. If you answered "No" to Question 3, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC.

Defendants.

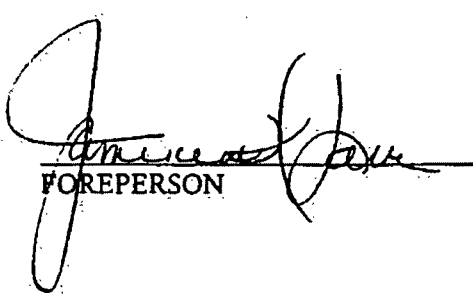
VERDICT FORM

4. PLEASE STATE THE TOTAL AMOUNT OF ACTUAL DAMAGES, IF ANY,
SUSTAINED BY PLAINTIFF ANN GREEN.

\$ 550,000⁰⁰ Actual Damages
Five hundred fifty thousand and 00/100
OR

For the Defendants.

September 13, 2013
Conway, South Carolina


FOREPERSON

NOTE: Please notify the Bailiff when deliberations are complete.

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)
Randall M. Green and Ann Green,)
Plaintiffs,)
vs.)
Wayne B. Bauerle, M.D., Wayne B.)
Bauerle, M.D., PC, Grand Strand)
Regional Medical Center, LLC and)
Carolinas Medical Response, Inc.,)
Defendants,)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO. 11-CP-26-7403

FOURTH AMENDED COMPLAINT

HORRY COUNTY
12 OCT 15 AM 11:20
CLERK OF COURT

The Plaintiffs, by and through counsel, complaining of and against these Defendants, allege as follows:

JURISDICTION AND VENUE

1. Plaintiffs Randall M. Green and Ann Green ("Plaintiffs") are citizens and residents of the County of Marion, State of South Carolina.
2. Plaintiffs, Randall M. Green and Ann Green are lawfully married.
3. Defendant Wayne B. Bauerle, MD, ("Bauerle") is a physician licensed and practicing in Horry County, South Carolina, and is upon information and belief, a citizen and resident of Horry County, in the state of South Carolina. At all times relevant to this Complaint Defendant Bauerle was acting within the course and scope of his employment or agency with Wayne B. Bauerle, M.D., P.C. and Grand Strand Regional Medical Center, LLC. Defendant Bauerle can be served by agreement through his counsel, John B. McCutcheon, Esquire, Thompson & Henry, P.A., 1300 Second Avenue, Third Floor, P. O. Box 174, Conway, South Carolina 29528.
4. Defendant Wayne B. Bauerle, M.D., P.C. ("Bauerle PC") is a medical office

organized and existing pursuant to the laws of the State of South Carolina operating as a medical care practice. At all times relevant to this Complaint, Defendant Bauerle was acting within the course and scope of his employment or agency with Bauerle, P.C. Defendant Bauerle, P.C. can be served by agreement through its counsel, John B. McCutcheon, Esquire, Thompson & Henry, P.A., 1300 Second Avenue, Third Floor, P.O. Box 174, Conway, South Carolina 29528.

5. Defendant Grand Strand Regional Medical Center LLC ("Grand Strand") is a limited liability corporation located in Horry County, South Carolina and provides, for profit, medical and emergency health care services to the general public. Said Defendant hospital through its agents and employees, was and is professionally knowledgeable about triage and evaluation and treatment of trauma patients. Defendant Grand Strand contacted various physicians in special areas of practice to treat the Plaintiff, without the knowledge or consent of the Plaintiff. Defendant Grand Strand had a non-delegable duty to render appropriate care. Defendant Bauerle was the apparent agent of Defendant Grand Strand. Defendant Grand Strand held itself out to the public by offering to provide services. At all times relevant to this Complaint, Defendant Bauerle was acting within the course and scope of his employment or agency with Grand Strand Regional Medical Center, LLC. The Defendant, Grand Strand can be served by agreement through its counsel, Weldon Johnson, Barnes, Alford, Stork & Johnson, LLP, 1613 Main Street, Columbia, South Carolina 29202.

6. The Defendants at all relevant times herein were responsible for the care, health, safety, and well being of Plaintiff Randall Green. The Defendant Grand Strand at all times relevant herein provided Emergency Room physicians, nurses and employees for the care of patients who presented at the Emergency Room. That at all times complained of herein all of the above-named Defendants did have a doctor-patient and/or health care provider-patient relationship with the

Plaintiff, Randall Green.

7. This Court has jurisdiction over the matters and the parties hereto. This action concerns claims for medical negligence, among other things, that occurred over the course of treatment by each and all Defendants, all of which took place in Horry County, State of South Carolina.

8. At all times complained of herein, Defendant Wayne B. Bauerle, M.D., was a licensed physician engaged in the practice of his specialty profession in the State of South Carolina, and still holds himself out today to the public as an Orthopaedic Surgeon and as a competent and skillful physician capable of properly and skillfully assessing, treating, and caring for patients, performing operations, diagnosing medical conditions, and otherwise providing competent and careful healthcare services. At all time pertinent hereto the Defendant Bauerle, was acting the scope and course of his employment and agency on behalf of the Defendants Bauerle, P.C. and Grand Strand.

FACTS

9. The Plaintiffs repeat and reallege all of the foregoing paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

10. On or around April 17, 2004, Mr. and Mrs. Green were seriously injured in an automobile collision when another driver crossed the center line and struck their vehicle, virtually head-on.

11. Plaintiffs were taken emergently to Grand Strand Regional Medical Center in Myrtle Beach, Horry County, South Carolina where Mr. and Mrs. Green were initially seen and evaluated by emergency room physicians and hospital staff.

12. Mr. Green was assessed as having a severe laceration to his right forearm that was

bleeding profusely.

13. As this condition was determined to be urgent, Grand Strand provided care by contacting and calling to the hospital a surgeon or surgeons for the continued care of his serious condition.

14. Physicians at Grand Strand Regional Medical Center also paged Dr. Bauerle to tend to Mr. Green for a hip injury. After two calls, Dr. Bauerle arrived at the hospital.

15. As Mr. Green was being prepped for imminent surgery on his bleeding forearm wound, Defendant Bauerle insisted that Mr. Green be taken for a second CT scan of his injured hip. Despite disagreement with another treating physician, and despite the urgent condition of Mr. Green's forearm wound, Grand Strand, as well as its agents, employees, nurses and physicians, failed to stop Dr. Bauerle.

16. At or about the time of his movement to the prep room for the operating room, morphine was administered to Mr. Green for pain pursuant to orders by one of the emergency room physicians.

17. During the time that it took Mr. Green to have the CT done, Mr. Green's bleeding continued and his blood pressure dropped markedly.

18. Grand Strand nurses and staff caring for Mr. Green during this time failed to properly monitor and to notify a physician of Mr. Green's dangerously low blood pressure and failed to take measures to correct Mr. Green's blood pressure or continuous forearm bleeding.

19. When Mr. Green returned from the radiological studies he "coded" from significant loss of blood from his forearm injury. He was resuscitated and underwent surgery to stop the oozing of blood from his arm.

20. Following this blood loss, Mr. Green became unable to move his extremities. Mr. Green was then transferred to The Medical University of South Carolina for further care. Mr. Green remains paralyzed from just above the waist down.

**FIRST CAUSE OF ACTION: PROFESSIONAL NEGLIGENCE/
MEDICAL MALPRACTICE**

21. The Plaintiffs repeat and reallege all of the foregoing paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

22. At all relevant times herein, Defendants owed a duty to provide proper and appropriate medical care to Mr. Green in accordance with the prevailing professional standards of care in the community but failed to do so in the following manners:

- a. In failing to properly care and treat Mr. Green;
- b. In failing to recognize the signs and symptoms of a traumatic injury with significant blood loss in Mr. Green;
- c. In failing to order the appropriate procedures to properly diagnose and treat Mr. Green's condition and symptoms;
- d. In repeatedly failing to conduct adequate monitoring of his vital signs while in the pre-operative and radiological areas;
- e. In failing to properly monitor, as well as to adequately communicate Mr. Green's declining vital signs to the appropriate medical care givers so that adequate treatment could be initiated to control his blood loss, preventing further decline of his condition;
- f. In delaying proper and necessary medical treatment;
- g. In failing to maintain proper training, education and expertise to exercise

appropriate judgment and skill in the treatment of Mr. Green;

- h. In failing to have appropriate policies, procedures, and protocols to ensure that patients with conditions similar to Mr. Green are treated in an appropriate manner; or in having such policies, procedures, and protocols, and failing to ensure such were carried out and followed;
- i. In administering morphine to a Plaintiff with arterial bleeding or the potential for arterial bleeding before closing the arteries;
- j. In failing to comprehend the impending danger to the Plaintiff by overriding another physicians orders and causing delay in the treatment of the Plaintiff;
- k. In failing to recognize the risks, hazards and dangers of the delay of treatment of the Plaintiff's bleeding forearm;
- l. In failing to permit, or in the alternative, in delaying the proper and appropriate medical and surgical procedures to avoid further foreseeable injury to the Plaintiff;
- m. In failing to follow generally accepted medical, surgical, diagnostic and hospital standards, practices and procedures;
- n. In failing to use the due degree of care and caution that reasonably prudent healthcare providers and medical practitioners would have used under the circumstances then and there prevailing and attendant;
- o. In failing to understand and appreciate, to comprehend and to interpret the medical significance of medical information and data present and available concerning the medical status and condition of the Plaintiff before, during

and after the Defendant's intentional, reckless and unnecessary delay of the Plaintiff's treatment;

p. In unnecessarily creating a medical emergency and in so creating this emergency causing serious and debilitating and permanent injury to the Plaintiff;

q. In negligently and recklessly failing to properly monitor, examine, assess and interpret Mr. Green and his medical condition and symptoms prior to causing the unnecessary delay in the treatment and earlier mandated surgical repair of the Plaintiff;

r. In failing to adequately train and supervise Dr. Bauerle and other agents and employees as to the obvious signs and symptoms of a traumatic bleeding injury;

s. In failing to do those things a properly trained medical staff would have done under the same or similar conditions regarding the examination, assessment, diagnosis, performance and consultations with other professionals;

t. In failing to coordinate or require communication between various agents and employees; and

u. In failing to adequately and minimally understand the basic medical tenets and standards for the "triage" or assessing of injured patients.

23. The Defendants did undertake the duty to render medical care to Mr. Green in accordance with the prevailing professional standards of care in the community.

24. Notwithstanding said undertaking, while Mr. Green was under the care of Defendants,

said Defendants departed from prevailing professional standards of care and treatment of Mr. Green and breached their duty to Mr. Green.

25. The Defendants had a duty to provide the type and level of care required for Mr. Green and failed to intervene when that was not done despite Defendants' obligations to do so.

26. Defendant Bauerle's negligent and reckless actions, complained of herein are attributed to Defendants Wayne B. Bauerle, M.D., PC and Grand Strand Medical Center, LLC.

27. Defendants' negligent and reckless actions were not in keeping with proper and appropriate standards of medical care and treatment but were negligent, careless, reckless, willful and wanton and did indeed cause injury to Mr. Green.

28. Had Defendants not acted recklessly and negligently as they did, Mr. Green would not have suffered an infarct, vascular injury and insult to his spinal cord.

29. Additionally, the bleeding, of which Dr. Bauerle halted the timely repair, also caused Mr. Green to be deprived of significant amounts of blood-carrying oxygen and his neurologic processes have been injured as well by Defendant Bauerle's negligent and reckless actions.

30. Mr. Green was fifty-five (55) years of age the time of this tragedy. He can no longer work, earn a living or support his wife and family as he did prior to this injury and he is now confined to a wheelchair and is adjusting badly. His prospects for any significant recovery are slim at best and diminishing rapidly. In all likelihood, he will never walk again.

31. The conduct of all the Defendants as set forth above were the proximate cause of the Plaintiff's debilitating and permanent injuries and pain and suffering and of actual damages of the Plaintiff, including medical expenses, pecuniary and economic loss, permanent disability and mental shock and pain.

SECOND CAUSE OF ACTION: VICARIOUS LIABILITY

32. The Plaintiffs repeat and reallege all of the above paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

33. Plaintiffs were transported emergently to Grand Strand Regional Medical Center and looked to that facility to provide them with adequate care. Plaintiffs relied on the Defendant Grand Strand Regional Medical Center to provide them with caregivers who were competent and skilled in treating trauma patients. The Defendant Grand Strand held itself out to the public as offering Emergency Room hospital services.

34. A person in similar circumstances would have reasonably believed that Dr. Bauerle and other physicians involved in providing care were hospital employees.

35. The duty of Defendant Grand Strand was non-delegable and Defendant Grand Strand is responsible for the acts of those to whom it entrusted the care of Mr. Green.

36. As a result of the herein referenced acts Mr. Green continues to suffer conscious pain and suffering, loss of enjoyment of life, medical and hospital expenses, loss of wages, mental anguish, emotional distress, personal injuries and trauma requiring hospitalization and treatment.

37. As a direct and proximate result of the Defendants' failures, breaches, and violations, Mr. Green suffered injuries and damages, for which Plaintiffs are entitled to recover.

THIRD CAUSE OF ACTION: NEGLIGENT HIRING, SUPERVISION AND TRAINING **(As To Grand Strand)**

38. The Plaintiffs repeat and reallege all of the above paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

39. Defendant Grand Strand negligently hired, supervised and/or trained nurses, contracted with physicians, and provided care by other health care professional to patients, including

Mr. Green.

40. Defendant Bauerle treated Plaintiff as a result of a contractual relationship with Defendant Grand Strand and was at all times acting in a capacity of apparent agency or was performing a non-delegable duty for Defendant Grand Strand.

41. Defendant Grand Strand negligently entrusted nurses, physicians and other health care professionals working in its facility to properly care for patients, including Mr. Green, which created an unreasonable risk of harm to patients.

42. Defendant Grand Strand knew or should have known that its acts created an undue risk of harm to patients, including Mr. Green.

43. As such, Defendant Grand Strand has direct liability for the negligent acts of these nurses, physicians and other health care professionals.

44. As a direct and proximate result of Defendant Grand Strand's negligence, Mr. Green suffered injuries and damages, for which Plaintiffs are entitled to recover.

FOURTH CAUSE OF ACTION-VICARIOUS LIABILITY
(As To Wayne B. Bauerle, M.D., PC)

45. The Plaintiffs repeat and reallege all of the above paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

46. At all times pertinent hereto, the Defendant Wayne B. Bauerle, M.D., was acting as the agent or employee of the Defendant Wayne B. Bauerle, M.D., PC, and was acting in the course and scope of his employment.

FIFTH CAUSE OF ACTION: LOSS OF CONSORTIUM

47. The Plaintiffs repeat and reallege all of the above paragraphs and all subsequent paragraphs as if each were set forth herein verbatim.

48. Randall M. Green and Ann Green are husband and wife.

49. Ann Green has been deprived of the comfort, companionship and consortium of her husband and is entitled to recover for these damages caused by Defendants' negligence.

50. Ann Green has incurred expenses as a direct result of the Defendants' negligence which directly and proximately caused her husband to become disabled.

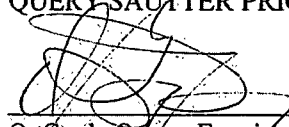
PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants jointly and/or severally, for the following:

- a. Actual damages for Plaintiffs' reasonable and necessary charges for items, including but not limited to, medical care and treatment including doctors' fees, hospital services, supplies, medicine, and loss of income;
- b. Damages related to Plaintiffs' conscious suffering, emotional pain and torment;
- c. Damages related to the loss of Plaintiff's companionship, comfort, society, support and guidance, all both past and future, suffered by Plaintiff Ann Green;
- d. Punitive damages;
- e. Costs of this action;
- f. Attorney's fees;
- g. Such other and further relief as this Court may deem just and proper.

Signatures on following page

QUERY SAUTTER PRICE & FORSYTHE, LLC



O. Grady Query, Esquire
147 Wappoo Creek Drive, Suite 202
Charleston, SC 29412
Telephone: 843-795-9500
Facsimile: 843-762-1500

Cristin Uricchio, Esquire
147 Wappoo Creek Drive, Suite 205
Charleston, SC 29412
Telephone: 843-795-9300
Facsimile: 843-795-3990

L. Morgan Martin, Esquire
1121 Third Avenue
Conway, SC 29526
Telephone: 843-248-3172
Facsimile: 843-248-2842

Attorneys for the Plaintiffs

Dated: 10/15/12
Conway, South Carolina

CERTIFICATE OF SERVICE

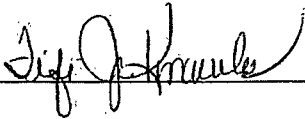
I, the undersigned, hereby certify that I served a copy of the foregoing document upon the following attorneys for the Defendants by placing a copy of same in the United States Mail with sufficient postage attached thereto and addressed as follows:

John B. McCutcheon, Jr., Esquire
Lisa A. Thomas, Esquire
Thompson & Henry, PA
P.O. Box 1740
Conway, SC 29528

Joseph P. McLean, Esquire
Clarke, Johnson, Peterson & McLean, PA
PO Box 1865
Florence, SC 29503

Weldon B. Johnson, Esquire
Barnes, Alford, Stork & Johnson
PO Box 8448
Columbia, SC 29202

Dated: 10/15/12



HURRY COUNTY
12 OCT 15 AM 11:20
MELANIE MURPHY-WARD
CLERK OF COURT

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)

Randall M. Green and Ann Green)
Plaintiffs,)

vs.)

Wayne B. Bauerle, MD, Wayne B.)
Bauerle, MD, PC and Strand Orthopaedic)
Consultants, LLC, Grand Strand Regional)
Medical Center, LLC and Carolinas Medical)
Response, Inc.)
Defendants.)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

HORRY COUNTY
13 SEP 23 PM 2:15
MELANIE HUGGINS-
CLERK OF COURT

MEMORANDUM OF LAW IN SUPPORT OF
DEFENDANTS WAYNE B. BAUERLE, MD,
WAYNE B. BAUERLE, MD, PC AND
STRAND ORTHOPAEDIC
CONSULTANTS, LLC'S
MOTION FOR SET OFF

FACTS

This case was tried before a jury during the week of September 9, 2013, with the Honorable Steven H. John presiding. The jury found for Randall M. Green in the amount of \$2.3 million and Ann Green in the amount of \$550,000.

Prior to trial, the Defendants Grand Strand Regional Medical Center, LLC, Carolinas Medical Response, Inc., and the at-fault driver settled with the Plaintiffs in an amount unknown to the undersigned.

Furthermore, the Medical University of South Carolina settled with the Plaintiffs in a separate suit, Case No. 2007-CP-10-5374, for \$160,000.00 for alleged medical malpractice.

Following the trial, defense counsel moved to off set the verdict with the amount paid by the Defendants Grand Strand Regional Medical Center, LLC, Carolinas Medical Response, Inc., and the at-fault driver who settled prior to trial, as well as the amount paid by MUSC, who subsequently settled with the Plaintiff.

For the below reasons, the Defendants' Motion for Set Off should be granted.

LAW AND ANALYSIS

“When a release or a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death: (1) it does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide, but it reduces the claim against the others to the extent of any amount stipulated by the release or the covenant, or in the amount of the consideration paid for it, whichever is the greater....” S.C. Code Ann. 15-38-50.

“A nonsettling defendant is entitled to credit for the amount paid by another defendant who settles.” Hawkins v. Pathology Associates of Greenville, PA, 330 S.C. 92, 113 (Ct.App. 1998) (citing Powers v. Temple, 250 S.C. 149, 156 S.E.2d 759 (1967); Vaughn v. City of Anderson, 300 S.C. 55, 386 S.E.2d 297 (Ct.App. 1989).

“Therefore, before entering judgment on a jury verdict, the court must reduce the amount of the verdict to account for any funds previously paid by a settling defendant, so long as the settlement funds were paid to compensate the same plaintiff on a claim for the same injury.” Smith v. Widener, 397 S.C. 468, 472-73 (Ct.App. 2012) (citing Hawkins v. Pathology Associates of Greenville, PA, 330 S.C. 92, 113 (Ct.App. 1998)). “When the settlement is for the same injury, the nonsettling defendant’s right to a setoff arises by operation of law.” Id. at 473 (citing Ellis v. Oliver, 335 S.C. 106, 113 (Ct.App. 1999)).

“Therefore, a plaintiff’s claim for actual and punitive damages arising from the same injury is the same claim for purposes of setoff under section 15-38-50(1).” Smith v. Widener, 397 S.C. 468, 473 (Ct.App. 2012).

“Application of the settlement credit was statutorily mandated in this case. Section 15-38-50 grants the court no discretion in determining the equities involved in applying a set-off once a release

has been executed in good faith between a plaintiff and one of several joint tortfeasors.” Ellis v. Oliver, 335 S.C. 106, 113 (Ct.App. 1999).

“Rule 8(c) does not list set-off as an affirmative defense which must be pled in order to be pursued at trial.” Id. at 342.

Pursuant to South Carolina Code Section 15-38-50, this Court should off set the jury verdict with the amount paid by the settling Defendants. In fact, the Court of Appeals for South Carolina held that the verdict must be off set by the amount paid by settling defendants if the settlement was for the same injury to the Plaintiff. Smith v. Widener, 397 S.C. 468, 472-73 (Ct.App. 2012).

In this case, the Plaintiffs sought to recover from all of the Defendants for the same injury to the Plaintiffs. The Plaintiffs alleged that the Defendants committed medical malpractice while treating Plaintiff Randall Green following an automobile accident. The at-fault driver injured the Plaintiff causing him to seek treatment from the Defendant doctors and hospital. The Plaintiffs alleged that Plaintiff Randall Green became a paraplegic due to the Defendants’ alleged medical negligence.

The Plaintiffs further alleged in a separate suit that employees or agents of the Medical University of South Carolina committed medical negligence in their treatment of the Plaintiff. Mr. Green would not have sought treatment at MUSC if he did not sustain injuries in the automobile accident and then damages following the alleged medical malpractice of Dr. Bauerle and the employees and agents of Grand Strand Regional Medical Center.

Because the Plaintiffs sought recovery from all Defendants for the same injury, this Court should set off the amount paid by the settling Defendants from the jury verdict.

CONCLUSION

For the foregoing reasons, the Defendants Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic Consultants, LLC's Motion for Set Off should be granted.

JOHN B. McCUTCHEON, JR.
LISA A. THOMAS
S. ASHLEY GWIN
Attorneys for the Defendants



THOMPSON & HENRY, PA
1300 Second Avenue
Conway, SC 29526

P.O. Box 1740
(843) 248-5741

September 23, 2013

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)
)
Randall M. Green and Ann Green,)
)
Plaintiffs,)
)
v.)
)
Wayne B. Bauerle, MD, and Wayne B.)
Bauerle, MD, PC,)
)
Defendants.)
_____)

IN THE COURT OF COMMON PLEAS
Docket No.: 2011-CP-26-7403

**PLAINTIFFS' MOTION AND
SUPPORTING
MEMORANGUM IN
OPPOSITION TO
DEFENDANTS' MOTION FOR
SETOFF**

NOW COME the Plaintiffs, Randall M. Green and Ann Green ("Plaintiffs"), by and through their undersigned counsel of record, and hereby submit their Motion and Memorandum in Opposition to Defendants' Motion for Set-off from the judgment rendered by this Honorable Court on September 13, 2013.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of the negligent treatment of Plaintiff Randall M. Green ("Mr. Green") by various medical providers, including Defendants Wayne B. Bauerle, MD and Wayne B. Bauerle, MD, PC (collectively "Bauerle"), for injuries Mr. Green suffered in an automobile accident on April 17, 2004 in Horry County. On December 7, 2004, Mr. Green settled with the at-fault driver, for One Hundred Thousand (\$100,000.00) Dollars under the liability policy and he received One Hundred Fifty Thousand (\$150,000.00) Dollars in under insured motorist coverage. Mrs. Green received One Hundred Thousand (\$100,000.00) Dollars under the at-fault driver's liability policy and Seventy-Five Thousand (\$75,000.00) Dollars in under insured motorist coverage. Subsequently, the Plaintiffs filed one suit against Defendants Bauerle, Grand Strand Regional Medical Center ("Grand Strand"), and Carolinas Medical Response, Inc. ("CMR") for medical negligence and loss of consortium. A separate suit was filed against the Medical University of

South Carolina ("MUSC") for damages arising from a sponge negligently left in Mr. Green's leg as a result of treatment rendered at MUSC, which resulted in distinct and different causes of action. The Plaintiffs eventually settled with all of the parties except Bauerle, thereby releasing the settling parties from liability. On February 14, 2010, the Plaintiffs settled with the ambulance carrier, CMR, for Twenty-Five Thousand (\$25,000.00) Dollars. On February 3, 2010, the Plaintiffs settled with MUSC for One Hundred Sixty Thousand (\$160,000.00) Dollars.

Grand Strand filled a Motion for Partial Summary Judgment dismissing the Plaintiffs' causes of action as to Grand Strand for Vicarious Liability and Negligent Hiring, Supervision, and Training. The Honorable Larry B. Hyman, Jr. granted Defendant Grand Strand's Motion for Partial Summary Judgment on April 18, 2013, dismissing all causes of action for which Grand Strand could be held vicariously liable for the actions of Bauerle. Subsequently, on May 31, 2013, Grand Strand settled with the Plaintiffs. (Stipulation and Covenant Not to Sue, Attached as Sealed Exhibit A). Bauerle did not appeal this Order or file a motion for reconsideration, therefore they now should not be able to avail themselves of the set-off from the stricken causes of action, which is the law of the case. Moreover, Bauerle stipulated to the dismissal of Grand Strand without requiring the Plaintiffs to allocate the proceeds of the Settlement.

The above-captioned trial was heard by this Honorable Court on September 11, 2013. At the end of the trial the jury found in favor of the Plaintiffs and returned a verdict of Two Million Three Hundred Thousand (\$2,300,000.00) Dollars in actual damages for Mr. Green's medical negligence claim and Five Hundred Fifty Thousand (\$550,000.00) Dollars actual damages for Mrs. Green's loss of consortium claim. Bauerle now seeks to set-off the settlement proceeds obtained by the Plaintiffs from the at-fault driver, Grand Strand, Carolinas Medical Response and the Medical University of South Carolina (collectively referred to as "Settling Defendants") from the verdicts

rendered on September 13, 2013. For the reasons set forth below, Bauerle's Motion should be denied.

ARGUMENT

I. APPLYING SET-OFF CONSTITUTES AN UNDUE TAKING.

Medical Malpractice and Loss of Consortium are separate causes of action involving separate plaintiffs. Hiott v. Contracting Servs., 276 S.C. 632, 281 S.E.2d 224 (1981)(In South Carolina, loss of consortium is an independent action, not derivative.); See S.C.Code Ann. § 15-75-20(1976) ("Any person may maintain an action for damages arising from an intentional or tortious violation of the right to the companionship, aid, society and services of his or her spouse.") The Settlement Agreement entered into by the Plaintiffs and Grand Strand did not specify how the Settlement funds are to be allocated between each of the Plaintiffs or their individual causes of action. There exists no authority pursuant to which this Court may determine the relative rights of the parties to the unallocated settlement proceeds as between Plaintiff Randall M. Green for his Medical Negligence claim and Plaintiff Ann Green for her Loss of Consortium claim. Each of the parties has an undeniable property right in an undisclosed and unallocated portion of the settlement proceeds. Essentially, Ann Green owns a portion of every cent of that settlement and Randall Green owns a portion of every cent. An allocation or reallocation by the court would necessarily deprive one plaintiff or the other of an existing property right and to do so would constitute a denial of due process and a denial of equal protection under the law in violation of not only the South Carolina Constitution, but the Constitution of the United States of America. The Court has no way to determine the relative rights of the parties to the settlement proceeds, and therefore, may not set-off against either.

Both the Covenant Not to Sue and the Stipulation of Dismissal are silent as to the proportionate ownership of either party. (Attached as Exhibit A). Bauerle entered into the Stipulation of Dismissal without objection to the silence of any apportionment between the two individual Plaintiffs. This Court has no jurisdiction to apportion or divide the settlement between the two Plaintiffs at this juncture. A set-off of any part of the verdict in favor of Randall Green would deprive Ann Green of her ownership right to the proceeds of the settlement and conversely, the set-off of any portion of Ann Green's verdict would deprive Randall Green of his ownership of a portion of the settlement proceeds, in both instances without any adjudication of their respective rights.

II. SET-OFF IS NOT REQUIRED UNDER SECTION 15-38-50.

The Defendants, Wayne B. Bauerle, M.D. and Wayne B. Bauerle, M.D., P.C ("Bauerle"), seek to set-off the amount of the Plaintiffs' settlement with the at-fault driver, Grand Strand, CMR and MUSC against the judgment entered by this Court against Bauerle on September 13, 2013. Set-off is not required under the statute because Section 15-38-50 requires that the reduction of a judgment from a settlement must be for the same injury arising under the same cause of action.

South Carolina Code Section 15-38-50 provides that a release or covenant not to sue executed in good faith to one of two or more persons liable in tort for the same injury "reduces the claim against the others to the extent of any amount stipulated by the release or covenant". However, the reduction in the judgment must be from a settlement for the same cause of action. Rutland v. S.C. Dep't of Transp., 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), cert. granted, (Oct. 19, 2011); Welch v. Epstein, 342 S.C. 279, at 313, 536 S.E.2d at 425 (2000). The supreme court explained, "[t]he reason for allowing such a credit is to prevent an injured person from

obtaining a second recovery of that part of the amount of damages sustained which has already been paid him. Or differently stated, it is almost universally held that there can be only one satisfaction for an injury or wrong." Truesdale v. South Carolina Highway Dept., 264 S.C. 221, 213 S.E.2d 740 (1975).

Here, Bauerle is not entitled to set-off from prior settlements with the at-fault driver, Grand Strand, CMR or MUSC for two reasons. First, the Plaintiffs' settlements do not arise out of the same cause of action as the judgment against Bauerle. Further, the Plaintiffs' settlements do not compensate the Plaintiffs for the same injuries as the judgment against Bauerle.

A. The settlement with Grand Strand and the judgment against Bauerle resulted from entirely and distinctly different causes of action.

Section 15-38-50 provides that a release or covenant not to sue executed in good faith to one of two or more persons liable in tort for the same injury "reduces the claim against the others to the extent of any amount stipulated by the release or covenant". However, the reduction in the judgment must be from a settlement for the same cause of action. Rutland v. S.C. Dep't of Transp., 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), cert. granted, (Oct. 19, 2011).

1. Grand Strand Regional Medical Center

The settlement with Grand Strand and the verdict against Bauerle resulted from entirely and distinctly different causes of action, and therefore Bauerle, the only non-settling defendant, should not be entitled to set-off the amount of the Settling Defendants' settlements from his judgment. The Plaintiffs Fourth Amended Complaint asserted four causes of action: Professional Negligence/Medical Malpractice, Vicarious Liability, Negligent Hiring, Training, and Supervision, and Loss of Consortium. The Complaint would make Grand Strand liable for the negligence of its employees, agents, and independent contractors under theories of vicarious liability and the nondelegable duty doctrine. By Order dated April 18, 2013, the Honorable Larry

B. Hyman granted Grand Strand's Motion for Partial Summary Judgment ("Order"). In so doing, Judge Hyman dismissed the Plaintiffs' causes of action against Grand Strand for Vicarious Liability and Negligent Hiring, Supervision, and Training. That Order provided:

Grand Strand cannot be held vicariously liable for the acts or omissions of its independent contractor physicians or any of its other independent contractors or employees for that matter because both the statute of limitations and the statute of repose have expired as to Grand Strand's independent contractors and employees, none of whom have been named in any of the five versions of the Complaint.

(Order for Summ. J., 3, April 18, 2013). Judge Hyman's Order further provided: "Grand Strand is entitled as a matter of law for judgment as to vicarious liability." *Id.* at 7. Further, Judge Hyman specifically held that Grand Strand could not be held responsible for the acts of negligence or recklessness on the part of Bauerle, based on the nondelegable duty doctrine of vicarious liability, stating "[t]hus because none of the first four iterations of the Complaint put Grand Strand on sufficient notice of a nondelegable duty claim, the relation back doctrine does not apply to that claim". *Id.* at 13-14. Judge Hyman concludes:

IT IS, THEREFORE, ORDERED that Grand Strand's Motion for Partial Summary Judgment is GRANTED. Judgment shall be entered in Grand Strand's favor on the Fourth Amended Complaint's causes of action for vicarious liability and negligent hiring, supervision, and training.

Id. at 15. Bauerle, did not oppose nor seek to modify in any manner, Judge Hyman's Order, nor has Bauerle sought reconsideration, appealed from the order, nor objected to the Order in any matter whatsoever. A ruling on an issue which disposes of the underlying cause of action is a judgment on the merits. Foran v. USAA Cas. Ins. Co., 311 S.C. 189, 427 S.E.2d 918 (Ct. App. 1993). If a ruling is adverse to a party, it is incumbent upon that party to appeal the ruling or be bound by it as the law of the case. Charleston Lumber v. Miller Housing, 338 S.C. 171, 525 S.E.2d 869 (2000); ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997) (unappealed ruling is law of the case).

Therefore, the only causes of action that remained as to Grand Strand after Judge Hyman's Order were Mrs. Green's Loss of Consortium claim and Mr. Green's Negligence claim alleging Grand Strand's direct negligence in the following particulars:

- a. In failing to have appropriate policies, procedures, and protocols to ensure that patients with conditions similar to Mr. Green are treated in an appropriate manner, or in having such policies, procedures, and protocols, and failing to ensure such were carried out and followed; and
- b. In failing to coordinate or require communication between various agents and employees

(Fourth Am. Compl., ¶ 22).

On the other hand, causes of action remained against Bauerle for Mrs. Green's Loss of Consortium Claim and Mr. Green's Medical Negligence claims. Since Grand Strand's liability for Bauerle's conduct could only be by virtue of vicarious liability, dismissing that cause of action dismissed Grand Strand's liability for Bauerle's actions. Similarly, Grand Strand's negligence in failing to implement policies and procedures cannot be imputed to Bauerle.

Shortly after Judge Hyman's Order, Grand Strand settled with the Plaintiffs in consideration of a Covenant Not to Sue. By way of the Stipulation and Covenant, the only causes of action asserted at trial against Bauerle were for Bauerle's negligence in interrupting Mr. Green's treatment and causing Mrs. Green loss of consortium. (Attached as **Exhibit A**). Therefore, Grand Strand's settlement funds were given to the Plaintiffs in consideration for completely different causes of action than those pursued against Bauerle at trial and for which the jury rendered a verdict against Bauerle. When Judge Hyman granted summary judgment on the Plaintiffs' vicarious liability claim and negligent hiring, supervision, and training, any right of Bauerle to assert the privilege of set-off to prevent double recovery under the same cause of action was eradicated. Bauerle should not now be allowed to claim a set-off necessarily based upon the causes of action stricken by Judge Hyman's Order when Bauerle stood by and did nothing to oppose the rulings in

that Order. In fact, pursuant to Question One of the Defendant Grand Strand's Request to Admit, Bauerle amended his answer on March 4, 2008 to admit that:

The employees of Grand Strand Regional Medical Center did not proximately cause or contribute to the injuries and damages alleged to have been sustained by Plaintiffs in the Third Amended Complaint.

(Def.'s Bauerle Am. Answer to Def. Grand Strands Req. to Admit, 2, March 4, 2008, Attached as **Exhibit B**).

2. At-Fault Driver

The Plaintiffs sued the at-fault driver for negligently operating his vehicle and in doing so causing the Plaintiffs to suffer injuries, including a lacerated arm and fractured and dislocated hip. There is no cause of action against Bauerle that alleges improper operation of a motor vehicle.

3. Carolina's Medical Response

The Plaintiffs sued CMR alleging that CMR was negligent in handling and transporting Mr. Green. The negligence of CMR is completely separate from that alleged against Bauerle and this negligence caused Mr. Green to suffer further damages and is alleged to have occurred after the paralysis found to have been caused by the negligence of Bauerle.

4. The Medical University of South Carolina

The Plaintiffs sued MUSC for negligently leaving surgical sponges in Mr. Green's leg, causing him to develop MRSA, infection, and extreme pain. MUSC's negligence is alleged to have occurred subsequent to the conclusion of the treatment by Bauerle, alleging facts that give rise to a separate cause of action in a separate lawsuit in Charleston County.

B. The settlements and judgment are for different injuries.

When a prior settlement involves compensation for the same injury for which the jury awarded damages, the right to set-off arises by operation of law. Smith v. Widener, 397 S.C.

468, 724 S.E.2d 188 (Ct. App. 2012) (*citing Ellis v. Oliver*, 335 S.C. 106, 112, 515 S.E.2d 268, 271-72 (Ct. App. 1999)). Likewise, when the prior settlement involves compensation for a different injury from the one tried to verdict, there is no set-off as a matter of law. *Smith* at 473; (*citing Hawkins v. Pathology Assocs. of Greenville, P.A.*, 330 S.C. at 114-15, 498 S.E.2d at 407) (holding that Georgia and South Carolina wrongful death actions involve different injuries and therefore are separate claims with no right of set-off).

Under South Carolina Code § 15-38-50, a non-settling defendant is entitled to a reduction in the verdict rendered against him by the amount of his co-defendants' settlement funds, "[h]owever, the reduction in the judgment must be from a settlement for the same cause of action." *Welch*, 342 S.C. 279, at 313, 536 S.E.2d at 425 (2000). In other words, in order for Bauerle to recover set-off from the Settling Defendants' settlement funds, he must prove that all of the Settling Defendants and Bauerle caused the Plaintiffs to suffer one indivisible injury for which the Settling Defendants and Bauerle settled or litigated under the same cause of action.

Here, the judgment against Bauerle was the injuries Mr. Green sustained when Bauerle negligently delayed Mr. Green's care. That delay caused Mr. Green to suffer cardiac arrest and subsequently become paralyzed. Mr. Green's injuries in the case at bar were confined to his paraplegia and the effect of his paraplegia on his life and on his wife through her loss of consortium claim. At trial, Dr. Chariker testified that the interruption in treatment to Mr. Green's right arm caused by Bauerle's order for CAT Scan "tipped the scales" and caused Mr. Green's arrest. Therefore, the sole injuries for which the Plaintiffs recovered from Bauerle are the result of Mr. Green's paralysis caused by Bauerle.

1. Grand Strand Regional Medical Center

The damages the Plaintiffs sought to recover from Grand Strand negligently failing to implement policies and procedures are different than those the Plaintiffs sought to recover from Bauerle for negligently interrupting treatment to Mr. Green. But for Bauerle's negligence, all of the expert medical testimony admitted at trial was that Grand Strand's administrative negligence would have caused Mr. Green minimal harm from blood loss and enduring low blood pressure for a prolonged period. Further, the Plaintiffs' experts testified at trial that absent the interruption by Bauerle, Mr. Green's cardiac arrest was not inevitable. However, all of the Plaintiffs' experts, as well as Bauerle's expert Dr. Smith, testified that even if Mr. Green suffered cardiac arrest in the operating room, and it occurred in the operating room instead of during the delay in the CAT Scan, he could have been resuscitated more quickly, given the assistance of the anesthesiologist who was present. Therefore, it would have been more probable than not that Mr. Green's arrest would not have caused him to become paralyzed, rather he would have only endured minimal damages from blood loss. The injuries alleged by the Plaintiffs caused by Grand Strand are separate and apart from those found to have been caused by Bauerle. Further, in the case at bar, no medical expenses incurred by the Plaintiffs while at Grand Strand were claimed as damages.

2. At-Fault Driver

Here, Bauerle overlooks the lawsuit filed against the at-fault driver alleging negligence in operating his vehicle and the fact that the Plaintiffs alleged different injuries from the at-fault driver's negligence than the negligence of Bauerle. The at-fault driver drove his vehicle in such a negligent way that he hit the vehicle in which Mr. Green was traveling head-on. This wreck caused Mr. Green to fracture and dislocate his right hip and suffer a severe laceration on his right forearm. Mr. Green's settlement with the at-fault driver was for these bodily injuries in addition to the

damage to Mr. Green's car. But for Bauerle's negligence, medical testimony indicated that Mr. Green would have left Grand Strand with only these two injuries. These injuries are completely separate than Mr. Green's paralysis caused by Bauerle, and it is even clearer that these are different causes of action. All of the causes of action against the at-fault driver alleging negligence in operation of a motor vehicle. Therefore, it cannot be said that this settlement and Bauerle's verdict are for the same injuries to the Plaintiffs nor do the injuries arise under the same cause of action.

3. Carolina's Medical Response

Carolina's Medical Response ("CMR") is the EMS provider who carried Mr. Green from Grand Strand to MUSC on April 18, 2004. The Plaintiffs filed suit against CMR alleging that CMR was negligent in handling and transporting Mr. Green, and that this negligence caused Mr. Green to suffer further injury than he endured as a result of Bauerle's treatment. Mr. Green was already paralyzed when CMR picked him up, so the injuries the Plaintiffs sought to recover from CMR were separate and apart from those the Plaintiffs recovered from GSRMC. The negligence of CMR is completely separate from that alleged against Bauerle.

4. The Medical University of South Carolina

Here again, the Defendant overlooks the lawsuit filed against MUSC alleging MUSC negligently rendered care to Mr. Green while at MUSC. While at Grand Strand, Mr. Green only had temporary surgery performed on his forearm laceration. It was not until Mr. Green was transferred to MUSC, on April 18, 2004, that he underwent surgery to repair his post-column acetabular fracture and remove bone fragments from his hip joint. After this surgery, while still at MUSC, several surgical wound vac sponges were inserted in Mr. Green's hip wound and negligently left inside Mr. Green's leg. As a result of this negligence by MUSC, Mr. Green developed a severe infection in his leg, slow healing sores, and MRSA. But for MUSC's negligence, Mr. Green would not have developed an infection, sores, or MRSA. It was for this

negligence that the Plaintiffs sued and eventually settled with MUSC, whereas Bauerle's negligence resulted in Mr. Green becoming paralyzed before he was transferred to MUSC. Additionally, in the case at bar, the Plaintiffs did not claim any medical expenses or damages involving MUSC. Therefore, the Plaintiff's settlement with MUSC was for completely different injuries than those recovered in the judgment against Bauerle.

Therefore, since the Plaintiffs recovered under different causes of action, for different injuries, set-off is not required under §15-38-50.

III. SET-OFF IS CONTRARY TO THE LEGISLATIVE INTENT OF §15-38-50

The court's primary concern in interpreting a statute is to ascertain and effectuate legislative intent. State v. Four Video Slot Machs., 317 S.C. 397, 453 S.E.2d 896 (1995); Spartanburg County Dep't of Soc. Servs. v. Little, 309 S.C. 122, 420 S.E.2d 499 (1992). "A statute must receive a practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of the lawmakers." Spartanburg, 309 S.C. at 125, 420 S.E.2d at 501.

A. There is no risk of the Plaintiffs recovering twice if set-off is not granted.

Under South Carolina law, a settlement or covenant not to sue with one tortfeasor does not discharge any other tortfeasor unless its terms so provide or the plaintiff has received full compensation. S.C.Code Ann. § 15-38-50(1). The South Carolina Supreme Court explained, "[t]he reason for allowing such a credit is to prevent an injured person from obtaining a second recovery of that part of the amount of damages sustained which has already been paid him. Or differently stated, it is almost universally held that there can be only one satisfaction for an injury or wrong." Truesdale v. South Carolina Highway Dept., 264 S.C. 221, 213 S.E.2d 740 (1975).

Mr. Green's damages as proven by evidence admitted at trial were so grave that even adding the settlement and the jury verdict together cannot reasonably compensate the Plaintiffs for the

damages they suffered, so there is no danger of the Plaintiffs receiving a double recovery. Furthermore, the trial judge has the inherent equitable jurisdiction and discretion to make a determination of the adequacy of the combined verdict and settlement and apply set-off only where he believes double recovery exists. In the case at hand, given the amount of the verdicts rendered by the jury for both Mr. Green and Mrs. Green, which combined were less than Mr. Green's total financial loss alone, and which appeared to allow nothing for his non-pecuniary damages, there is no double recovery. The Plaintiffs' damages have not been satisfied, and there should be no set-off.

1. Randall M. Green's damages are not satisfied.

Following the Plaintiffs' five-day trial against Bauerle, the jury deliberated for over eight hours before returning a verdict in favor of Mr. Green. Specifically the jury found that Bauerle negligently departed from the standard of care in his treatment of Mr. Green, and that his negligence proximately caused Mr. Green damages in the amount of Two Million Three Hundred Thousand (\$2,300,000.00) Dollars.

The total damages awarded by the jury was still less than the total financial loss testified to by Plaintiffs' Economic Loss Expert, Dr. Oliver Wood. Dr. Wood testified that Mr. Green's total financial loss was Three Million Six Thousand Seven Hundred Ninety-One (\$3,006,791.00) Dollars, not including the cost of potential complications of his condition. (Plaintiffs' Trial Exhibit 15, Chart 7; Chart 9.) In fact, in the nine years since Mr. Green became paralyzed, he has experienced many of the potential complications listed Mr. Wood's Chart and is at an increased risk of developing additional complications because of his paraplegia, as testified to by the Plaintiffs' expert Nurse Sarah Lustig. Bauerle did not challenge the expert qualification of Nurse Lustig or Dr. Wood and did not provide any evidence to the contrary.

The verdict rendered for Mr. Green was less than his total financial loss. The trial judge charged the jury that damages for which the Plaintiffs are entitled include pain and suffering, loss of enjoyment of life, and mental distress; however, the jury verdict for did not allow the jury to indicate upon which elements of damages the verdict was based. Therefore, it cannot be said that the Two Million Three Hundred Thousand (\$2,300,000.00) Dollar verdict satisfied Mr. Green's damages caused by Bauerle's negligence. For the above-mentioned reasons, set-off is not necessary to prevent a double recovery.

2. Ann Green's Damages have not been satisfied.

The Plaintiffs make the same argument on behalf of Mrs. Green and the jury's Five Hundred Fifty Thousand (\$550,000.00) Dollar Loss of Consortium verdict. At trial Mrs. Green offered compelling testimony concerning her relentless devotion to Mr. Green since the day he returned home nine years ago. Mrs. Green testified that from that day forward, she dedicated her life to keeping her husband alive and that she will continue to do so until the day she dies.

Further, Mrs. Green offered testimony that Mr. Green's most intimate marital relations have been damaged since she can no longer sleep in the same bed as Mr. Green or even hold him for fear of complicating his medical condition. Bauerle's negligence caused Mrs. Green to give up her life, in order to save her husband's life. Her Five Hundred Fifty Thousand (\$550,000.00) Dollar Loss of Consortium verdict can hardly be said to account for Mrs. Green's total damages.

B. The Settling Defendants and Bauerle are not joint tortfeasors.

Section 15-38-50 only applies to true joint tortfeasors. In Atkinson v. Orkin Exterminating Co. Inc., 604 S.E.2d 385 (2004), the plaintiffs sued Terminix and Orkin for structural damages to their home caused by termite infestation. Terminix settled with the plaintiffs and subsequently a judgment was rendered against Orkin. The supreme court reversed the trial court's award of set-

off to Orkin because it determined that Orkin and Terminix were not joint tortfeasors, since the duties that the two defendants owed the plaintiffs were based upon independent, unrelated contracts, not a common duty of care. Id. at 172. Further, the court held that there was no indication that the claims against the settling defendant constituted a contributing factor to the non-settling defendant's negligence, and therefore, the proceeds from the settlement was a collateral source, and could not be set-off. Id.

Similarly, here it cannot be determined that the parties were joint tortfeasors. In fact, in his Response to Plaintiffs' Request to Admit, Bauerle specifically admits that Grand Strand did not proximately cause or contribute to the Plaintiffs' injuries. (Defendant Bauerle Amended Answer to Defendant Grand Strand Request to Admit, 2, March 4, 2008, **Exhibit B**). Bauerle cannot now be allowed to abandon his own admission.

C. Equitable indemnification does not allow set-off.

The principles of equitable indemnification bode against applying a set-off in this situation.

Under equitable indemnification, the cost of settling a case is recoverable

(1) if the settlement is bona fide, with no fraud or collusion by the parties; (2) if, in the circumstances, the decision to settle is a reasonable means of protecting the innocent party's interest; and (3) if the amount of the settlement is reasonable in light of the third party's estimated damages and the risk and extent of defendant's exposure if the case is tried.

Vermeet Carolina's, Inc. v. Wood/Chuck Chipper Corp., 336 S.C. 53, 518 S.E.2d 301 (Cl. App. 1999).

Here, the third element does not apply because the jury clearly indicated that Bauerle's negligence proximately caused the Plaintiffs paralysis. Clearly, under the present facts, to grant a set-off would effectively result in equitable indemnification for the party at greatest fault.

IV. IF THIS COURT DETERMINES SET-OFF IS REQUIRED UNDER § 15-38-50, THE PARTIES' SETTLEMENTS CANNOT BE EQUITABLY REALLOCATED BETWEEN MEDICAL NEGLIGENCE AND LOSS OF CONSORTIUM.

When a prior settlement involves compensation for the same injury for which the jury awarded damages, the right to set-off arises by operation of law. Smith v. Widener, 397 S.C. 468, 724 S.E.2d 188 (Ct. App. 2012) (*quoting* Ellis v. Oliver, 335 S.C. at 112-113, 515 S.E.2d at 271-72 (Ct.App. 1999)). Likewise, when the prior settlement involves compensation for a different injury from the one tried to verdict, there is no set-off as a matter of law. Smith, 397 S.C. at 473 (*quoting* Hawkins, 330 S.C. at 114-15, 498 S.E.2d at 407 (Ct. App. 1998)). On the other hand, when a settlement is argued to involve two claims, one of which involves the same injury as the claim tried to verdict and one of which does not, the circuit court must make a factual determination of how to allocate the settlement between the two claims. Smith, 397 S.C. at 473. "The trial court's jurisdiction to set-off one judgment against another is equitable in nature and should be exercised when necessary to provide justice between the parties." Rutland v. S.C. Dep't of Transp., 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), *cert. granted*, (Oct. 19, 2011).

If this Court determines that a right to set-off exists, then equity requires that the amount of the settlement funds determined to be set-off by the Court in its discretion, provide justice between the parties. A defendant is only entitled to set-off from a settlement involving injuries sustained by that same plaintiff arising from the same cause of action. Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000). Further, it is undisputed that Medical Negligence and Loss of Consortium are separate causes of action involving separate plaintiffs and that the damages or injury for Medical Negligence and Loss of Consortium are different as a matter of law. See Graham v. Whitaker, 282 S.C. 393, 397, 321 S.E.2d 40, 43 (1984) ("It is well settled in South Carolina that one spouse's cause of action for medical expenses and loss of consortium resulting from negligent

injuries to the other spouse is a different and distinct cause of action from one maintained by the injured spouse; judgment in favor of the defendant in one action is not a bar to the other action.”) The Plaintiffs have further set forth, here and above, their arguments that the causes of action against the Settling Defendants and Bauerle are different. The Plaintiffs’ Covenant Not to Sue with Grand Strand states that Grand Strand’s settlement funds were given in consideration of Plaintiffs’ Covenant, but does not indicate how the settlement funds are to be allocated between the Plaintiffs’ causes of actions, nor does it specify the amount allocated to either of the two Plaintiffs. (Attached as **Exhibit A**). Thus the Court would be required to revise the settlement agreement between Grand Strand and the Plaintiffs. Although this Court has the authority to reallocate settlement funds for the same injury when equity requires, it would be fundamentally unjust to do so in this circumstance for two reasons. First, the precedent in South Carolina case law appears to limit the authority to do so. Second, equity is not served by doing so.

A. There is no binding case law in South Carolina mandating reallocation of settlements.

Here, binding and enforceable releases have been executed in good faith between the Plaintiffs and the Settling Defendants. None of the Settling Defendants’ releases with the Plaintiffs state how the settlement funds are to be allocated between the Plaintiffs or their causes of action, therefore, the Court cannot determine how the settlement funds should be allocated. Welch v. Epstein, 342 S.C. 279, at 313, 536 S.E.2d at 425, reiterates that “the reduction in the [plaintiff’s] judgment must be from a settlement for the same causes of action”, but permits reallocation between different cause of action despite allocation set forth in a pretrial settlement agreement with a different tortfeasor. Id.

In the case at bar, the Plaintiff, Randall Green, settled with Grand Strand on the causes of action that remained after Judge Hyman’s Order and the Plaintiff, Ann Green, settled with Grand Strand

on her cause of action for Loss of Consortium. Even assuming arguendo that the Court would be justified in the reallocation of damages for the different causes of action between the settling and non-settling tortfeasors, there is absolutely no authority pursuant to which the Court can allocate the settlement proceeds between the individual Plaintiffs where no such allocation is provided for in the settlement agreement. Neither equity nor legal precedent would allow this Court to deprive either of the Plaintiffs of their claim to the entire amount of the Settlement proceeds or any portion thereof.

Justice Pleicones, in his dissent in Rutland, argues that Welch should be overruled to the extent that it grants authority for the reallocation of settlement proceeds. 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), cert. granted, (Oct. 19, 2011). The majority did not specifically disagree with Justice Pleicones and it appears that the majority kept the door open to overruling Welch in the future. The majority acknowledged Justice Pleicones dissent and made a point to note that Petitioner Rutland did not ask the court to overrule Welch, nor did he petition to argue against precedent as required by Rule 217, SCACR. Rutland, 390 S.C. at 85-86, 700 S.E.2d at 455, fn.4.

Therefore, the majority wrote, “[w]e decline, as we must, to entertain arguments not presented to us.” Id. at 86; (citing Langley v. Boyter, 284 S.C. 162, 181, 325 S.E.2d 550, 561 (Ct. App. 1984)), quashed on other grounds, 286 S.C. 85, 332 S.E.2d 100 (1985) (“[A]ppellate courts in this state, like well-behaved children, do not speak unless spoken to and do not answer questions they are not asked.”).

B. The allocation of settlement funds must yield to fairness and justice.

The trial court's jurisdiction to set-off one judgment against another is equitable in nature and should be exercised when necessary to provide justice between the parties. Welch, 342 S.C. at 313, 536 S.E.2d at 425; (citing Smalls v. South Carolina Dep't of Education, 339 S.C. 208, 528 S.E.2d

682 (Ct.App.2000)). A set-off is not necessarily founded upon any statute or fixed rule of court, but grows out of the inherent equitable jurisdiction of the court and should be exercised so as to do justice between the parties. Welch, 342 S.C. at 313, 536 S.E.2d at 425; (citing Rookard v. Atlanta & Charlotte Air Line Ry., 89 S.C. 371, 71 S.E. 992 (1911)). Therefore, such motions are addressed to the discretion of the court—a discretion which should not be arbitrarily or capriciously exercised. When two different causes of action are involved, the allocation of settlement funds between two causes of action must yield to fairness and justice. Welch, 342 S.C. 279, at 313, 536 S.E.2d at 425.

Here, even if the Court determines that set-off applies, there is no way for the court to determine how the settlement funds should be allocated between causes of action or between the individual plaintiffs. As discussed above, it is undisputed that Medical Negligence and Loss of Consortium are separate causes of action involving separate plaintiffs. See Graham v. Whitaker, 282 S.C. 393, 397, 321 S.E.2d 40, 43 (1984).

In Hawkins v. Pathology Assocs. of Greenville, P.A., 330 S.C. 92, 113, 498 S.E.2d 395, 407 (Ct. App. 1998), the South Carolina Court of Appeals overturned the trial court's award of set-off of a settlement in a Georgia wrongful death lawsuit against a jury verdict in a South Carolina wrongful death case. In determining whether to allow set-off, the case turned on the fact that the only common element of damages between the two statutes is the award of economic value for the deceased's life expectancy. While the court recognized that "it is almost universally held that there can be only one satisfaction for an injury or wrong", the court reasoned that the Georgia and South Carolina wrongful death statutes do not compensate a plaintiff for the same elements of damage; therefore, suits under both statutes do not constitute the same cause of action. Id. at 113-114.

Additionally, the court noted that at trial neither party requested that the jury specify the amount it awarded for each element of damages, therefore, there was not enough evidence to indicate set-off was necessary to prevent the plaintiff from double recovery. Id. at 114.

Similarly, in the present case, the Plaintiffs both received separate and distinct injuries for which they brought separate and distinct causes of action under which they could recover different damages. We do not know how the jury allocated the Plaintiffs' damages within those separate causes of action. To resolve this matter, the Plaintiffs requested that the Court use a jury verdict form that listed 20 different types of compensatory damages to which the jury could find that the Plaintiffs were entitled under each cause of action, and would have allowed the jury to indicate the amounts awarded for those various elements of damages. Bauerle objected and, although the Court charged the jury with the elements of damages, the Court declined to use the Plaintiffs' verdict form. Since the Court is now unable to determine how the jury intended to allocate its actual damages and Bauerle made no attempt to allow the jury to do so, he cannot, now, allege that the jury's verdict is for the same element of damages as any of the earlier settlements. See Gasque v. Voyager Life Ins. Co. of S.C., 288 S.C. 629, 344 S.E. (2d) 182 (Cl. App. 1986) (Failure to object to the charge at trial waives any alleged error in the charge). To reallocate the settlement funds now would not yield to fairness and justice.

C. The reallocation of settlement agreements is contrary to public policy.

First, the renegotiation of settlement agreements discourages a plaintiff from settling. Second, it does not allow the plaintiff to choose whom to sue.

1. Reallocation discourages plaintiffs from settling.

It has long been held that public policy favors settlement. See Hensley v. Alcon Labs., Inc., 277 F.3d 535, 540 (4th Cir. 2002) (recognizing the value settlements generally bring by "providing

an orderly and peaceful resolution of controversies"). Applying §15-38-50 so that courts can relocate settlement funds, it is foreseeable that a plaintiff's recovery as to one defendant will be inequitably reduced by his recovery against another defendant. This scenario was confronted by the United States Supreme Court in McDermott, Inc. v. AmClyde, 511 U.S. 202, 212-21 (1994). There, the Supreme Court discussed possible inequities of setting off a judgment by the full amount of a settlement rather than requiring a non-settling defendant to pay its proportionate share of damages.

The expansion of this statute to allow equitable reallocation so that settlement proceeds from a defendant for one cause of action can be applied to his co-defendants jury, provides further disincentive for defendants to enter into reasonable, good faith settlement negotiations.

The statute was eventually amended in 2005, several months after the facts of this case took place, in attempt to remedy this situation. At that time South Carolina modified its joint and several liability laws to reflect the concept of comparative negligence.

2. Reallocation violates the Plaintiffs' right to choose his defendant.

The right to set-off is founded in equity. Revising a settlement agreement between a plaintiff and another tortfeasor requires a plaintiff to defend to the court the viability of a claim she has not made. In his dissent from the majority in Rutland v. S.C. Dep't of Transp., 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), cert. granted, (Oct. 19, 2011), Justice Pleicones argues that this violates the established principle that the plaintiff may choose her defendant. See Chester v. S.C. Dept. of Public Safety, 388 S.C. 343, 345-46, 698 S.E.2d 559, 560 (2010) (refusing to find the "firmly entrenched common law principle" of plaintiff's sole right to choose her defendant abrogated by the Torts Claims Act even when the result was to make a non-settling defendant liable for a greater share of the damages).

Here, if reallocation is allowed, the court stands to say the only way the Plaintiffs' could have avoided reallocation would have been to argue to the jury the Plaintiffs' claims against the Settling Defendants. The Plaintiffs would have then had to show how their settlements with the Settling Defendants were for separate causes of action as those against Bauerle than those for which the Plaintiffs sought to recover from Bauerle. As noted above, this would be fundamentally unfair and would only serve to confuse the jury by mentioning irrelevant issues and facts.

V. IN THE ALTERNATIVE, IF THE COURT FINDS THAT THE SETTLEMENT WITH GRAND STRAND WAS NOT FOR A SEPARATE NEGLIGENCE CAUSE OF ACTION, THEN THE ONLY CAUSE OF ACTION EXISTING AT THE TIME OF SETTLEMENT AGAINST GRAND STRAND WAS FOR LOSS OF CONSORTIUM AND ANY SET-OFF SHOULD ONLY APPLY TO REDUCE THE VERDICT FOR THAT CLAIM.

The purpose of the set-off doctrine is to prevent a plaintiff from a windfall or double recovery. Hawkins v. Pathology Assocs., 330 S.C. 92, 498 S.E.2d 395 (Ct. App. 1998). Under certain circumstances, funds already received by the plaintiff are offset against that owed by the defendant. See id.

In 1988, the UCATA codified a tortfeasor's right to set-off in S.C. Code Ann. § 15-38-50, which the Defendants cite as the basis for their motion. With respect to settling tortfeasors, this section provides:

When a release or a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death:

(1) it does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide; but it reduces the claim against the others to the extent of any amount stipulated by the release or the covenant, or in the amount of the consideration paid for it, whichever is the greater...

S.C. Code Ann. § 15-38-50 [emphasis added]. South Carolina courts interpreting this statute have held that, when a prior settlement involves compensation for the same injury for which the

jury awarded damages, the right to set-off arises by operation of law. Ellis v. Oliver, 335 S.C. 106, 112, 515 S.E.2d 268, 271-72 (Ct.App. 1999). However, when the prior settlement involves compensation for a different injury from the one tried to verdict, there is no set-off as a matter of law. Smith v. Widener, 397 S.C. 468, 724 SE 2d 188 (Ct.App. 2012); Hawkins v. Pathology Assocs. of Greenville, P.A., 330 S.C. 92, 113, 498 S.E.2d 395, 407 (Ct.App.1998)(holding that Georgia and South Carolina wrongful death actions involve different injuries and therefore are separate claims with no right of set-off).

Where set-off applies, the verdict is only reduced by the amount of settlement funds "...paid to compensate the same plaintiff on a claim for the same injury." Id. at 472 (emphasis added); (citing Hawkins, 330 S.C. 92, 498 S.E.2d 395).

A. The Medical Malpractice verdict in favor of Randall Green is not subject to the set-off provision of S.C. Code Ann. § 15-38-50 as Grand Strand Regional Medical Center was not, and could not be, "liable in tort" to Plaintiff Randall Green as of the date of settlement.

An order is considered a judgment on the merits when it is a determination of a matter forming the whole or part of a cause of action. Ex parte Capital U-Drive-It, Inc., 369 S.C. 1, 630 S.E.2d 464 (2006). A ruling on an issue which disposes of the underlying cause of action is a judgment on the merits. Foran v. USAA Cas. Ins. Co., 311 S.C. 189, 427 S.E.2d 918 (Ct. App. 1993). If a ruling is adverse to a party, it is incumbent upon that party to appeal the ruling or be bound by it as the law of the case. Charleston Lumber v. Miller Housing, 338 S.C. 171, 525 SE 2d 869 (2000); ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997)(unappealed ruling is law of the case); Buckner v. Preferred Mut. Ins. Co., 255 S.C. 159, 161, 177 S.E.2d 544, 544 (1970) (an unchallenged ruling, "right or wrong, is the law of this case and requires affirmance.")

1. The Order expressly absolved Grand Strand from liability arising out of the causes of action for Vicarious Liability and Negligent Supervision, Hiring, and/or Training.

Here, the Fourth Amended Complaint asserted four causes of action: Professional Negligence/Medical Malpractice, Vicarious Liability, Negligent Hiring, Training, and Supervision, and Loss of Consortium. By Order dated April 18, 2013 and filed May 1, 2013, The Honorable Larry B. Hyman, Jr. granted partial summary judgment to Grand Strand Regional Medical Center on the Vicarious Liability and Negligent Hiring, Training, and Supervision causes of action.

The Order stated that “[b]ecause the plaintiffs are barred by the statute of limitations and the statute of repose from asserting a direct cause of action for medical malpractice against Grand Strand’s independent contractors and employees, Grand Strand cannot be held vicariously liable for their acts or omissions. (Order, p. 3). Judge Hyman further ruled that “...no potential liability exists to flow through to Grand Strand.” (Order, p. 7). Accordingly, Grand Strand had a substantive right to be free from liability for any Professional Negligence or Medical Malpractice of its staff, nurses, and doctors.

Additionally, the Order found that the hospital could not be held liable for Negligent Hiring, Training, and Supervision without allegations that Grand Strand had some knowledge that a specific employee created an undue risk of harm to the public. Nor could Grand Strand be held separately liable for Negligent Supervision as there were no allegations that any specific employee or independent contractor acted outside the scope of their employment or intentionally caused harm to the Plaintiffs. After finding that there were no facts from which Grand Strand could be charged with a duty to exercise due care in hiring, training, and/or supervising its employees, Judge Hyman held that Grand Strand was entitled to judgment as a matter of law on

this cause of action as well. Accordingly, the Plaintiffs' only potential remaining causes of action were for Professional Negligence/Medical Malpractice and Loss of Consortium.

2. The Order also extinguished the Medical Malpractice Cause of Action as to Grand Strand.

In Simmons v. Tuomey Regional Medical Center, the Supreme Court provided a basis for holding a hospital liable for medical malpractice after recognizing a duty to provide competent services to the public. 341 S.C. 325, 33 S.E.2d 312 (2000). In providing this basis for liability, the Court recognized that hospitals do exert control over the practice of medicine and should be held accountable under certain circumstances for the malpractice of its independent contractor physicians. Id. However, the Simmons Court did not go so far as to impose an absolute duty on hospitals, nor did it create a new cause of action. It simply created an additional basis for holding a hospital liable for malpractice outside of traditional agency principles. Osborne v. Adams, 550 SE 2d 319 (S.C. 2001) (Simmons II did not create a new cause of action or abolish any existing immunity, but merely recognized a new remedy to vindicate existing rights.) This would not have been necessary if the hospital as an entity could be held directly liable for medical malpractice for the negligent failure to supervise or train the medical practitioners providing care within its facilities in the absence of specific facts giving rise to such a duty.

Here, the Professional Negligence/Medical Malpractice Cause of Action was supported by allegations applicable to Grand Strand based on vicarious liability for the actions of the physicians and nurses; and based on direct negligence in failing to properly train, supervise, or hire its agents and employees. Judge Hyman's Order found that Grand Strand was free from liability for any malpractice committed by employees or agents not named in the Complaint, as well as for any malpractice committed by physicians classified as independent contractors under

the non-delegable duty doctrine. Plaut v. Spendthrift Farm, Inc., 514 U.S. 211 (1995) (dismissal of an action on statute of limitations grounds is a judgment on the merits.) Accordingly, the only basis for which Grand Strand could be held liable for Medical Malpractice would be based on a theory of direct negligence arising out of its own acts or omissions.

As the hospital as an entity cannot, as a matter of law, be held directly liable for medical malpractice, the only remaining basis for direct negligence is contained in allegations pled in support of this cause action and address the hospital's own conduct in failing to implement and enforce appropriate policies and procedures. Accordingly, if this court finds that such allegations do not constitute a separate negligence cause of action against Grand Strand, then there was no existing liability to Randall Green at the time of settlement. *Ex parte capital U-Drive-It, Inc.*, 369 S.C. 1, 630 S.E.2d 464 (2006) (An order is considered a judgment on the merits when it is a determination of a matter forming the whole or part of a cause of action.); Ellis v. Niles, 324 S.C. 223, 479 S.E.2d 47 (1996); Sharpe v. South Carolina Dep't of Mental Health, 292 S.C. 11, 16, 354 S.E.2d 778, 781 (Cl.App. 1987) (Bell, J., concurring) (Whether the law recognizes a particular duty is a matter of law for the court. If there is no duty, then the defendant is entitled to a judgment as a matter of law.)

Finally, the Defendant's memorandum in support of their motion for set-off concedes that any medical negligence asserted against the hospital was based on vicarious liability for the actions of its employees and agents. Defendants' Memorandum in Support of Motion, p. 3) ("Mr. Green would not have sought treatment at MUSC if he did not sustain injuries in the automobile accident and then damages following the alleged medical malpractice of Dr. Bauerle and the employees and agents of Grand Strand Regional Medical Center.") Judge Hyman's Order expressly stated that no potential liability existed to flow through to Grand Strand for the medical

malpractice of its employees or independent contractors. Accordingly, the only remaining cause of action still pending against Grand Strand as of the date of settlement was for Ann Green's Loss of Consortium, which was based on a general negligence claim.

3. As of the date of settlement, Grand Strand had a substantive right to be free from liability to Plaintiff Randall Green.

"A statute of repose creates a substantive right in those protected to be free from liability after a legislatively determined period of time." Capco of Summerville v. JH GAYLE CONST., 368 S.C. 137, 132, 628 S.E.2d 38 (2006)(emphasis added); (citing Langley v. Pierce, 313 S.C. 401, 403-04, 438 S.E.2d 242, 243 (1993)). Once the time limit has expired under a statute of repose, liability no longer exists and is not tolled for any reason. Id. at 404, 438 S.E.2d at 243; Florence County School District No. 2 v. Interkal, Inc., 348 S.C. 446, 559 S.E.2d 866 (Ct.App.2002)(finding that the thirteen year statute of repose applicable to actions to recover damages for improvements to real property was applicable to bar claims for contribution under the Uniform Contribution Among Joint Tortfeasors Act)(emphasis added).

On May 10, 2013, the Plaintiffs entered into a settlement with Grand Strand and a stipulation of Dismissal signed on behalf of all parties, including Bauerle, was filed on June 11, 2013. At the time of this settlement, the tort claims against Grand Strand for Medical Malpractice, Vicarious Liability based on the Non-Delegable Duty Doctrine, and Negligent Supervising, Hiring, and Training had been extinguished by summary judgment. This unappealed judgment on the merits remains the law of the case. Additionally, no additional claims could be asserted, or reasserted, due to the expiration of the Statute of Repose. Accordingly, Grand Strand could no longer be held liable in tort for Randall Green's injuries, and there was no common liability between the hospital and Dr. Bauerle to be reduced by the

settlement. As such, the plain language of S.C. Code Ann. § 15-38-50 does not mandate an offset against the medical malpractice verdict rendered in Randall Green's favor.

B. S.C. Code Ann. §15-38-50 does not mandate a set-off in the present case as Randall Green and Ann Green suffered different injuries represented by different verdicts which can only be reduced by settlement funds allocated to their respective claims.

Set-off under § 15-38-50 applies when two or more persons are liable for the "same injury" or "same wrongful death." In Ellis, the South Carolina Court of Appeals interpreted the term "injury" broadly enough to include all damages, including those attributable to both survival and wrongful death causes of action, which result from the same negligence of the responsible parties. Ellis v. Oliver, 335 S.C. 106, 113, 515 S.E.2d 268, 272 (1999). Ellis arguably expanded the common law limitation for set-off. However, more recently, the Court of Appeals in Smith v. Widener, noted that its previous holding in Ellis was inconsistent with prior and subsequent case law holding that survival and wrongful death actions were different claims for different injuries. 397 S.C. 468, 471, 724 S.E.2d 188 (Cl. App. 2012) (see footnote 1). The South Carolina Supreme Court most recently addressed the issue in Rutland v. S.C. Dep't of Transp., stating, "[a] non-settling defendant is entitled to credit for the amount paid by another defendant who settles for the same cause of action." 390 S.C. at 85-86, 700 S.E.2d 451 (Cl. App. 2010), cert. granted, (Oct. 19, 2011).

Accordingly, courts may still consider the similarity between the cause of action for which the party seeks set-off and the cause of action previously settled. For instance, in Hawkins v. Pathology Assocs. of Greenville, 330 S.C. 92, 498 S.E.2d 395 (Cl. App. 1998), the court of appeals overturned a trial court's set-off of a Georgia wrongful death lawsuit against a jury verdict in a South Carolina wrongful death case. In doing so, the court did not mention the UCATA and concluded that the only common element of damages between the South Carolina

and Georgia Wrongful Death Statutes was the award for the economic value of the deceased's life expectancy. As a result, set-off was not necessary to prevent double recovery. Id. 330 S.C. at 114-115, 498 S.E.2d at 407.

1. Ann Green and Randall Green suffered different injuries for which they received separate verdicts on their respective claims.

In Welch v. Epstein, the Court of Appeals held that a judge's reallocation of a settlement between the survival and wrongful death actions was in compliance with §15-38-50 because it provided for but one complete satisfaction of the decedent's injury. The Defendant requested that the settlement be reallocated as it had applied the majority of the funds to the survival action, with only a small amount applied to the wrongful death action. In affirming the trial court's reallocation of most of the settlement proceeds to the wrongful death action, the Court of Appeals considered that there was no evidence that the decedent had endured any conscious pain and suffering or mental anguish, so that the only amount recoverable under the survival cause of action was the amount of his medical bills. Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000).

However, the Welch court noted that a wrongful death action included different elements of damages, inclusive of future pecuniary loss to the family to which an economic expert had testified at trial. Additionally, the court noted that damages recoverable in the wrongful death action were distinct in that they reimbursed the beneficiaries for mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship; and deprivation of the use and comfort of the intestate's society, including the loss of his experience, knowledge, and judgment in managing the affairs of himself and of his beneficiaries. Accordingly, the settlement amounts reallocated to the survival and wrongful death actions were set-off against their respective verdicts. In doing so, the Court distinguished the two causes of action, both arising out of the

same physical injury to the decedent, as distinct claims for different injuries under S.C. Code §15-38-50. Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000); see also Hawkins v. Pathology Assocs. of Greenville, P.A., 330 S.C. 92, 498 S.E.2d 395 (Ct. App. 1998) (holding that Georgia and South Carolina wrongful death actions involve different injuries and therefore are separate claims with no right of set-off).

The present case involved distinct claims for different injuries suffered by two different Plaintiffs, each arising out of the same physical injury, for which two separate verdicts were rendered. It is undisputed that Medical Negligence and Loss of Consortium are separate causes of action involving separate plaintiffs and that the damages or injury for Medical Negligence and Loss of Consortium are different as a matter of law. See Graham v. Whitaker, 282 S.C. 393, 397, 321 S.E.2d 40, 43 (1984) ("It is well settled in South Carolina that one spouse's cause of action for medical expenses and loss of consortium resulting from negligent injuries to the other spouse is a different and distinct cause of action from one maintained by the injured spouse; judgment in favor of the defendant in one action is not a bar to the other action.") The injuries and damages sustained by Ann and Randall Green were distinct and separate. Each party brought distinct causes of action for which different damages were recoverable, reflecting the individual nature of their respective injuries and loss. Accordingly, § 15-38-50 does not mandate a set-off, and a reduction of the Plaintiffs' verdicts would be inequitable.

Furthermore, the Defendant did not request that the settlement proceeds be reallocated, which would be necessary, although impossible, in the present case unless the entire settlement was allocated to Mrs. Green's Loss of Consortium claim.

C. There is no evidence that a set-off is necessary to prevent a double recovery, as there was no allocation of settlement proceeds and there is no way to allocate the damages included in the verdicts.

Under S.C.Code Ann. § 15-38-50(1), the court must reduce the amount of the verdict to account for any funds previously paid by a settling defendant, "...so long as the settlement funds were paid to compensate the same plaintiff on a claim for the same injury." Smith v. Widener, 397 S.C. 468, 471, 724 S.E.2d 188 (Ct. App. 2012)(emphasis added); (citing Hawkins, 330 S.C. at 113, 498 S.E.2d at 406-07). In applying the statutory set-off where a settlement arguably involved two claims, only one of which was tried to verdict, the court must make a factual determination of how to allocate the settlement between the claims. Smith v. Widener, 397 S.C. 468, 724 S.E.2d 188 (Ct. App. 2012). The verdict is reduced only by that portion of the settlement allocated to compensate the same plaintiff for the same injury. Id.

Distinguishing this case from Welch, the settlement in the present case was not allocated between the different claims, and there is no way to determine which portion of the damages awarded to each by the jury overlapped with that settlement. In Welch, the court was able to ascertain an exact amount to allocate to the survival action, as the only amount recoverable was for the medical bills, the exact amount awarded by the jury.

The non-settling defendant, Bauerle, failed to insist upon allocation of the settlements to the different Plaintiffs or the different causes of action or different injuries and in fact executed a stipulation of dismissal as to the Settling Defendants, thereby waiving any right to complain that the settlement was not allocated.

D. If the Court finds that the settlement should be reallocated, it should be reallocated in its entirety to the Loss of Consortium claim and operate only to reduce Ann Green's verdict for same.

The settlement should be allocated, if at all, entirely to Ann Green on the Loss of Consortium cause of action, as Grand Strand arguably remained liable to her as of the date of settlement under a theory of general negligence. Whereas Judge Hyman's Order granting partial

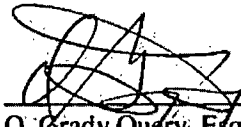
summary judgment eliminated the remaining claims of Randall Green. That Order remains the law of this case. Of note, the verdict form, consistent with the Complaint as well as the arguments set forth above, indicated that Randall Green's damages depended on the medical malpractice cause of action while Ann Green's damages for Loss of Consortium depended on a general negligence claim. (Verdict Form, Sept. 13, 2013, Attached as **Exhibit C**). As there was no allocation of settlement proceeds between the Plaintiffs' separate claims, any set-off must be as to Mrs. Green's claim for loss of consortium.

In the present case, Ann and Randall Green both received separate and distinct injuries for which they brought separate and distinct causes of action under which they could recover different damages. There is no way to decipher which portion of the settlement should be allocated to their different injuries in order to apply a set-off against the corresponding portion of their respective verdicts. Furthermore, the Plaintiffs presented expert testimony at trial as to economic damages exceeding both the amount of the settlement and verdicts rendered. Accordingly, as in Hawkins, there is no evidence that either Plaintiff will receive a double recovery for their injuries.

CONCLUSION

For the foregoing reasons, the Defendants Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC's Motion for Set-Off should be dismissed.

(Signature follows on the next page.)



O. Grady Query, Esquire
Query Sautter Forsythe, LLC
The Wappoo Centre
147 Wappoo Creek Drive, Suite 202
Charleston, SC 29412

L. Morgan Martin, Esquire
L. Morgan Martin, PA
1121 Third Avenue
Conway, SC 29526

Cristin Uricchio, Esquire
Uricchio Law Firm
147 Wappoo Creek Drive, Suite 205
Charleston, SC 29412

September 30, 2013
Charleston, SC

EXHIBIT

B

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Randall M. Green and Ann Green

Plaintiffs,

vs.

Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC, Grand Strand Regional
Medical Center, LLC and Carolinas Medical
Response, Inc.

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

**AMENDED
ANSWER TO
DEFENDANT GRAND STRAND
REGIONAL MEDICAL CENTER
REQUEST TO ADMIT**

**TO: THE DEFENDANT, GRAND STRAND REGIONAL MEDICAL CENTER, LLC AND
ITS ATTORNEY, WELDON R. JOHNSON, ESQUIRE**

The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC, answering Defendant, Grand Strand Regional Medical Center's Request to Admit,
would state as follows:

I. RESERVATION OF RIGHTS

1. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any rights to pursue and be
heard on any and all defenses set forth in its Answer to the Complaint.

2. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any objections which may
be appropriate to Request to Admit.

3. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any objections which may

be otherwise available to it and further states that no response should be deemed as an admission of relevancy, materiality or admissibility of any response or document produced. It further reserves the right to amend or supplement its response, if appropriate.

II. GENERAL OBJECTION

1. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic Consultants, LLC object to responding to any Interrogatory or Request for Production that seeks information which constitutes confidential attorney-client communication or which falls within the scope of Rule 26(b) or which exceeds the scope of discovery otherwise provided by the South Carolina Rules of Civil Procedure or by statute or common law.

III. RESPONSES

1. The employees of Grand Strand Regional Medical Center did not proximately cause or contribute to the injuries and damages alleged to have been sustained by Plaintiffs in the Third Amended Complaint.

ANSWER: Admit.

JOHN B. McCUTCHEON, JR.
LISA A. THOMAS
Attorneys for Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC


McCUTCHEON, McCUTCHEON & BAXTER, PA
208 Elm Street P. O. Box 1003
Conway, SC 29526 (843)248-7225

March 4, 2008

EXHIBIT

C

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

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO. 2011 CP-26-07403.

RANDALL M. GREEN, AND ANN GREEN

WAYNE B. BAUERLE, M.D. AND WAYNE B. BAUERLE,
M.D. PC

PLAINTIFF(S)

DEFENDANT(S)

Submitted by:

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

DISPOSITION TYPE (CHECK ONE)

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

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

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☐ Statement of Judgment by the Court.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk:

WE THE JURY, FIND FOR THE PLAINTIFF, RANDALL M. GREEN IN THE AMOUNT OF \$2,300,000.00 ACTUAL DAMAGES. WE FIND FOR THE PLAINTIFF, ANN GREEN IN THE AMOUNT OF \$550,000.00 ACTUAL DAMAGES AS TO LOSS OF CONSORTIUM.

INFORMATION FOR THE PUBLIC INDEX

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

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
RANDALL M. GREEN	WAYNE B. BAUERLE, MD AND WAYNE B. BAUERLE, MD PC	\$2,300,000.00
ANN GREEN	WAYNE B. BAUERLE, MD AND WAYNE B. BAUERLE MD, PC	\$550,000.00
		\$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest

SCRPC Form 4C (10/2011)

Page 1 of 2

A.H.D.

or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Steven H. John
Circuit Court Judge

129
Judge Code

9/13/13
Date

For Clerk of Court Office Use Only

This judgment was entered on the 16th day of Sept, 2013 and a copy mailed first class or placed in the appropriate attorney's box on this 16th day of Sept, 2013 to attorneys of record or to parties (when appearing pro se) as follows:

N. MORGAN MARTIN

O. GRADY QUERY

ATTORNEY(S) FOR THE PLAINTIFF(S)

JOHN B. MCCUTCHEON

LISA ARLENE THOMAS

ATTORNEY(S) FOR THE DEFENDANT(S)

Melanie Huggins-Ward
CLERK OF COURT

Court Reporter: HENRY YOUNG

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

Instructions: Mark the appropriate response to the following questions. Each response must be unanimous.

1. DO YOU FIND THAT DEFENDANTS WAYNE B. BAEURLE, M.D. AND WAYNE B. BAEURLE, M.D., PC NEGLIGENTLY DEPARTED FROM THE STANDARD OF CARE IN TREATING PLAINTIFF RANDALL M. GREEN AND THAT THIS NEGLIGENT DEPARTURE FROM THE STANDARD OF CARE PROXIMATELY CAUSED PLAINTIFF RANDALL M. GREEN'S INJURIES?

Jan

✓ YES: IF YES, GO TO QUESTION 2.

— NO: IF YOU ANSWER NO, STOP AND DELIBERATE NO FURTHER.

FILED
HORRY COUNTY
3 SEP 16 AM 8:04
KELAN HUGHES-WARD
CLERK OF COURT

NOTE: If you answered "Yes" to Question 1, please continue to Page 2 for a determination of damages. If you answered "No" to Question 1, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

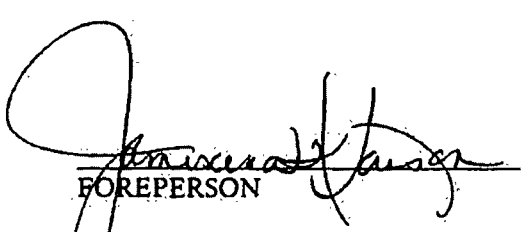
2. PLEASE STATE THE TOTAL AMOUNT OF DAMAGES, IF ANY, SUSTAINED BY
PLAINTIFF RANDALL M. GREEN

\$ 2,300,000.00 Actual Damages
Two Million, three hundred thousand dollars and 00/100

OR

For the Defendants.

September 13, 2013
Conway, South Carolina


FOREPERSON

NOTE: If you awarded actual damages, please continue to Question 3 on Page 3. If you did not award actual damages, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

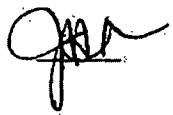
v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

VERDICT FORM

3. DO YOU FIND THAT DEFENDANTS WAYNE B. BAUERLE, M.D. AND WAYNE B. BAEURLE, M.D., PC WERE NEGLIGENT AND THAT SUCH NEGLIGENCE PROXIMATELY CAUSED THE PLAINTIFF ANN GREEN'S LOSS OF CONSORTIUM?



✓ YES: IF YES, GO TO QUESTION 4.

____ NO: IF YOU ANSWER NO, STOP AND DELIBERATE NO FURTHER.

NOTE: If you answered "Yes" to Question 3, please continue to Page 4 for a determination of damages. If you answered "No" to Question 3, please stop deliberating and notify the Bailiff.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
2011-CP-26-07403

RANDALL M. GREEN and ANN
GREEN,

Plaintiffs,

v.

WAYNE B. BAUERLE, M.D. and
WAYNE B. BAEURLE, M.D., PC,

Defendants.

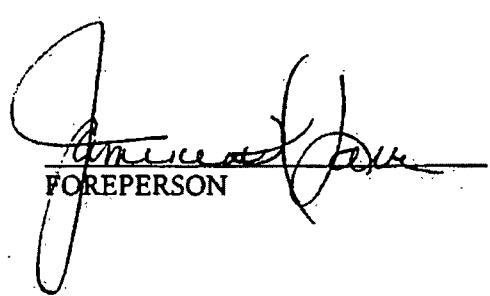
VERDICT FORM

4. PLEASE STATE THE TOTAL AMOUNT OF ACTUAL DAMAGES, IF ANY,
SUSTAINED BY PLAINTIFF ANN GREEN.

\$ 550,000⁰⁰ Actual Damages
Five hundred fifty thousand and 00/100
OR

For the Defendants.

September 13, 2013
Conway, South Carolina


FOREPERSON

NOTE: Please notify the Bailiff when deliberations are complete.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

Randall M. Green and Ann Green,

Plaintiffs,

v.

Wayne B. Bauerle, MD, and Wayne B.
Bauerle, MD, PC,

Defendants.

IN THE COURT OF COMMON PLEAS
Docket No.: 2011-CP-26-7403

**PLAINTIFFS' MOTION TO
ALTER OR AMEND ORDER
GRANTING PARTIAL SET -
OFF**

13 OCT 30 PM 2:25
CLERK OF COURT

Pursuant to Rule 59(e) S.C.R.C.P. the Plaintiffs, Randall M. Green and Ann Green ("Plaintiffs"), by and through their undersigned counsel of record, hereby submit their Motion to Alter or Amend the Order, dated October 17, 2013, (Attached as **Exhibit A**) granting partial set off to the Defendants.

PROCEDURAL HISTORY

This Honorable Court presided over the above-captioned jury trial September 9-13, 2013. At the end of the trial, the jury found for Mr. Green, under a medical malpractice cause of action, in the amount of \$2.3 million and Mrs. Green, under a loss of consortium cause of action, in the amount of \$550,000. Following the verdict, the record reflects the Defendants, Wayne B. Bauerle, MD and Wayne B. Bauerle, MD, PC (collectively "Bauerle"), verbally requested that the verdict be set off by all sums paid to the Plaintiffs by settling defendants following the Plaintiff's automobile accident on April 17, 2004. The record further reflects that the Plaintiffs objected to any set off and the Honorable Judge John requested that the parties submit written memoranda to the Court in support of their positions.

Pursuant to the Court's instructions, the Defendants filed a written memorandum in support of their Motion for Set Off and the Plaintiffs filed their memorandum in opposition. By

Order dated October 17, 2013, this Court partially granted Bauerle's Motion for Set Off as to Carolina Medical Response ("CMR") and Grand Strand Regional Medical Center ("Grand Strand") and, in so doing, set off the settlement proceeds obtained by the Plaintiffs from the verdict rendered on September 13, 2013, in the same proportion or ratio as the jury verdicts to the Plaintiffs in the case at bar.

RELIEF REQUESTED

The Plaintiffs respectfully move that this Court alter or amend the Order Granting Partial Set Off, as the Court misinterpreted and misapplied the relevant case law, improperly allocated the Plaintiffs' settlements with CMR and Grand Strand, and misapplied the Plaintiffs' settlements with CMR and Grand Strand against the jury verdicts rendered in the case at bar. The Plaintiffs request that this Court consider and rule on all arguments set forth in the Plaintiffs' Memorandum Opposing Set Off in addition to the argument further set forth herein. For the foregoing reasons, the Order Granting Partial Set Off should be altered and amended to deny set off from the jury verdicts rendered to each Plaintiff.

ARGUMENT

- I. **It was an error of law for the trial court to interpret Section 15-38-50 by strict adherence to *Ellis* without applying the principles set forth in *Rutland* and *Welch*.**

This honorable court misconstrued the prevailing case law pertaining to set off by applying *Ellis v. Oliver*, 335 S.C. 106, 113, 515 S.E.2d 268, 272 (1999), in the Order allowing partial set off. *Ellis* is a 1999 South Carolina Court of Appeals case. More recently, the South Carolina Supreme Court addressed the issue of set off by interpreting section 15-38-50 to allow a set off only where the reduction in the judgment is from a settlement for the same cause of

action. *Rutland v. S.C. Dep't of Transp.*, 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), cert. granted, (Oct. 19, 2011) (*citing Welch v. Epstein*, 342 S.C. 279, at 313, 536 S.E.2d at 425 (2000)).

Here, the Plaintiffs' settlement with Grand Strand was for a different cause of action than the Plaintiffs' recovery from Bauerle. The Plaintiffs' Fourth Amended Complaint alleges specific acts and omissions on the part of Grand Strand, Bauerle, and Grand Strand's employees and independent contractors giving rise to a cause of action for Medical Malpractice. However, on April 18, 2013, the character of the case was dramatically altered when the Honorable Larry B. Hyman issued an Order Granting Partial Summary Judgment ("Order") striking all causes of action against Grand Strand founded in vicarious liability or non-delegable duty in addition to all causes of action alleging negligent hiring, supervision, and training on the part of Grand Strand. The only causes of action against Grand Strand not extinguished by the Order were Mrs. Green's Loss of Consortium claim and Mr. Green's *general negligence* claim for

 failing to have appropriate policies, procedures, and protocols to ensure that patients with conditions similar to Mr. Green are treated in an appropriate manner, or in having such policies, procedures, and protocols, and failing to ensure such were carried out and followed. (Fourth Am. Compl., ¶ 22).

Thus, the only remaining cause of action against Grand Strand other than the loss of consortium claim of Ann Green, is purely an administrative function that could not involve Bauerle, who was at all times in private practice. A hospital, as an entity, cannot be held directly liable for medical malpractice as a matter of law.¹ Therefore, there are absolutely no overlapping negligence claims between Bauerle and Grand Strand.

¹ In *Simmons v. Tuomey Regional Medical Center*, the Supreme Court provided a basis for holding a hospital liable for medical malpractice after recognizing a duty to provide competent services to the public, 341 S.C. 325, 33 S.E.2d 312 (2000). However, the *Simmons* Court did not go so far as to impose an absolute duty on hospitals, nor did it create a new cause of action. It simply created an additional basis for holding a hospital liable for malpractice outside of traditional agency principles. *Osborne v. Adams*, 550 SE.2d 319 (S.C. 2001).

The causes of action imputing Bauerle's negligence to Grand Strand were never restored, nor did the Plaintiffs, or Bauerle make any attempt to restore them; therefore, Judge Hyman's Order was the law of the case at the time the Plaintiffs entered into a settlement agreement with Grand Strand on May 31, 2013. Now, over five months later, it would be unjust to allow Bauerle to claim entitlement to set off from proceeds that Grand Strand paid to extinguish its own negligence, negligence that cannot be imputed to Bauerle under any theory of the law of this case. Therefore, since Section 15-38-50 only allows set off for settlements received for the same cause of action and here, the Plaintiffs' settlement with Grand Strand was for a patently different cause of action than the Plaintiffs' recovery from Bauerle there is no basis under the law of this case for set off.

II. The Plaintiffs' settlements with Carolina Medical Response and Grand Strand Regional Medical Center were improperly allocated.

A. The Court incorrectly relied on Rutland.

The Court incorrectly applied the holding in *Rutland v. South Carolina Department of Transportation*, 390 S.C. 78, 700 S.E.2d 451 (Ct. App. 2010), *cert. granted*, (Oct. 19, 2011). In *Rutland*, the South Carolina Supreme Court affirmed the decision of the trial court to equitably *reallocate* settlement funds between two causes of action where the parties had already agreed to the allocation of the settlement funds. The Order of the Court misinterprets *Rutland* to mean, this Court has the authority to equitably *allocate* previously unallocated settlement funds between two causes of action, one of which existed at the time of settlement and one of which did not. While this Court may have authority to *reallocate* a settlement between two or more existing causes of action in order to render justice between the parties, there is no precedent for the *allocation* of unallocated settlement funds for a cause of action that did not exist at the time of settlement.

South Carolina allocation cases have relied upon distinctions between causes of action and have looked to evidence supporting individual causes of action. In *Welch v. Epstein*, 342 S.C. 279, 536 S.E.2d 408 (2000), the Court of Appeals allowed the trial court to reallocate previously allocated settlement funds between a wrongful death action and a survival action. The court noted that wrongful death included different elements of damages, inclusive of future pecuniary loss to the family to which an economic expert had testified at trial. Additionally, the court held that damages recoverable in the wrongful death action were distinct in that they reimbursed the beneficiaries for mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the intestate's society. Accordingly, the settlement amounts reallocated to the survival and wrongful death actions were set off against their respective verdicts. In doing so, the Court distinguished the two causes of action, both arising out of the same physical injury to the decedent, as distinct claims for different injuries under S.C. Code Ann. §15-38-50.

Alternatively the one cause of action against both Grand Strand and Bauerle clearly not affected by the Order of Judge Hyman is Plaintiff Ann Green's Loss of Consortium claim. Should this Court continue to find that set off is required, the only set off that should be allowed is against her Loss of Consortium claim since settlement and verdict would be based upon the same cause of action.

In the case at bar, ample evidence was presented during the trial to support the damages awarded to each of the Plaintiffs. The settlement should be viewed by the court as belonging to both of the parties. Here, the Court applies an ex post facto analysis to grant set off, using the ratios between the jury verdict for Mr. Green and the jury verdict for Mrs. Green in this case to allocate the settlement as between the parties. If the Court determines that allocation between the

parties is permitted based on the cases that allowed reallocation between causes of action, the only fair and reasonable way to do so would be to allocate one half of the settlement proceeds to each of the Plaintiffs and then for each of the Plaintiffs' portions of the settlement to be set off against his or her individual verdict. Clearly this would more justly address Mr. Green's horrendous injury and his need for life care while still compensating Mrs. Green for her Loss of Consortium claim.

B. Rutland Dissent.

Justice Pleicones writes the dissent in Rutland, in which he argues that the court did not have the authority to reallocate the plaintiff's settlement with the settling defendants and allowing the court to do so violates well established public policy. *Rutland v. South Carolina Department of Transportation*, op. No.: 27185. Similarly, for the same reasons laid out by Justice Pleicones, here the Court did not have the authority to allocate the Plaintiffs' settlement with Grand Strand and Carolinas Medical Response.

First, Justice Pleicones writes equity is not served by reallocating a binding settlement agreement because doing so requires the plaintiff to defend to the court the viability of claims they haven't made and such practice violates the settled rule that plaintiffs may choose their defendants. *Chester v. S.C. Department of Public Safety*, 388 S.C. 343, 698 S.E.2d 559 (2010). Similarly, the Court's revision of the Plaintiffs' settlement agreement with Grand Strand and Carolinas Medical Response is inequitable because to do so requires the Plaintiffs, first, to defend to the Court the continuing viability of Vicarious Liability and Negligent Hiring, Training, and Supervision claims against Grand Strand, which were struck from the Complaint by Judge Hyman's Order which became the law case.

Second, Justice Pleicones argues granting the court authority to allocate a settlement agreement inequitably reduces the plaintiff's recovery against at-fault defendants. *See McDermott, Inc. v. AmClyde*, 511 U.S. 202, 212-21 (1994). Likewise, here, it is impossible to ascertain from the jury's verdict in this case, whether a jury would have found Grand Strand liable for causes of action against them and the amount of the verdict the jury would have returned against Grand Strand.

Third, Justice Pleicones finds fault with the court's ex post facto analysis used to grant set off because such analysis benefits from hindsight and disregards a variety of legitimate bases for the parties ex ante decisions. *See McDermott, supra*. For example, the Parties to the settlement agreement were able to bargain on the settlement amount in light of the unsettled law regarding Plaintiffs' claims against Grand Strand, regarding non-delegable duty and vicarious liability for contracting physicians even though those causes of action had been stricken by the Order of Judge Hyman.

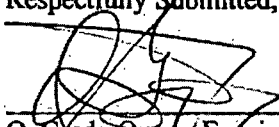
Lastly, Judge Pleicones argues that the law contains no rigid rule against overcompensation of the plaintiffs. *McDermott, Inc. v. AmClyde*, 511 U.S. 202, at 219 (1994). Several doctrines, such as the collateral benefits rule, recognize that making tortfeasors pay for the damage they cause can be more important than preventing overcompensation. Further, the unfortunate result of allocation in this case, where there is no suggestion of fraud or other wrongdoing by the Plaintiffs, is to discourage the Plaintiffs from settling and encourage joint tortfeasors to litigate, contrary to our strong public policy favoring settlement. *See Chester*, 388 S.C. at 346, 698 S.E.2d at 560. Here, to allow Bauerle a set off in the amount of the Plaintiffs' settlements with Grand Strand and Carolinas Medical Response significantly reduces the amount Bauerle must pay the Plaintiffs, substantially benefiting Bauerle and substantially harming the Plaintiffs. This

result will discourage plaintiffs from settling in the future because it will appear just as advantageous for plaintiffs to take the gamble of litigation.

CONCLUSION

For the foregoing reasons, the order of the court should rescind the order granting partial set off and deny in full the motion for set off.

Respectfully Submitted,



O. Gady Query, Esquire
Query Sautter Forsythe, LLC
The Wappoo Centre
147 Wappoo Creek Drive, Suite 202
Charleston, SC 29412

L. Morgan Martin, Esquire
L. Morgan Martin, PA
1121 Third Avenue
Conway, SC 29526

Cristin Uricchio, Esquire
Uricchio Law Firm
147 Wappoo Creek Drive, Suite 205
Charleston, SC 29412

October 25, 2013
Charleston, SC

13 OCT 30 PM 2:25
CLERK OF COURT

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a copy of the foregoing document upon the following attorneys for the Defendants by placing a copy of same in the United States Mail with sufficient postage attached thereto and addressed as follows:

John B. McCutcheon, Jr., Esquire
Lisa A. Thomas, Esquire
Thompson & Henry, PA
P.O. Box 1740
Conway, SC 29528

Dated: 10-25-13



STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS

Randall M. Green and Ann Green,
Plaintiff,

Civil Action No. 2011-CP-26-7403

v.

Wayne B. Bauerle, MD, and
Wayne B. Bauerle, MD, PC,
Defendants.

NOTICE OF MOTION AND
MOTION TO ALTER OR AMEND ORDER

HORRY COUNTY
13 NOV 8 PM 2:48
CLERK OF COURT
MELANIE J. JENNINGS-WARD

TO: THE HONORABLE STEVEN H. JOHN

O. GRADY QUERY, ESQUIRE, L. MORGAN MARTIN, ESQUIRE, AND
CRISTIN A. URICCHIO, ESQUIRE, COUNSEL FOR PLAINTIFFS

YOU WILL PLEASE TAKE NOTICE that the undersigned attorney for the Defendants Wayne B. Bauerle, M.D. and Wayne B. Bauerle, M.D., P.C., will move before the Honorable Steven H. John at the Horry County Judicial Center, Conway, South Carolina, at such time and place as may be set by the Court, for an for an Order pursuant to Rule 59(e), SCRPC, altering or amending the Order Granting in Part and Denying in Part Defendants' Motion for Set-Off filed October 17, 2013. Counsel for the Defendants received a filed copy of the Order from the Clerk of Court on October 29, 2013.

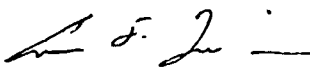
The Defendants' motion is based on the following:

1. In the Order filed October 17, 2013, the Court ruled that the settlement on behalf of the at-fault driver (including the underinsured motorist payments) is not subject to a set-off. In arguing their entitlement to that set-off, the Defendants pointed out that the Plaintiffs had alleged that Dr. Bauerle committed medical malpractice while treating Randall M. Green

following the automobile accident with the at-fault driver. The Defendants argued that the at-fault driver's actions thus caused Mr. Green to seek medical care and treatment from Dr. Bauerle, and as a result, the at-fault driver was legally responsible for the injuries resulting from the medical malpractice found by the jury. South Carolina law provides that "the negligence of an attending physician is reasonably foreseeable" and that "[t]he general rule is that if an injured person uses ordinary care in selecting a physician for treatment of his injury, the law regards the aggravation of the injury resulting from the negligent act of the physician as part of the immediate and direct damages which naturally flow from the original injury." *Graham v. Whitaker*, 282 S.C. 393, 399, 321 S.E.2d 40, 44 (1984). See also, *Bessinger v. DeLoach*, 230 S.C. 1, 94 S.E.2d 3 (1956). Based on the rule from *Graham* and *Bessinger*, the Defendants submit that they are entitled to a set-off for the settlements made on behalf of the at-fault driver (including the underinsured motorist payments). In the Order filed October 17, 2013, the Court did not rule on this particular issue. The Defendants respectfully request that the Court issue a ruling on that particular issue.

The Defendants' motion is based upon the pleadings filed in this case, the rules of court, and such other matters as may be properly presented to the Court at the time of the hearing.

DAVIDSON & LINDEMANN, P.A.

BY: 

ANDREW F. LINDEMANN
1611 Devonshire Drive
Post Office Box 8568
Columbia, South Carolina 29202
(803) 806-8222

-AND-

JOHN B. MCCUTCHEON, JR.
LISA A. THOMAS
THOMPSON & HENRY, P.A.
Post Office Box 1740
Conway, South Carolina 29528
(843) 248-5741

Counsel for Defendants

Columbia, South Carolina

November 7, 2013

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS
2005-CP-26-02805

COUNTY OF Horry

RANDALL M. GREEN and)
ANN GREEN,)
)
)
-vs-)
)
)
WAYNE M. BAUERLE, MD,)
)
Defendant.)

September 9-13, 2013

B E F O R E:

HONORABLE STEPHEN H. JOHN

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

L. MORGAN MARTIN, Esquire
GRADY O. QUERY, Esquire
MICHAEL W. SAUTTER, Esquire
CRISTIN ANN URICCHIO, Esquire
Attorneys for the Plaintiffs

JOHN B. McCUTHEON, JR., Esquire
LISA ARIENE THOMAS, Esquire
Attorneys for the Defendant

Henry P. Young
Court Reporter

VOLUME I OF V
September 9, 2013

1 come to me and again we'll handle the matter,
2 whatever it might be.

3 When we have concluded the evidentiary
4 portion of the trial, when we have heard all the
5 evidence in this case, the witnesses and any kind
6 of documentary, other type evidence presented, you
7 have heard the closing arguments of the attorneys
8 and then the Court has given to you the law that
9 you will apply to the facts and evidence that you
10 find to be true in this particular case, then the
11 Court will submit the case to you for your
12 deliberations and your unanimous decision in this
13 particular matter. The foreperson's duties and
14 responsibilities change in this regard. The
15 foreperson is going to act like the chairperson at
16 a meeting, it is necessary to guide discussions,
17 hopefully not keep good order, but it's important
18 to note that the foreperson's voice and vote
19 carries no more weight than any other member of the
20 panel. Everybody is equal in that regard but we do
21 need to have somebody in charge if necessary.

22 The final job, duties and responsibility of
23 the foreperson is once the jury has well and truly
24 deliberated in this matter and you have reached
25 your unanimous verdict on the matters presented to

1 you the foreperson will take the written verdict
2 form that the Court will provide to you and either
3 check the appropriate blocks or write the
4 appropriate words and thereafter sign their name
5 indicating that that verdict as recorded on the
6 verdict form is the unanimous verdict of all the
7 members of the jury, of this particular panel.

8 So, understanding the duties and
9 responsibilities of the foreperson, I'm going to
10 ask that you go back to your jury room, select your
11 foreperson, knock on the door, let the bailiff know
12 who the foreperson is.

13 Now, Mr. Dyson and Miss Hardwick, you all are
14 the alternates in this particular matter. You can
15 vote on the foreperson but obviously being the
16 alternate you cannot be the foreperson of this
17 particular jury. So, with that, if you would all
18 go with the bailiff to the jury room and then let
19 us know who the foreperson is going to be.

20 Thank you.

21 (Jury excused from the courtroom).

22 THE COURT: All right, ladies and gentlemen
23 of the jury panel that were not selected for this
24 particular case, I'm going to ask that you go back
25 downstairs to the jury assembly room, Judge McMahon

1 is going to make a decision as to that particular
2 case, either pick a jury or if the matter is
3 resolved, I don't know, but I need for you to go
4 downstairs, Judge McMahon will meet with you
5 shortly, so you go downstairs to the jury assembly
6 room, you go in, sit on the left just like you were
7 this morning. If or when you are excused by Judge
8 McMahon, remember we still need for you to call
9 back on the juror information line after 6:00
10 o'clock. With this particular case that's being
11 tried in this courtroom and the other civil case
12 that Judge McMahon has, that will exhaust all the
13 civil cases that are going to be tried in this
14 particular week but criminal cases still remain on
15 the docket with Judge Cottingham, so there may be a
16 need for you to be a juror in a criminal case, so I
17 need for you all to go downstairs and if you're
18 excused remember call back on that jury information
19 line tonight after 6:00 o'clock.

20 Thank you very much.

21 (Jury panel excused from the courtroom).

22 THE COURT: All right, gentlemen, any matters
23 that we need to talk about before we break for
24 lunch at this point in time?

25 From the plaintiff?

1 this particular matter but we have found through
2 experience that when we allow the taking of notes,
3 especially when some case would last longer than a
4 week, we can go into a couple weeks, the tendency
5 of jurors is to, one, they are taking notes and
6 they are not listening to the next question and
7 answer which could be a lot more important than
8 what they are taking notes about.

9 And then there is the tendency of some jurors
10 to believe that since they have got it down on a
11 piece of paper it's much better than somebody
12 else's memory, and that is just not the case. The
13 Court equates the normal memory of the jury to be
14 equal if not better than something someone wrote
15 down on a piece of paper. So, in this particular
16 matter we're going to follow the common practice
17 and the usual course of business and we will not
18 allow the taking of notes in this particular case.

19 The very first thing that is going to happen
20 in this particular matter, then, is the swearing of
21 the jury.

22 Now, Miss Larson, the jury has selected you
23 to be the foreperson in this particular case, is
24 that correct?

25 JUROR: Yes, sir.

1 hear as we go through this trial, because of
2 Randy's paralysis. Randy's paralyzed essentially
3 from here down. He does have use of his arms but
4 he requires 24 hour a day care.

5 And the evidence, the things that I'm telling
6 you, I tell you that the evidence will show. Some
7 of it is important enough I want you to get the
8 feel for now, and that is nine years she's been by
9 him every day, every night. Nobody has took care
10 of him for one day, for one night. Her life is no
11 longer hers. Her losses are tremendous.

12 Now, before we sue the doctor and collect
13 from them we have to prove the case, that is only
14 fair, that's the way it ought to be, and in this
15 case, as the judge told you, I want to be sure you
16 understand because probably some people in the
17 court setting for the first time they get it wrong.

18 This is not a criminal trial, we don't have
19 to prove this case beyond each and every reasonable
20 doubt. You hear that on television, Nancy Grace
21 has explained that to you if you have seen it
22 before, but this is a civil case in which the
23 burden of the plaintiff in this case is to tip
24 those scales ever so slightly because that's the
25 way the law is written, that's the kind of case

1 we've got here and we submit to you that from the
2 witnesses that we call to establish that you will
3 feel comfortable finding for the plaintiff in this
4 matter.

5 What happened was this. On that day, that
6 Saturday in April there was an automobile accident
7 on Highway 22, Randy, his wife, son, all in the
8 truck. Somebody, another driver lost control of
9 their vehicle out on 22, ran into them there on 22
10 and caused a tremendous automobile accident and all
11 three of them were injured in varying degrees. But
12 this case is about medical injuries, we're not
13 going into the other injuries. Ann's losses are a
14 result of being married to Randy. This lawsuit
15 deals with Randy's injuries, the injuries is what
16 the lawsuit deals with and the treatment of those
17 by Dr. Bauerle that day is what is at issue here.

18 Now, this accident occurred somewhere around
19 11:30 in the morning. EMS people arrived at the
20 scene along with Randy's daughter who you will hear
21 she got a call from somebody that the family had
22 been in a wreck, she and her husband sped down to
23 the scene, got there before they left. She will be
24 here to testify throughout the trial.

25 But the ambulance took Randy to Grand Strand

1 surgery to repair this arm.

2 Now, remember I told you he also had a hip
3 injury. He had a fractured bone in his hip,
4 dislocated, and they determined that by CT scan,
5 CAT scan.

6 Now, Dr. Lintz had talked to Dr. Bauerle, per
7 the medical records, that is where we get our
8 information there, twice by telephone, consulting
9 with him about this particular case and the hip
10 injury and what to do about it. Dr. Bauerle as
11 best we can tell from the records arrived at the
12 hospital around 2:00 o'clock, Randy had been there
13 some two hours and five or ten minutes
14 approximately. Randy is in the pre-op room.

15 Now, the records say he's at OR, operating
16 room. Now, some of them say he wasn't actually in
17 the operating room, he was right outside getting
18 ready to go into the operating room, and I believe
19 that the record will show that that is the first
20 time Dr. Bauerle saw him, was at 2:05.

21 Now, the key to this situation, and I want to
22 go over it with you because I want you to listen to
23 the testimony as you go through, there will be
24 evidence in the medical record that Dr. Lintz says
25 he believes that it was very important that they

1 All right. So, ladies and gentlemen, this
2 young lady is going to play the part of Dr.
3 Cranberg. These are the questions that were posed
4 or asked of Dr. Cranberg and these are his answers,
5 you will take that as the testimony under oath of
6 Dr. Lee D. Cranberg.

7 Mr. McCutcheon, is there any objection?

8 MR. McCUTCHEON: No, sir, Your Honor.

9 THE COURT: You may proceed, sir.

10 MR. SAUTTER: Thank you, Your Honor.

11 (The direct examination of the deposition of
12 Dr. Lee D. Cranberg is being read to the
13 jury).

14 MR. SAUTTER: Your Honor and Mr. McCutcheon,
15 at this time I would offer Dr. Cranberg as an
16 expert in the field of neurology.

17 MR. McCUTCHEON: I don't have any objection.

18 THE COURT: All right. He's offering him --

19 MR. SAUTTER: As an expert.

20 THE COURT: He is qualified, then, to give
21 his opinions in the field of neurology.

22 You may proceed.

23 MR. SAUTTER: Thank you, Your Honor.

24 MR. SAUTTER: Your Honor, I move this
25 document as plaintiff's Exhibit Number 1 which is

1 Dr. Bauerle's assessment.

2 THE COURT: Any objection to that?

3 MR. McCUTCHEON: No, sir.

4 THE COURT: All right, Plaintiff's 1 is in
5 evidence without objection. Has it also been so
6 marked by the court reporter?

7 MR. SAUTTER: Yes, sir.

8 THE COURT: All right, very good.

9 (Dr. Bauerle's report was marked and received
10 in evidence as Plaintiff's Exhibit Number 1).

11 (QUESTION: Did you read Dr. Cozart's
12 deposition?

13 ANSWER: Yes.

14 QUESTION: Dr. Cozart was the surgeon that was
15 going to repair this gentleman's arm, correct?

16 ANSWER: Yes.

17 QUESTION: What did he say about having an
18 arrest in the OR?)

19 MR. SAUTTER: Your Honor, I'm going to
20 object. Counsel is trying to pit one expert
21 witness against another.

22 MR. McCUTCHEON: I don't think I am, Your
23 Honor, I think I'm simply asking what he said in
24 his deposition.

25 THE COURT: Is Dr. Cozart going to be a

1 (Reconvened 9:00 a.m., September 10, 2013).

2 THE COURT: Okay. Is the plaintiff ready for
3 the jury to come in?

4 MR. MARTIN: Yes.

5 THE COURT: And the defense?

6 MR. McCUTCHEON: Yes, sir.

7 THE COURT: All right, ask the jury to come,
8 in, please, ma'am.

9 MR. MARTIN: While they are coming in we have
10 delivered the original Cranberg deposition
11 transcript to the clerk.

12 THE COURT: Good. Are you going to start off
13 with another deposition?

14 MR. MARTIN: The video deposition of Dr.
15 Lintz.

16 THE COURT: All right. And you all already
17 have the video queued up?

18 MR. MARTIN: We do. I think we're ready to
19 go on that.

20 THE COURT: Very good.

21 (The jury returned to the courtroom).

22 THE COURT: Good morning, ladies and
23 gentlemen. I want to tell you, just so you know,
24 if you happen to see one or more parties coming in
25 and out of the courtroom, that I have given

1 permission to the parties, based on their
2 particular needs, to come and go as they need to,
3 all right?

4 All right, I have been informed the first
5 witness this morning is going to be another
6 deposition. This one is going to be a video
7 deposition of Dr. Scott Lintz, L-i-n-t-z. Remember
8 what I told you about a deposition, that it is the
9 testimony of a witness under oath, the attorneys
10 had the full opportunity to question Dr. Lintz at
11 that point in time with the questions they wanted
12 to have him answer. This is the sworn testimony of
13 Dr. Lintz for this particular matter.

14 All right, counsel.

15 MR. MARTIN: If it please the Court, Your
16 Honor, we would play the video deposition of Dr.
17 Scott Lintz. Prior to that and attendant to it we
18 move to introduce for the record Plaintiff's
19 Exhibit Number 2 which is an ER report dictated by
20 Dr. Scott Lintz.

21 THE COURT: Is there any objection to that,
22 Mr. McCutcheon?

23 MR. McCUTCHEON: No, sir.

24 THE COURT: All right. Plaintiff's 2, then,
25 is in evidence without objection.

1 (Emergency room report marked and received
2 in evidence as Plaintiff's Exhibit Number 2).

3 MR. MARTIN: And Number 3, another ER report
4 dictated by Dr. Scott Lintz.

5 THE COURT: Any objection?

6 MR. McCUTCHEON: No objection, Your Honor.

7 THE COURT: All right.

8 (Emergency room report marked and received in
9 evidence as Plaintiff's Exhibit Number 3).

10 MR. MARTIN: And Number 4.

11 THE COURT: All right.

12 MR. MARTIN: And four is again an adendum ER
13 report by Dr. Scott Lintz who the deposition is of.

14 MR. McCUTCHEON: No objection.

15 THE COURT: Very good. Plaintiff's Exhibits
16 2, 3 and 4 are in evidence without objection.

17 (Emergency Room report marked and received in
18 evidence as Plaintiff's Exhibit Number 4).

19 THE COURT: All right, you may proceed.

20 (Video deposition of Dr. Scott Lintz is
21 being played to the jury).

22 THE COURT: All right, counsel, you all come
23 up and talk to me for a second.

24 (Unrecorded bench conference).

25 THE COURT: All right, Mr. Martin.

1 THE COURT: All right, let's just take a very
2 short break, then we'll come back, all right?

3 Thank you.

4 (Recessed at 10:43 a.m.).

5 (Resumed at 10:54 a.m.).

6 THE COURT: All right, ask the jury to come
7 in, please.

8 (The jury returned to the courtroom).

9 THE COURT: Mr. Martin?

10 MR. MARTIN: May it please the Court, with
11 the Court's permission I will publish the medical
12 records that were dictated by Dr. Lintz. The first
13 dictation is 1:09.

14 THE COURT: Mr. Martin, could you maybe use
15 that microphone, if you don't mind, turn it toward
16 you, that would be great.

17 MR. MARTIN: Patient, Randall Green.

18 Can you hear me?

19 Date 4/17/2004, Scott Rintz, post motor
20 vehicle crash, HVI, the patient is a 54 year old
21 while male who was the unrestrained driver of the
22 vehicle which was apparently struck on the front
23 side of the vehicle. The car was laid on its side,
24 patient denies any loss of consciousness, he was
25 brought in on a long spinal board and cervical

1 collar and placed to room 12. History of the
2 accident was obtained from the officer. The
3 patient complained of pain in his right arm along
4 with his right lower chest and right hip. Primary
5 survey reveals initial blood pressure to be in the
6 80, 90 systolic, he had strong peripheral pulses
7 with the exception of the right wrist, which the
8 pulse was only noted by Doppler. The patient
9 denies any neck pain, denies any headache. He
10 denies any blurred vision.

11 Meds. Only aspirin, no known allergies, PPH
12 none. Physical examination. Primary survey
13 reveals him to be awake and alert, he had no
14 evidence of confusion, he had no evidence of any
15 face or scalp trauma, his nose is symetric, heart
16 regular, lungs clear throughout, abdomen soft and
17 completely non tender. The patient has no pelvic
18 tenderness until I asked him to straight leg raise
19 which causes pain to the right femoral region. The
20 patient has strong loralis pedis and posterior
21 tibular pulses. He has normal sensation. The
22 patient has normal left upper extremity.

23 Evaluation of his right arm reveals a
24 significant wound to the right proximal forearm.
25 The ulnar surface of the forearm reveals a

1 significant wound, probably down to the bone. It
2 is at least six to seven centimeters in length and
3 deep, most likely to the bone. There is chronic
4 oozing of blood. There is no foreign body noted
5 and the wound appears very clean. A sterile
6 pressure dressing was applied over the wound. The
7 patient could not flex his digits. A stat xray of
8 the forearm was performed which revealed no obvious
9 fracture. A portable C-spine, a chest and pelvis
10 xray was performed which revealed probable fracture
11 of the right acetabulum. A CT scan of his chest
12 and pelvis was performed which revealed he has most
13 likely a acetabular fracture with a hematoma. I
14 contacted Dr. Erickson for evaluation of the
15 patient's wounds. He stated he does not operates
16 below the elbow for vascular injuries. Dr. Cozart
17 was contacted and he has arrived in the ER. The
18 patient was given tetanus shot for prophylactic.
19 He will be going to the operating room. I
20 discussed the case with Dr. Bauerle who would
21 eventually like reconstructive CAT scan of the
22 patient's, of the patient's acetabulum. The
23 patient will need a complete C-spine when he has
24 post-op. He denied any neck pain and he was
25 rolled, with no mid or lower back pain. The

1 patient was able to flex his right hand -- strike
2 that.

3 The patient was able to flex his right elbow
4 normally. The patient was given a bolus of normal
5 saline and his pressure came up over 100 systolic.
6 The patient had intermittent episode of
7 hypertension. His labs revealed white count of 13
8 with a normal HTH. His cardiac enzymes are normal,
9 his cardiacs are normal and his liver function
10 tests are mildly elevated. The patient did admit
11 to drinking alcohol, smoking cigarettes on a
12 regular basis. EKG reveals a normal sinus rhythm
13 at 87 beats per minute, he has non specific ST/T
14 wave abnormalities with no evidence of acute
15 ischemia. The patient will be admitted most likely
16 to Dr. Nicholson, trauma surgeon, who is in the ER.
17 Critical care time spent with the patient was well
18 over an hour and a half.

19 Again, this is dictated 1:09 and transcribed
20 at 2:13 on April the 17th, electronically signed by
21 Dr. Scott Lintz. That is Exhibit Number 2.

22 Exhibit Number 3, again, is an ER report
23 dictated by Scott Lintz at 2:05, 2:05 that day,
24 again regarding Randall Green. Same date of birth,
25 this is addendum. The radiologist confirmed a

1 posterior hip dislocation. Prior to the patient
2 going to the operating room for his forearm injury
3 he was given four milligrams of morphine and one
4 milligram of Bursa 4. The hip was reduced without
5 difficulty. There was a significant clunk heard in
6 the hip. The patient had improvement of his
7 discomfort. He had a persistent strong femoral
8 pulse and a dorsalis pedis pulse. He moves his
9 toes normally, there is no color discrepancies
10 between the two extremities. However, prior to the
11 sedation the patient's neck was palpated by myself
12 and Dr. Nicholson. He denies any midline bony neck
13 pain. Portable lateral xrays of the neck and
14 swallowers' view of his neck reviewed no
15 malalignment or obvious fracture. The collar was
16 then removed. Dr. Bauerle was contacted
17 concerning, Dr. Bauerle was contacted regarding the
18 patient's hip injury a second time. He had asked
19 for reconstructive views, however due to the
20 patient's injury to his right forearm requiring
21 surgical intervention I felt that it was better
22 warranted, than holding up the patient, to get the
23 hip CAT scan. When I notified Dr. Bauerle he was
24 pretty adamant about getting the CAT scan of the
25 hip first. Dr. Bauerle has come in and the patient

1 is currently in CAT scan. Dr. Bauerle will follow
2 up with the CAT scan and make sure there are no
3 fragments in the hip injury itself, hip joint
4 itself. Dr. Cozart will be repairing the forearm
5 injury. The patient continued to have Dopplerable
6 pulse in his right radial area, received sedation
7 for hip closed relocation. Dictated 2:05 on April
8 17.

9 Exhibit Number 4, again an addendum report by
10 Dr. Scott Lintz which is dictated at 3:31 on that
11 same date. The patient is a 54 year old male who
12 was waiting to go to the operating room pending
13 results of the xray of his right hip. Again Dr.
14 Bauerle was adamant the patient getting those prior
15 to going to the operating room to make sure his hip
16 is reduced. While waiting for the results of the
17 CAT scan reading from the radiologist I walked by
18 the room and noted the patient started to become
19 bradycardic. His heart rate went from 60 to 50 to
20 40. The patient had just completed, had just
21 complained of some difficulty breathing. He had
22 escalated bronchial sound bilaterally. The patient
23 had only been given four milligram of morphine and
24 one milligram of Versa. He had minimal response to
25 the sternal rub. We checked his pulse and could

1 not palpate it. For this reason the patient was
2 intubated with an endotracheal tube with 22
3 centimeters at the hip, CPR was initiated. We gave
4 him a milligram of Atropine and a milligram of EPI
5 4. The patient's heart rate increased to over 100
6 in a wide complex fashion. I had paged anesthesia
7 just prior to intubating the patient. The patient
8 had a Dopplerable pulse over femoral artery. Dr.
9 Cozart, Dr. Nicholson and Dr. Bauerle were present
10 at some time during this initial code. The patient
11 appeared to be very pale on repeat exam. CPR was
12 performed for under a minute, the patient was
13 bagged with 100 percent oxygen prior to intubation,
14 Dr. Peters performed a right IJ central line, blood
15 which was called for arrived from the blood bank
16 and the patient was transfused four units of bagged
17 red blood cells. We did repeat an H and H which
18 revealed a hemoglobin of 5.5 and platletes of five.
19 The lab was unsure if this was normal as there was
20 a clot in the tube. This was ordered prior to the
21 patient getting the blood. The patient had already
22 received the three liters of normal saline. Dr.
23 Cozart began operating on the patient's forearm in
24 the ED to stop the oozing from the patient's
25 forearm injury. There was no gross bleeding when

1 he started, that I could observe. A left arterial
2 line was performed by Dr. Peters with varying
3 increase in blood pressure in the 50's to the 60's.
4 The patient had a second episode of bradycardia and
5 hypotension and was given another milligram of
6 Atropine and Epinephrine. The patient was started
7 on EPI and Levophed drip. The patient's son-in-law
8 was outside the room and I intermittently discussed
9 the event with him. I ordered two units of
10 platletes for him. The patient's blood pressure
11 had increased to over 100 systolic.

12 Procedures. Endotracheal intubation.
13 Critical care of the patient was over an hour.
14 Again on the top of what I had performed before, I
15 also contacted the hospitalists services for
16 medical consults and called the echo tech for a
17 stat echocardiogram after discussing the case with
18 Dr. Trask. The patient's hypotension and
19 bradycardia appears to be the most likely, appears
20 to be most likely due to anemia and volume loss.
21 The patient I believe is improving due to at least
22 3.5 to four liters of normal saline and the packed
23 red blood cells. Incidentally, the CAT scan of the
24 right hip did reveal some small fragments in the
25 right hip but the hip reduction was successful.

1 MR. QUERY: That's fine, Your Honor, I have
2 no problem with that.

3 THE COURT: Very good.

4 All right, you may proceed.

5 MR. QUERY: Thank you, Your Honor.

6 This is the deposition of Dr. Douglas E.
7 Norcross, given on October 28, 2009, at 3:00 p.m.,
8 at the Medical University of South Carolina. Page
9 five, line 20.

10 (The deposition of Dr. Douglas Norcross is
11 being read to the jury).

12 THE COURT: All right, very good. Is that
13 the end of that deposition, then?

14 MR. QUERY: Your Honor, with regard to that
15 deposition, we have a stipulation.

16 THE COURT: All right.

17 MR. QUERY: And I would publish that with the
18 Court's permission.

19 THE COURT: Is that correct, Mr. McCutcheon?

20 MR. McCUTCHEON: Yes, sir.

21 THE COURT: All right, very good. Go ahead.

22 MR. QUERY: Come now the parties herein named
23 by and through their undersigned counsel of record
24 who hereby stipulate and agree that Dr. Norcross'
25 affidavit dated July, 2013, is sufficient to show

1 that all of his opinions stated during his
2 deposition taken on October 28, 2009, are based
3 upon a reasonable degree of medical certainty in
4 his field and that Dr. Douglas Norcross is
5 qualified as an expert in the field of traumatic
6 surgery to testify as to such matters. All
7 substantive objections are preserved. Signed by
8 Morgan Martin and by John B. McCutcheon, Jr.

9 THE COURT: Very good.

10 All right, do you want to proceed on with
11 another deposition?

12 MR. QUERY: Yes, Your Honor.

13 THE COURT: All right.

14 MR. QUERY: Your Honor, I apologize, there
15 were some followup questions I overlooked.

16 THE COURT: Ma'am, could you come back to the
17 stand, please ma'am. Thank you.

18 MR. QUERY: My witness was kind enough to
19 point that out, Your Honor, so I'm going to let her
20 tell us where to go on this. Page 39.

21 (Continued reading of Dr. Douglas Norcross'
22 deposition).

23 THE COURT: All right. What is the
24 deposition?

25 MR. MARTIN: Dr. Ed Chariker.

1 THE COURT: Do you all have the original?

2 Ladies and gentlemen, I know I said it the
3 last time, but depositions continue to be the sworn
4 testimony of that particular witness, taken at a
5 different point in time, most likely to accomodate
6 them in their practice, but it is the testimony of
7 all those witnesses under oath regarding the
8 particular matter.

9 All right, sir, you may proceed.

10 (The deposition of Dr. Ed Price Chariker is
11 being read to the jury).

12 MR. McCUTCHEON: Your Honor, just for
13 purposes of the record and clarification, this was
14 a discovery deposition.

15 THE COURT: All right, sir.

16 MR. McCUTCHEON: Taken by Miss Thomas, so
17 just for the record.

18 MR. MARTIN: That's correct.

19 THE COURT: All right, very good.

20 Go ahead.

21 (Continued reading of the deposition of Dr.
22 Ed. Chariker).

23 (Q And when you get those documents back,
24 I will specifically go back to them, but
25 sitting here right now do you have any

1 (Resumed at 1:45 p.m.).

2 THE COURT: Okay, are we ready for the jury,
3 Mr. McCutcheon?

4 MR. McCUTCHEON: Yes, Your Honor, While they
5 are coming in I had some exhibits to review.
6 Exhibits 4 through 9 presented by the plaintiff, I
7 have no objection.

8 THE COURT: Hold on one second. I had it as
9 5 through 12.

10 MR. QUERY: I'm sorry, we changed the number
11 on one of them.

12 THE COURT: All right. Exhibits 2, 3 and 4
13 are already in evidence.

14 All right.

15 MR. McCUTCHEON: 4 through 9.

16 THE COURT: You all come up.

17 (Unrecorded bench conference).

18 THE COURT: Mark 5 through 12 in evidence
19 without objection.

20 (Plaintiff's Exhibits 5, 6, 7, 8, 9, 10, 11
21 and 12 were received in evidence).

22 THE COURT: All right, Mr. Martin, your next
23 witness, please.

24 MR. MARTIN: Annette Slate.

25 ANNETTE SLATE,

1 after being first duly sworn, testified as follows:

2 THE CLERK: Please state your name for the
3 court reporter.

4 THE WITNESS: Annette Slate, S-l-a-t-e.

5 THE COURT: Ma'am, you're going to have to
6 speak up, now, because everybody is going to need
7 to hear you, so you need to speak directly into
8 that microphone. Speak up, please.

9 You may proceed, Mr. Martin.

10 DIRECT EXAMINATION BY MR. MARTIN:

11 Q Annette, give us your full name.

12 A Annette Slate.

13 Q Okay. Where do you live?

14 A Conway.

15 Q And what kind of work do you do?

16 A I'm a pharmacist at Conway Medical Center.

17 Q How long have you been doing that?

18 A Three and a half years.

19 Q Married?

20 A Yes, sir.

21 Q Children?

22 A One.

23 Q One, okay, all right. How are you related to
24 Randy and Ann Green?

25 A They are my mom and dad.

1 price.

2 Q You didn't want to be in the timber business?

3 A No, sir, not after high school.

4 Q Okay. How about your mama, how was she in

5 their relationship before he suffered this

6 paraplegia? Tell us a little bit about that.

7 A Everything was good. They, we all had, we

8 had a good happy home, she would faint at the sight

9 of blood but now she's hard as nails. I always

10 tell her she needs an angel award because of what

11 all she has come through the last nine years. She

12 would faint at the sight of blood but now she's my

13 dad's fulltime caregiver, she does everything for

14 him, caths, everything.

15 Q Does she have any hired help to help with

16 your dad?

17 A No, sir, she does everything for my dad.

18 Q Has she ever had any hired help over the past

19 nine years?

20 A No, sir.

21 Q From your vantage point what does taking care

22 of your dad entail for her?

23 A Getting up first thing in the morning, cath

24 my dad and --

25 Q Doing what, now?

1 A She will cath my dad.

2 Q Catherization so he can empty his bladder?

3 A Yes, sir. And then she has a cup of coffee,
4 she runs errands for him if he need supplies. She
5 has to run to Sam's a lot so she can buy in bulk.
6 She makes lunch, then about 12:00 or 12:30, 1:00
7 o'clock, just depends on, you know, dad's system,
8 she has to cath him again.

9 Then the afternoon she's either on the road
10 again running more errands or she's, she's normally
11 at home, she doesn't like to run that much, she
12 doesn't like to be away from dad, she's afraid that
13 if he falls out of his chair there is going to be
14 nobody there. Just if he had an emergency he would
15 have a hard time getting somebody there.

16 Then about 5:30, 6:00 o'clock she caths him
17 again, cooks dinner, and usually about 8:00 o'clock
18 she'll go to sleep, she will set her alarm for
19 11:00, 11:30 and she wakes up again, caths my dad
20 again and then goes back to bed.

21 Q Do they live in a neighborhood or otherwise?

22 A No, sir, they live in the country, there is
23 no one near them.

24 Q And is that the same home they lived in at
25 the time of his paraplegia?

1 A Yes, sir.

2 Q How long had they been in that home at that
3 time, if you recall?

4 A Twenty some years. My dad built it from the
5 ground up, it was still a work in progress.

6 Q When you were a child?

7 A Yes, sir. We all helped but my dad did
8 everything but the fireplace. He built the whole
9 thing.

10 Tell me a little bit about your dad's ability
11 or how his ability to participate in the life of
12 your child and his other grandchildren changed.

13 A He hasn't been able to do pretty much
14 anything as far as travel to recitals, to games
15 where my daughter plays in the band. He hasn't
16 been hands on like he was.

17 Q How was he hands on before, what kind of
18 things would he do?

19 A He would go and pick up my niece from
20 daycare. He couldn't do that for my daughter
21 because of course I lived in Little River, an hour
22 and a half away. But, you know, anytime papa, that
23 is what they call him, anytime they needed
24 something from papa he was there for them. He was
25 just hands on, you know, and to this day, I mean,

1 he does what he can for them but as far as like
2 anything pertaining to him having to leave the
3 house, he does not. If we want to see him we take
4 the girls to Marion.

5 Q Is there a time through the day he has to be
6 catherized?

7 A It's the same time every day, so if we want
8 to take my mom out to lunch or have dinner, you
9 know, just to have some time with my mom one of us
10 will try and stay at the house with dad and we'll
11 take my mom over to Florence, which is about 25
12 minutes from Marion, but she's constantly on terror
13 watch, it is like we've got to get back.

14 As far as coming to my house in Conway, she
15 has only been twice in the last nine years. She's
16 never seen my sister's house because she lived in
17 Marietta, Georgia up until three months ago but my
18 sister is here now.

19 Has he been on vacation in the last nine
20 years?

21 A No, sir, not at all.

22 Q To your knowledge has she spent the night
23 away from your dad in the last nine years?

24 A No, sir.

25 Q Has she been on vacation?

1 A No, sir, not at all.

2 MR. MARTIN: One minute.

3 That's all the questions I have.

4 THE COURT: Cross examination?

5 MR. McCUTCHEON: We have no questions.

6 THE COURT: All right, ma'am, you may step
7 down.

8 (Witness excuse).

9 THE COURT: Next witness, please.

10 MR. QUERY: Call Mark Green, please.

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1 JONATHAN MARK GREEN,

2 after being first duly sworn, testified as follows:

3 THE CLERK: State your name for the Court and
4 spell your last.

5 THE WITNESS: Jonathan Mark Green, Green is
6 G-r-e-e-n.

7 THE COURT: All right.

8 MR. QUERY: Thank you, Your Honor.

9 DIRECT EXAMINATION BY MR. QUERY:

10 Q Mark, what is your relationship to Randy
11 Green?

12 A He's my father.

13 Q And were you here for most of your sister's
14 testimony?

15 A A good portion of it there at the end.

16 Q All right. I only say that, I just didn't
17 want to go over the same thing too much, but you
18 grew up over there on Bubba Lane, too?

19 A Yes, sir.

20 Q Bubba Road, I guess?

21 A Bubba Road. We moved there when I was two
22 years old and we, mom and dad have lived there ever
23 since and that's been home.

24 Q Okay. Tell us a little bit about growing up
25 there as being the only son.

1 A Well, with dad, dad has done just about every
2 job in the book. Officially he has been a logger
3 and a timber buyer, timber cruiser. In the process
4 of logging, you know, he has done everything from
5 mechanic work, welding, you name it, across the
6 board, that is what dad does, did and continued to
7 do up until he was unable to.

8 My grandfather was a carpenter and in dad's
9 younger years he was a carpenter as well, he
10 specialized in cabinetry making and I did hear my
11 sister say he did build the house that we live in
12 currently, they live in currently, from the ground,
13 up. Again, I believe the fireplace is the only
14 thing he did not directly have a hand on.

15 Q During the time you were growing up there did
16 you spend much time with your dad?

17 A Of course. Dad worked a full-time job and it
18 sometimes was late for him coming home simply from
19 working all day long and so if a piece of equipment
20 tore up or anything like that he would be there
21 trying to get it fixed for the next day to where
22 they could continue to work.

23 Q When you all did have time just to yourself,
24 the two of you, did you all play video games and
25 watch television much time?

1 A No, sir, there wasn't a lot of that. Dad was
2 more of a fishing and hunting and being outdoors
3 type. He did not like being inside and I think he
4 hated it when it rained and he had to be inside,
5 but there was always something going on that we
6 needed to work on or fix or repair, what not, and
7 you know, as a little kid I helped him with as much
8 of that as I could and looking back on it right now
9 I see as a kid I was more getting in the way than
10 anything else but those were, those were the
11 memories that I kind of look back on now and say,
12 you know, I really appreciate that.

13 Q Now, on that day in April of 2004 --

14 A Yes, sir.

15 Q -- you were with your dad?

16 A Yes, sir.

17 Q And you and your mom and dad were headed to
18 your sister's?

19 A My sister's house in Little River, South
20 Carolina at the time for my niece's birthday party.

21 Q And you all were involved in an accident?

22 A Yes, sir.

23 Q You were hurt in that accident as well, we
24 have already heard, I think?

25 A Yes, sir. I broke both my legs. The left

1 ankle was, well, the doctor used the term
2 pulverized, was in real bad shape, broke my femur
3 in my right leg, three toe bones in my right foot,
4 my pinky finger and wrist on my right hand.

5 Q You all were transported from the accident by
6 ambulance?

7 A Yes, sir. To Grand Strand Hospital.

8 Q All right. And were you all in the same
9 ambulance?

10 A Yes, sir. My mother was able to get out of
11 the vehicle on her own, dad and I were both pinned
12 and when the rescue squad responded they had to cut
13 us out and dad and I were both transported in the
14 same ambulance to the hospital.

15 Q All right. And did you see your dad any then
16 after you all got to the emergency room at Grand
17 Strand?

18 A No, sir.

19 Q Okay. You were transported that same day on
20 to the Medical University?

21 A Yes, sir. About four hours later they
22 shipped me off to MUSC in Charleston. At the time
23 I didn't want to leave because I knew mom and dad
24 were both staying, and in hindsight I'm very glad
25 and thankful that I did leave that hospital.

1 Q And then did you complete your treatment
2 there then at MUSC and your therapy at MUSC therapy
3 facility?

4 A Yes, sir.

5 Q How long did that go on?

6 A It was about a week in the actual hospital
7 and then three weeks subsequent in the rehab
8 facility.

9 Q And was your father subsequently moved down
10 to MUSC as well?

11 A Yes, sir. The day following the accident he
12 came down to MUSC. I believe he was in the
13 intensive care unit, which was a different wing or
14 floor from where I was at, as I understand it.

15 Q Did there come a time then when you saw him
16 in the hospital?

17 A I think I saw him twice in the hospital while
18 I was there or in the therapy hospital, what they
19 call the TCU.

20 Q Where did you go from the hospital? When you
21 were released from the hospital where did you go?

22 A I stayed with my father's brother, my Uncle
23 Mike who lives on James Island in Charleston, South
24 Carolina, very close to MUSC. I wanted to be as
25 near my father as I possibly could. My sisters at

1 the time were back here in Myrtle Beach in this
2 area to where they could keep an eye on my mother
3 and keep up with her prognosis and treatment from
4 the hospital and I kind of felt, even as limited as
5 I was, at least an obligation to be as close to my
6 father as I could at the time.

7 Q What was his condition then?

8 A It was pretty poor when I was first released
9 or when I was --

10 Q I mean specifically was he paralyzed at that
11 time?

12 A Yes, sir.

13 Q And did there come a time later on that you
14 learned that he was going to be released from MUSC
15 as well?

16 A Yes, sir. I think it was about a month in
17 the actual hospital, then he was in the TCU, which
18 is their rehab facility, for several months, I
19 don't know the exact timing.

20 Q And did you come back then to Bubba Road?

21 A Yes, sir. I came back, we had a good bit of
22 work to do on the house to try to get it ready for
23 dad to come home in the shape he was in. He was in
24 the wheelchair. Again, at that time I spent about
25 three months in a wheelchair myself, so I think the

1 big biggest help since I was not able to swing a
2 hammer or anything like that but I was able to get
3 around in the chair and see what --

4 Q You were a test case?

5 A Right. Where dad would be able to go and
6 what he would be able to do in the house.

7 Q Tell us very briefly what you all had to do
8 with the house.

9 A The big thing was flooring. All the carpet
10 had to come out, it just wasn't feasible with a
11 wheelchair. There were a few places in the floor,
12 at this time a 30 year old house, a few soft spots
13 in the floor, the master bathroom was gutted and
14 remodeled to where a wheelchair could get in there,
15 tile shower basically instead of a tub situation.
16 Everything that was involved in that, pedestal sink
17 that he could actually get up to in a wheelchair.
18 Let's see.

19 Q Did you have to do anything so that he could
20 get into the house?

21 A Yes, sir. A wheelchair ramp was built.

22 Q Who built that?

23 A All the work that was done was done by my
24 three uncles. I mentioned my father's brother
25 Michael who lives in Charleston here, and my

1 do but the important things were always taken care
2 of.

3 Q And was he there for your stuff at school?

4 A Absolutely, absolutely. He was there for any
5 awards ceremonies and, you know, graduation of
6 course and one of my best memories is mom and dad
7 and they even got grandma up there for my
8 graduation at Clemson. Unfortunately it rained and
9 they were outside but they were there. And for
10 them, you know, them traveling, that was a big deal
11 and it really meant a lot to me.

12 Q Did the family take vacations together?

13 A Mom and dad have always been kind of home
14 bodies but they would travel as much as they could
15 but they tried to limit themselves to, you know,
16 trips to the beach, you know, that sort of thing.

17 Q But the family did that together?

18 A Yes.

19 MR. QUERY: Thank you, Mark. Please answer
20 any questions that counsel may have.

21 THE COURT: Cross-examination.

22 MS. THOMAS: Thank you, Your Honor.

23 CROSS EXAMINATION BY MS. THOMAS:

24 Q Good afternoon. You told us earlier that you
25 were in the accident with your parents?

1 Q In fact you were somewhere else and other
2 doctors and nurses where taking care of you, is
3 that correct?

4 A Yes.

5 MS. THOMAS: That's all the questions I have
6 for you.

7 THE COURT: Any redirect?

8 MR. QUERY: None, Your Honor.

9 THE COURT: All right sir, you may step down.
10 (Witness excused).

11 THE COURT: All right, next witness, please,
12 gentlemen.

13 MR. QUERY: Call Lynn Green, Your Honor.

14 THE COURT: Please come around and be sworn.

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1 LYNETTE GREEN GRAHAM,
2 after being first duly sworn, testified as follows:

3 THE CLERK: All right, have a seat. State
4 your name and spell your last name for the Court.

5 THE WITNESS: My name is Lynette Green
6 Graham, G-r-a-h-a-m.

7 THE COURT: Go ahead.

8 DIRECT EXAMINATION BY MR. QUERY:

9 Q Do you prefer Lynette or Lynn?

10 A Lynn.

11 Q Okay, Lynn. Except at home?

12 A Yes.

13 Q Lynn, where do you live now?

14 A I live with my sister in Conway currently, we
15 moved from Marietta, Georgia three months ago.

16 Q And by we?

17 A My husband and my daughter and I.

18 Q Okay. And where are you working?

19 A Coastal Cancer Center, I'm an oncology nurse.

20 Q I haven't done a very good job of getting
21 this in order for the jury so why don't you tell me
22 who the oldest, youngest and middle is. Annette
23 and you are identical twins?

24 A She's older by seven minutes and then my
25 brother came along.

- 1 A Yes.
- 2 Q Did he teach you all how to fish?
- 3 A Yes.
- 4 Q Well, I'm sure working on the house and those
5 chores that we heard Mark talk about, you didn't
6 get dragged into any of that, did you?
- 7 A Yes, we all did. I helped dad shingle the
8 house several times, it was hot work. We enjoyed
9 it, enjoyed when school started, if that makes any
10 sense.
- 11 Q Of course then there came the time in April
12 of 2004 when there was the accident and the
13 hospitalization and after that your dad was
14 paralyzed?
- 15 A Right.
- 16 Q And so tell us a little bit about how things
17 changed.
- 18 A It changed dramatically. They are not as
19 happy as they used to be, there is a lot of stress
20 involved, mom worries a lot, she has aged the last
21 nine years twice what she should have. It's just
22 not the same.
- 23 Q Does your dad have to have care 24 hours a
24 day?
- 25 A 24 hours a day.

- 1 Q And who all takes care of that?
- 2 A Mom does.
- 3 Q How about the medical things that we have
- 4 heard about that he has to have, be catheterized how
- 5 many times a day?
- 6 A Anywhere from four to five.
- 7 Q Who does that?
- 8 A Mom does.
- 9 Q And who prepares the meals there at the
- 10 house?
- 11 A Mom does.
- 12 Q Cleans the house?
- 13 A Mom does.
- 14 Q Can your dad bathe by himself?
- 15 A No.
- 16 Q Who does that?
- 17 A Mom does.
- 18 Q Can he get out of bed by himself?
- 19 A He can use, he participates and uses a
- 20 transfer board from the bed onto the wheelchair.
- 21 Q By himself?
- 22 A No.
- 23 Q Who helps him?
- 24 A Mom does.
- 25 Q Her day is pretty full?

1 A Yes.

2 MR. QUERY: Thank you, Lynn. I appreciate
3 you being here. Please answer any questions
4 counsel may have.

5 THE COURT: Cross-examination.

6 MS. THOMAS: No questions, Your Honor.

7 THE COURT: All right, you may step down,
8 ma'am.

9 (Witness excused).

10 THE COURT: All right, next witness, please,
11 gentlemen.

12 MR. QUERY: Your Honor, we have a couple
13 little set-up things, if it would not be
14 inappropriate for us to have five minutes or so?

15 THE COURT: All right, very good.

16 All right, ladies and gentlemen, go to your
17 jury room and in about five minutes or so we'll
18 come back out.

19 MR. QUERY: Thank you.

20 THE COURT: Everyone else remain seated while
21 the jury retires.

22 (Jury excused from the courtroom).

23 THE COURT: All right, gentlemen, counsel,
24 we'll be at ease for about five minutes or so.
25 Thank you.

1 (Recessed at 2:35 p.m.);

2 (Resumed at 2:46 p.m.).

3 THE COURT: All right, gentlemen, ready to
4 proceed.

5 MR. SAUTTER: Yes, Your Honor, just a second.

6 THE COURT: All right. Is the plaintiff
7 ready for the jury to come in?

8 MR. SAUTTER: Yes, sir, Your Honor.

9 THE COURT: All right.

10 Mr. McCutcheon, the jury, ready for them?

11 MS. THOMAS: There is something we need to
12 discuss.

13 THE COURT: Okay, what do we need to talk
14 about?

15 MS. THOMAS: Your Honor, it is our
16 understanding the next witness to be presented by
17 the plaintiff is the nurse that prepared the life
18 care plan and prior to today we have never been
19 provided any doctor's opinion as to the necessity
20 of the things outlined in the life care plan.
21 Today we were presented with a doctor who had
22 signed off on some of those things, we have
23 objected to those being introduced or being shown
24 to the jury and plaintiffs' counsel has agreed they
25 will not show those matters to the jury. The

1 original deposition back.

2 Ask the jury to come in.

3 (Life care plan marked as Plaintiff's
4 Exhibit 13 and received in evidence).

5 (The jury returned to the courtroom).

6 THE COURT: Gentlemen, here, you're going to
7 need these plaintiff's exhibits, if you want to
8 collect it

9 All right, counsel, next witness, please.

10 MR. SAUTTER: Thank you, Your Honor. I would
11 like to call Nurse Sara Lustig to the witness
12 stand, please.

13 THE COURT: Please come around and be sworn,
14 ma'am.

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1 SARAH LUSTIG,

2 after being first duly sworn, testified as follows:

3 THE COURT: Have a seat and state your name,
4 please.

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6 THE WITNESS: Sarah Lustig, L-u-s-t-i-g.

7 DIRECT EXAMINATION BY MR. SAUTTER:

8 Q All right, Nurse Lustig, where are you
9 employed?

10 A Currently employed at Lustig Consulting, LLC.

11 Q What does Lustig Consulting do?

12 A Lustig Consulting offers forensic evaluation
13 and life care planning.

14 Q What does forensic mean?

15 A Litigation.

16 Q That is what we're here on today?

17 A Yes, expert testimony, yes.

18 Q Do you maintain any licensure with the State
19 of South Carolina?

20 A I do.

21 Q What is that?

22 A Registered Nurse under the State Board of
23 Nursing in South Carolina.

24 Q And will you please share with the jury your
25 work experience, your work history after graduation

1 We have no objection, Your Honor.

2 THE COURT: Very good.

3 BY MR. SAUTTER:

4 Q Nurse Lustig, come down here.

5 THE COURT: Do you wish the witness to step

6 down?

7 MR. SAUTTER: Yes, sir, please, I'm sorry.

8 May the witness step down?

9 THE COURT: You may do so, ma'am. Make sure

10 you speak, get closer to the microphone on the jury

11 box there, on the frame.

12 THE WITNESS: Okay.

13 THE COURT: The microphone, speak up, get

14 next to that.

15 THE WITNESS: Do you want me to stand here or

16 over there?

17 THE COURT: Whichever the jury can hear. The

18 jury wants you to speak to the box so everybody can

19 hear you.

20 THE WITNESS: Okay.

21 BY MR. SAUTTER:

22 Q Go ahead and describe -- do you believe that

23 illustration is accurate as to Mr. Green's injuries

24 and requirements for healthcare?

25 A Yes. This document here is nicely done, it

1 illustrates the level at which the spinal cord was
2 injured, and below this level, T6 to T12, all
3 these, the rest of the body from this level down is
4 affected by spinal cord injury, all your systems
5 are affected in this case except pulmonary but most
6 all the other systems are affected because of
7 immobility. When someone has a spinal cord injury
8 they can't move and that causes a lot of other
9 symptoms, dysfunction.

10 Q Is it just the fact he can't move his legs,
11 or are there other systems of the body that are
12 affected by Mr. Green's injury?

13 A Yes. I mean, with this type injury below T6
14 the lungs are spared, so his lungs probably will be
15 not affected by this injury, but he has difficulty
16 bending at the waist, he has muscle spasm into the
17 lower extremities, pain in his back from sitting in
18 the chair, redness.

19 Q Redness there you are pointing to?

20 A This right here would indicate to me
21 pressure. You're sitting in a chair for a long
22 time, it gets red. So this is, I'm not sure if
23 this indicates pain but I assume that is a pressure
24 point. So, his skin integrity, any skin that is
25 touching the wheelchair surface is at risk for

1 breakdown, so going down, we have, we're getting
2 lower into the GI tract here, which a patient --

3 Q What Is the GI tract?

4 A The GI trct is what holds our digestive
5 system. So, your digestion starts in the mouth and
6 ends in the end of the bowel. So, his GI, the
7 entire tract except from the mouth down, right
8 above the esophagus is affected because he is
9 immobile, which means that his GI trct slows down.

10 So, whenever you have static, non movement,
11 it slows everything in your body down, so he has
12 decreased digestion and he has a nerveless bowel.

13 Q What is that?

14 A That means he doesn't have any nerves
15 communicating to his bowels to initiate a bowel
16 movement, which is nice to have one every day. In
17 this case he can't control that, so he has to have
18 someone to physically examine him and pull the
19 stool out because he can't do it himself.

20 Also I'm going down farther, getting to this
21 bladder, the bladder, you have nerves in your
22 bladder, he can't stand up and urinate, he doesn't
23 have control, so somebody has to stick a catheter,
24 a little tube, and it drains the urine from his
25 bladder.

1 Q What is your understanding of who has been
2 providing that service to Mr. Green?

3 A His wife.

4 So, going down farther, talking about fecal
5 impaction, anytime you digitally disimpact someone,
6 they also lose that sphincter control and so there
7 is some accidents in between the bowel regimen.

8 So, he has sexual dysfunction, the inability
9 to initiate, maintain an erection, and that all has
10 to do with nerve damage in this area here. All
11 these yellow marks, lines are nerves stemming from
12 the spinal cord, all these are affected, okay, from
13 the level T6, down.

14 The ulcer means skin breakdown, so see the
15 redness here, he has had some contact with the
16 wheelchair. Wearing shoes or even having too tight
17 a sock on, that can actually irritate the skin.
18 The reason he has a decreased skin integrity is
19 because he's immobile, he doesn't move blood around
20 his system and that skin is constantly under
21 pressure, against any pressure point, as I said,
22 socks, shoes, bed, wheelchair.

23 And then we have increased risk of secondary
24 accident.

25 Q What does that mean?

1 A Mr. Green tries to be independent as much as
2 possible and in doing so that makes increased risk
3 of falling. If he reaches a little bit too far and
4 he is not in an appropriate wheelchair he can fall
5 out of the wheelchair and break a bone.

6 Anytime he's being transferred from wheelchair
7 to chair or chair to wheelchair or wheelchair to
8 bed, or vice versa, anytime there is transfer with
9 caregiver support he is at a fall risk just by
10 nature of his disability and having no movement in
11 his lower extremities he cannot support himself.

12 Acid reflux. Again, if you're sitting in a
13 chair and slumped over and eating and drinking, if
14 you're slumped over you get acid reflux, that
15 happens during meals.

16 Abdominal discomfort. Again that is just
17 from being slumped over in a chair, sitting at 90
18 degrees, try to recline a little bit, but that
19 causes abdominal discomfort.

20 Intolerance to cold. So, when you're mobile
21 and ambulating, walking, blood circulates through
22 your body. If you have ever been cold and you jump
23 in place for a long time, that is what you're
24 doing, you're trying to increase that blood flow to
25 your body. And because he is immobile he cannot do

1 that. His legs are constantly cold, so he needs to
2 wear fleece lined clothes, stockings, to keep his
3 legs warm. So, he does have temperature
4 intolerance.

5 He occasionally has rapid heartbeat -- this
6 has to do with positioning. If you have ever been
7 in bed and you're laying down, you stand up too
8 fast, what happens, you get dizzy. Also he has
9 occasional rapid heartbeat. That is just trying to
10 get his body's blood pumping at a normal pace.

11 And of course he requires a power wheelchair.

12 Q Let's talk about that. Is it important that
13 Mr. Green have the appropriate wheelchair?

14 A Yes, it is. For for any paralyzed patient
15 you have limited upper body strength and obviously
16 at a high risk of fall. At this T6 it is standard
17 to have customized wheelchair. The patient lives
18 in their chair, the chair becomes part of their
19 identity, it keeps them safe, so it is extremely
20 important for them to have a comfortable
21 wheelchair.

22 Also, one thing I don't see on here is --

23 Q Do you know, without having to look at your
24 notes, what the expected cost of the appropriate
25 wheelchair for Mr. Green is?

1 to go home, the home was accommodated.

2 Q Who did that?

3 A I believe Mark and friends of the family.

4 Q All right.

5 A So, also there is only one, there is two
6 entrances to the house. One entrance, if there was
7 a fire he can't escape from the back, there is no
8 ramp, so that would need to be added.

9 Q Are those items addressed in the plan?

10 A Yes. So, one of the most important things to
11 consider for this type of patient, T6 or below, is
12 osteodysplasia.

13 Q What is that?

14 A That is is a very life threatening condition
15 and patients at that level of spinal injury have
16 the problem and it is, it is their response to an
17 illness or injury, so let me explain. If you have
18 a full bladder after being in court for six hours,
19 everybody here, you know you have a full bladder
20 and you know you're getting ready to get up and go,
21 most of you can hold back until you find a
22 bathroom. After four to six hours sitting here Mr.
23 Green having a full bladder and if that bladder is
24 not emptied on time his body doesn't say you can go
25 in half an hour, you can wait that time. His body

1 doesn't say that. It starts to adjust to
2 osteodysplasia. That causes leak, there is heart
3 irregularity, severe headaches. It is life
4 threatening and if not taken care of it can cause
5 cardiac arrest and death.

6 Q Because of his condition he is at risk for
7 developing that syndrome, correct?

8 A Yes.

9 Q First of all how does Mr. Green address that
10 risk and how do you address it in your life care
11 plan?

12 A So, it is indicated in the record, he has
13 been educated about it since day one, since his
14 accident, the life care plan, if implemented
15 appropriately and the caregiver supports it,
16 because he cannot empty his bowels, because he's
17 not emptying his bladder, that if they are not
18 taken care of appropriately the response is he
19 could die because of the injury to the
20 osteodysplasia. So, in the plan the plan provides
21 safety measures, if implemented appropriately we
22 should prevent that from happening.

23 Q But I mean, what is the frequency of safety
24 measures required by the plan for someone, how many
25 times a day should he empty his bowels?

1 A His level of care, he cannot remove fecal
2 matter, 24/7.

3 Q 24 hours, seven days a week?

4 A Yes.

5 THE COURT: Counsel, are you done with the
6 exhibit, or are you still working on the exhibit?

7 MR. SAUTTER: I believe we're done with it.
8 Your Honor, may the witness come back to the
9 witness stand?

10 THE COURT: Go ahead, ma'am.

11 BY MR. SAUTTER:

12 Q So, is it your testimony to a reasonable
13 degree of nursing and life care certainty that Mr.
14 Green most probably requires care 24 hours a day
15 seven days a week?

16 A Yes.

17 Q And who has been providing that care?

18 A His wife Mrs. Green.

19 Q Are you able to give an opinion as to the
20 quality of the care that she provides?

21 A I think she's doing a great job.

22 Q Are you able to give an opinion to a
23 reasonable degree of nursing certainty and life
24 care planning as to how long a spouse will be able
25 to provide that care?

1 A You know, I think she's doing a great job but
2 I also know that Mrs. Green is supremely tired and
3 didn't know she would be providing basically
4 certified nursing aid caregiving skills which it
5 takes a lot of effort and work and organization and
6 coordination and facilitation of care and she's
7 doing a very good job. She's been trained by
8 nurses, doctors, physical therapists to provide the
9 care that she has chosen at this point to give to
10 her husband. I think that Mrs. Green also is
11 suffering from depression and anxiety and has lost
12 her husband as he was prior to this accident and I
13 think that she has caregiver role strain.

14 Q What is caregiver role strain? First of all
15 is that recognized in your field of expertise and
16 what is it?

17 A Registered Nurses are able to diagnose the
18 human response to illness and injury. Nurses do
19 not provide medical diagnoses, we do not refer
20 patients for surgery, we do not prescribe
21 treatment, but as nurses we treat the patient's
22 human response to illness and injury and we do that
23 at bedside and we are the doctors' eyes and ears.

24 What we do as nurses, we provide care plans
25 at the bedside, we assist, diagnose, plan,

1 implement, identify outcomes, re-evaluate the
2 patient's response to our caregiving and then we
3 make, we hope that what we're doing is working
4 because of a positive outcome. So, nurses, that is
5 what nurses do, so what I just said was a diagnosis
6 and nursing diagnosis and it is in the life care
7 plan and it's caregiver role strain.

8 What that means is that Mrs. Green's social
9 life has been affected tremendously, she's given up
10 her friends and previous active life. I don't mean
11 she gave them up completely. What I mean is she is
12 not getting out of the house and getting with her
13 friends like she was.

14 Physically Mrs. Green is caring for her
15 husband, she's physically lifting him, washing him,
16 assisting him with meals, hygiene, eating, meal
17 prep, cleaning. So, this is a fulltime job.
18 Again, she's doing a great job but this is not what
19 she had planned on doing.

20 Q And you talked about catheterization to help
21 Mr. Green urinate. Do you have, do you have any
22 information of how many times each day Mrs. Green
23 has to do that?

24 A At least six times a day.

25 Q And is it safe for Mr. Green to do that?

1 A No.

2 Q Why not?

3 A Because Mr. Green is in a wheelchair, he has
4 upper body weakness and immobility, fine motor
5 skills are blurred and he has an enlarged prostate,
6 so when you are inserting a catheter it is very
7 difficult to bypass the prostate safely. He
8 actually uses a specialized catheter to do that but
9 it is very difficult for him to even hold the
10 catheter and get it in and get it out safely.

11 Q Can you, can you reuse those catheters or are
12 they just a one time use?

13 A These are one time use, they are disposable.

14 Q And does the life care plan consider, is that
15 part of the medical supplies that are necessary?

16 A Yes.

17 Q And is that in the life care plan?

18 A It is.

19 Q Now, are you saying that Mrs. Green has to
20 stay up all night every night to look after and
21 care for her husband?

22 A No, but Mrs. Green also is very vigilant, as
23 if women have children or if women have cousins
24 that are children or any children that are around,
25 you have to remain vigilant and I'm not saying Mr.

1 Neurologist would be three times evaluation
2 over his lifetime and it would be \$133.

3 Pulmonologist, two evaluations over his life,
4 at \$133.

5 Cardiologist would be two times over his
6 life, at \$133.

7 Orthopedic three times over his life, at
8 \$133.

9 Physical therapy is four evaluations over his
10 life at \$131. And occupational therapy evaluations
11 would be provided four times over his life.

12 Q What is occupational therapy, Nurse?

13 A Well, this is actually an evaluation for PT
14 and evaluation for OT. An evaluation by physical
15 therapists is a meet and greet, they review the
16 diagnoses, they assess the patients's functional
17 status and ability to perform everyday activities
18 otherwise known as activities of daily living,
19 maintaining hygiene, et cetera, getting dressed in
20 the morning, and that is occupational.

21 Physical would be is he physically strong
22 enough to do it and if he is not what modalities
23 can be implemented during physical therapy he is
24 receiving to increase that function.

25 Q You talked about activities of daily living.

1 What is that?

2 A It's the activities that we do day to day,
3 getting up in the morning, brush your teeth, get
4 dressed, or take a shower first, get dressed,
5 prepare your breakfast, feed yourself, put your
6 dishes in the sink, get in your car, off to work,
7 or doing whatever you're doing.

8 Q Is that really what the model of a life care
9 plan is, to address Mr. Green's ability to do the
10 activities of daily living?

11 A Yes.

12 Q All right. What are the some of the other
13 categories of items needed in the life care plan?

14 A Physical therapy sessions where he is
15 actually going and following up with the evaluation
16 as is set forth. Over his life time he has been
17 given 30 sessions. For occupational therapy
18 sessions he has been given 30 over his life.

19 Psychological counseling, he gets 20 sessions
20 over his life and that would be for when he's tired
21 of living with the disability and he is getting
22 down on himself, which he does, it is rare but he
23 does. The winter months are harder for him, he
24 can't get out in the garden, it is cold, the cold
25 affects his body, temperature, muscles, joints, he

1 hurts more.

2 Q It would limit him more in the winter months?

3 A In the winter months he might get in a more
4 depressive state. Also we have allotted 20, excuse
5 me, 10 sessions of psychological counseling for
6 Mrs. Green and/or her twin daughters or her son
7 and/or the two grandchildren.

8 Q Is this a family tragedy?

9 A Yes, obviously.

10 Q Okay.

11 A Diagnostics -- I didn't know how much, the
12 physical therapy sessions, each session is \$253,
13 each occupational therapy session is \$244,
14 psychological counseling, probably 30, 45 minutes,
15 is \$140, and family counseling is \$159 per session.

16 Diagnostics. There are quite a few. The
17 only diagnostics testing that are annually is the
18 urological studies and that would be to assess his
19 nerves in his bladder and his urether status,
20 prostate status and to assess urinary tract
21 infections and to prevent septic shock, and that
22 would be annually at \$71.

23 Other diagnostics are xrays of the spine five
24 times over his life at \$316.

25 MRI of the spine thoracic and lumbar spine,

1 five times at \$2,804..

2 The xrays of the upper extremities are three
3 times over his life, at \$134:

4 Nerve conduction studies are three times over
5 his life, at \$1,899 each.

6 The abdominal ultra sound is five times over
7 his life, that would be looking at his GI tract
8 inside his belly, that is \$510.

9 The MRI of the lateral hip two times over his
10 life, at \$3,244.

11 Ultra sound of the lower bilateral
12 extremities to look for blood clots is \$760, and
13 that is three times over his life.

14 And then lastly the bone scan, that is one
15 time over his life, at \$251. The bone scan is to
16 look for osteoperosis and bone loss.

17 Q Is that something that Mr. Green is at risk
18 for due to his condition?

19 A Anybody who is immobile and is not bearing
20 weight is losing bone minerals.

21 Q All right. And what are the other major
22 elements of the life care plan?

23 A I'm sorry, there is more. Lab work annually
24 and that is more, you know, your complete metabolic
25 panel, look at your electrolytes and blood,

1 Then we go into transportation, he needs a
2 proper vehicle, van that can transfer him safely
3 and his caregiver and providing, accomodating his
4 van over his life time is \$105,447.

5 So, what is left is his home and this is the
6 most important part of life care plans. This is,
7 he has life threatening symptoms and to prevent him
8 from experiencing life threatening illnesses and
9 responses to his injuries and preventing him from
10 getting to the ER and being hospitalized and
11 enduring life saving measures we need him to have
12 home attendant care in the form of certified nurse
13 assistants and/or Mrs. Green who has been trained
14 and I feel who's certainly been qualified and has
15 done a good job, because he's only had a couple ER
16 visits.

17 Q And over the lifetime of Mr. Green what is
18 the amounts required for the home healthcare?

19 A So, annually to have someone in the home
20 caring for his needs in the event the support
21 system which I believe, in the event that fails, in
22 order to prevent the life threatening responses to
23 this injury, it will require spending \$134,400 a
24 year to have someone in the house to care for him.

25 Now, having a CNA, certified nursing

1 And we also have an alarm system for the
2 house. That would be a one time fee at \$3,749.

3 The only other thing is, and this is the last
4 thing, a case manager would come into the house in
5 the event the support system fails, Mrs. Green, a
6 case manager would come in and coordinate,
7 facilitate, ensure the house is fitting and meeting
8 Mr. Green's needs to protect his life, and that
9 would be annually to pay a case manager to oversee
10 everything that we have discussed, all the elements
11 in the plan, is \$4,800 a year.

12 Q And I might have missed it but I didn't, I
13 didn't think I heard you, you gave a figure on the
14 amount necessary for home healthcare over the
15 expected life expectancy of Mr. Green?

16 A So, the attendant care service is \$15 an hour
17 and over the lifetime, annually, I guess, 24/7, 24
18 hours a day, seven days a week, that comes out to
19 annually \$134,400.

20 Q How about over his expected life expectancy?

21 A That comes out to, I'm reading my total here,
22 \$2,584,536.

23 Q And what is the total cost of the life care
24 plan over the life expectancy of Mr. Green, if you
25 have that there?

1 A Prior to Dr. Woods testifying, he's the
2 economist that will look at my numbers, that is,
3 the total lifetime cost is \$3,668,176.

4 MR. SAUTTER: Your Honor, that's all I have
5 of this witness.

6 THE COURT: Cross-examination.

7 MS. THOMAS: Thank you.

8 If it please the Court?

9 THE COURT: Yes, ma'am.

10 CROSS EXAMINATION BY MS. THOMAS:

11 Q Miss Lustig, when you first took the stand
12 and talked about this poster that we have here, it
13 contains a list of a lot of horrible things that
14 could happen to a person with the injuries that Mr.
15 Green has. Is that true?

16 A Sure, yes.

17 Q And in fact Mr. Green has lived with these
18 injuries for nine years now, hasn't he?

19 A Yes.

20 Q And thankfully all of these horrible things
21 have not happened to Mr. Green, have they?

22 A No, they haven't.

23 Q And in fact you used the big word and correct
24 me if I don't say it right, osteodysplasia, is that
25 right?

1 the son Mark testified earlier, I think he
2 described the van.

3 Q Certainly. They could certainly purchase
4 another new or used vehicle, couldn't they?

5 A Yes.

6 Q And in looking at your plan, you have
7 projected therapeutic modalities and projected
8 monies?

9 A To a reasonable degree of nursing certainty,
10 this is a foreseeable item in the future based on
11 the disability and diagnosis of Mr. Green.

12 Q It means a guess, doesn't it?

13 A I'm sorry?

14 Q It means a guess, doesn't it?

15 A No, this is not guesswork, this is all based
16 on science.

17 Q Excuse me, projected monies in the future,
18 doesn't it?

19 A Yes, to a reasonable degree of nursing
20 certainty based on my experience, training
21 knowledge, education, skill, medical foundation
22 found in the records, treating providers, my
23 assessment as a Registered Nurse of Mr. Green.

24 Q But projected also means it may not come to
25 past?

1 A Projected in this plan is to a reasonable
2 degree of nursing certainty, greater than 50
3 percent it's going to happen, probable.

4 Q In every case, in every patient or patients
5 that has the injuries Mr. Green has?

6 A I'm not here to testify about another
7 patient, I'm here to testify what Mr. Green needs
8 to a reasonable degree of medical certainty as
9 provided in this plan.

10 Q Let's talk about another section of your plan
11 called diagnostics. I think you went through every
12 item in that list and those include things such as
13 xrays, MRI, ultrasound. Nurse Lustig, these are
14 all things that have to be ordered by a doctor,
15 correct?

16 A Yes. Nurses do not prescribe diagnostics,
17 medication, surgery, we provide nursing diagnoses.

18 Q So, in order for him to need these things a
19 doctor is going to have to say at some point in the
20 future that he needs to have these studies done,
21 correct?

22 A Ultimately the doctors make that decision.

23 Q And in the medical records that you have
24 reviewed so far no doctor has said he needs all
25 these things to happen?

1 A No doctor in medical notes that I have ever
2 seen in my experience, I have read thousands and
3 thousands of medical records, do physicians ever
4 say this patient will need an x-ray every three
5 years for the rest of their life. The time that a
6 physician says that is when a Registered Nurse like
7 myself or a rehab consultant with the
8 certifications and licenses that we hold, we
9 collaborate with treatment providers based on the
10 medical foundation in the record and based on
11 assessing the patient, then we collaborate with
12 that medical provider to project life long care.
13 That is life care planning, doctors don't do life
14 care planning.

15 Q But we do have nine years of medical records,
16 we know what he has had, don't we?

17 A Yes.

18 Q And the same goes for the section of your
19 plan called lab work. There again, nurses don't
20 order lab work, do they?

21 A Right. As I said before, we do not order or
22 prescribe diagnostics, surgeries or medication.

23 Q Or surgery?

24 A Or surgery. I may have said that.

25 Q So, there again, whether or not that is

1 needed in the future will depend on the doctor

2 saying that he needs the particular lab work?

3 A Ultimately a physician makes that decision.

4 Q And the same is true for medications, is it

5 not?

6 A Yes, same answer.

7 Q So, actually this plan is very fluid, isn't

8 it?

9 A I don't know what you mean. It is a dynamic
10 evolving document and right now as it sits the life

11 care plan is being implemented and it is to a

12 reasonable degree of medical, I mean nursing

13 certainty.

14 Q But I believe you stated earlier that some

15 things may be necessary, some things may not be

16 necessary in the future, is that true?

17 A No. I believe that everything in this life

18 care plan is foreseeable based on his disability

19 and diagnosis, and his life care plan was drafted

20 after collaborating with his providers.

21 Q Miss Lustig, you put in this plan every

22 potential bad thing that can happen to Mr. Green,

23 certainly we all hope it does not, but that is what

24 you did when you drafted this plan, isn't that

25 correct?

1 A I'm sorry, you're talking about Mrs. Green?

2 Q Mr. Green?

3 A Could you repeat the question?

4 Q Certainly. In formulating this life care
5 plan you have put in and assigned a value to
6 potentially every bad thing medically that can
7 happen to Mr. Green, haven't you?

8 A No. I really don't understand your question.
9 These are medical items. I'm not projectng bad
10 things that will happen, I'm projectng a plan that
11 if implemented it will prevent complications, so I
12 may just be misunderstanding your question. The
13 life care plan doesn't have some items in this
14 plan, this plan is a conservative plan, in my
15 opinion. I don't think, there are not even
16 hospitalizations in this plan for Mr. Green, so I
17 did not project every bad thing that can happen,
18 because I believe any hospitalization is bad unless
19 you're having a healthy baby in a hospital, but I
20 didn't project hospitalizations for Mr. Green and I
21 consider that bad.

22 Q Now, certainly no physician has stated that
23 Mr. Green needs a live in provider such as a CNA,
24 have they?

25 A Actually they have.

1 Q Does he have a live in provider?
2 A No -- well, actually he does, Mrs. Green.
3 Q Correct.
4 A Yes.
5 Q A professional CNA, no doctor has prescribed
6 that?
7 A They have but currently Mrs. Green provides
8 that care 24 hours a day, seven days a week.
9 Q Which medical provider has prescribed for Mr.
10 Green a live in provider?
11 A I believe Dr. Garner, his primary care
12 provider.
13 Q Is that according to medical records that you
14 have reviewed?
15 A Yes.
16 Q And certainly no one has prescribed a case
17 manager, have they?
18 A No.
19 MS. THOMAS: Thank you.
20 THE WITNESS: Thank you.
21 THE COURT: Redirect?
22 MR. SAUTTER: No questions, Your Honor.
23 THE COURT: You may step down, ma'am.
24 Do you wish this witness to be excused?
25 MR. SAUTTER: We do, Your Honor.

1 DR. OLIVER G. WOOD, JR.,
2 after being first duly sworn, testified as follows:

3 THE CLERK: Be seated, state your name for
4 the Court, spell your last name.

5 THE WITNESS: Oliver G. Wood, Jr., W-o-o-d.

6 DIRECT EXAMINATION BY MR. SAUTTER:

7 Q Dr. Wood, where do you live?

8 A Columbia.

9 Q And where are you from originally?

10 A I grew up in Greer, South Carolina.

11 Q And how long did you live there?

12 A Eighteen years.

13 Q Please describe your educational background
14 for the jury.

15 A I have a Bachelor of Science Degree in
16 Business Administration from the University of
17 South Carolina, a Master's Degree in Economics from
18 the University of South Carolina, and a Doctorate
19 in Economics from the University of Florida.

20 Q Please describe your professional background.

21 A I was hired by the University of South
22 Carolina in 1965 to teach economics and banking and
23 finance courses and I taught at the University for
24 29 years. I'm now Distinguished Professor
25 Emeritus. Translated, that means I'm retired from

1 MR. SAUTTER: Thank you.

2 BY MR. SAUTTER:

3 Q Dr. Wood, were you asked to do a study on
4 economic loss in this case?

5 A Yes.

6 Q What facts have you used?

7 A All right. In the case of Mr. Green, he was
8 born on March 11th, 1950, he was injured on April
9 17th, 2004. At that time his age was 54.11.
10 According to the South Carolina Code Section
11 19-1-150 the average life expectancy for a male
12 that age is average additional 25.65 years. That
13 would have carried him to his age 79.76?

14 According to Mr. Green, before he was injured
15 he had no reason to expect less than a normal life
16 expectancy. According to Mr. Green, he intended to
17 work until age 70. According to Mr. Green, at the
18 time of his injury he owned and operated Randall
19 Green Land and Timber and was a junior partner in
20 Marion Wood Products. According to Mr. Green he
21 estimated that at the time of his injury his income
22 net of expenses was approximately \$30,000 per year.
23 According to Mr. Green, after his injury he did not
24 return to work. I have assumed this estimate that
25 he provided, 30,000, is a reasonable estimate of

1 his earning capacity. I have assumed that he is
2 unemployable in the competitive labor market.

3 Before he was injured Mr. Green performed an
4 average of ten hours a week of family services
5 around his home. This included such things as
6 cooking, washing dishes, vacuuming, grocery
7 shopping, auto care and lawn and yard care.
8 According to Mr. Green, since his injury he has
9 been unable to do any of these chores. I valued
10 those at \$8.00 per hour.

11 Lastly, Miss Peggy Nielson, Registered Nurse
12 and Certified Life Care Planner, prepared a life
13 care plan and Miss Sarah Lustig who just testified,
14 is that correct, Certified Life Care Planner,
15 reviewed this plan for Mr. Green.

16 And those are the facts that I took into
17 account.

18 Q Dr. Wood, based upon those facts do you have
19 an opinion based upon a reasonable economic
20 certainty as to the past and future economic loss
21 to Mr. Green in this case?

22 A Yes.

23 Q And have you prepared any charts to
24 illustrate loss?

25 A Yes..

1 MR. SAUTTER: Your Honor, I would request
2 that Mr. Green come down here.

3 THE COURT: Mr. Wood?

4 MR. SAUTTER: I'm sorry, Dr. Wood. Would you
5 go through your chart?

6 THE WITNESS: Thank you.

7 THE COURT: All right. Do you need him to
8 come down and go through those?

9 MR. SAUTTER: Yes, sir, Your Honor.

10 THE COURT: All right. Have you got a board
11 or something?

12 MR. SAUTTER: Yes, sir.

13 THE COURT: Very good, go ahead and do that.

14 MR. SAUTTER: Your Honor, I have just handed
15 the court reporter a copy of his charts and a copy
16 has also been provided to Mr. McCutcheon.

17 THE COURT: All right, very good.

18 BY MR. SAUTTER:

19 Q Can everyone see these charts?

20 A This first chart looks at the before trial
21 loss and this a period of April 18th, '04, through
22 September 10th, 2013, a period of 9.39 years. In
23 terms of cases this is one of the longest periods I
24 have ever had from date of injury to time of trial.
25 The first step is to look at Mr. Green's

1 earning capacity. That is his ability to earn in a
2 competitive labor market. I'm relying in this case
3 upon Mr. Green who says he was earning
4 approximately \$30,000 per year. Over that period
5 of time he would have earned \$281,700.

6 The second part is to look at the services he
7 provided around the home. He said he provided ten
8 hours a week. I valued those in the last few years
9 at \$8.00 per hour. In the earlier years going back
10 to 2005 I used \$7.00. This is my estimate of what
11 is a minimum amount you would have to pay somebody
12 to do chores around your house. Federal minimum
13 wage is \$7.25 an hour, I used \$8.00 an hour. So,
14 the cost to replace those services is \$35,710, and
15 that makes a total estimate to date of \$317,410.

16 Chart number two looks at the estimate of his
17 earning capacity for the rest of his work life to
18 age 70. That is a period of six and a half years.
19 Over this period of time he would have earned
20 \$208,989. However, our court system requires that
21 you have to look at money flows now but that money
22 flows were not going to occur for the future they
23 must be discounted to present cash value. When you
24 discount his earning capacity that total is
25 \$174,183.

1 case. It is in evidence over the objection of the
2 defendant.

3 Thank you very much.

4 (Charts marked and received in evidence
5 as Plaintiff's Exhibit Number 15).

6 MR. SAUTTER: Thank you, Your Honor.

7 Dr. Wood, that is all the questions I have.

8 THE COURT: Cross-examination.

9 MS. THOMAS: Yes, Your Honor.

10 CROSS EXAMINATION BY MS. THOMAS:

11 Q Just a few questions for you, Dr. Wood. In
12 going through your chart you told us how you
13 arrived at the various components that you included
14 in the economic damages, and the first section that
15 you went over was the loss of earning capacity?

16 A Correct.

17 Q And there are things we can look at to get
18 those numbers, we can certainly look at Mr. Green's
19 past tax returns?

20 A It's possible, yes.

21 Q And we can also look at the average earnings
22 for someone in the industry that he worked in,
23 could we not?

24 A We could.

25 Q Did you do either of those things in arriving

1 standard of care for Dr. Bauerle, nothing like
2 that?

3 A No.

4 MS. THOMAS: That's all the questions I have.

5 THE COURT: Thank you. Any redirect?

6 MR. SAUTTER: Very briefly, Your Honor.

7 THE COURT: Yes, sir.

8 REDIRECT EXAMINATION BY MR. SAUTTER:

9 Q Dr. Wood, counsel asked you about what your
10 figures included and I just want to make this
11 clear. Did the figures you provided the jury
12 include anything for past medical care costs?

13 A No.

14 Q For loss of enjoyment of life?

15 A No.

16 Q For the loss of consortium claim of Mrs.
17 Green?

18 A No.

19 Q Anything at all for pain and suffering of Mr.
20 Green?

21 A No.

22 MR. SAUTTER: No further questions, Your
23 Honor.

24 THE COURT: All right. Anything on those
25 questions, ma'am?

1 MS. THOMAS: No, Your Honor.
2 THE COURT: All right. Do you wish the
3 witness to be excused?
4 MR. SAUTTER: Yes, Your Honor, I would ask he
5 be excused.
6 THE COURT: Any objection?
7 MR. McCUTCHEON: No, sir.
8 THE COURT: All right, sir, you are released
9 from your subpoena to go back to your regular
10 duties, sir.
11 THE WITNESS: Thank you.
12 (Witness excused).
13 THE COURT: All right, gentlemen, your next
14 witness, please.
15 MR. MARTIN: The Court's indulgence for one
16 moment, please.
17 THE COURT: Yes, sir.
18 MR. MARTIN: Could we approach just one
19 second?
20 THE COURT: Certainly.
21 (Unrecorded bench conference).
22 THE COURT: We're going to have another
23 deposition?
24 MR. QUERY: Yes, Your Honor.
25 MR. MARTIN: Who might that be?

1 MR. QUERY: Dr. James Garner, Your Honor.

2 THE COURT: All right. Do you have the
3 original of that?

4 MR. QUERY: I do, Your Honor.

5 THE COURT: Hand it up.

6 Who is going to read that, please?

7 MR. QUERY: Miss Hurt is going to read it,
8 Your Honor.

9 THE COURT: All right. She can use the
10 original.

11 MR. McCUTCHEON: That's fine.

12 MR. QUERY: Thank you, Your Honor.

13 THE COURT: All right, go ahead, sir.

14 MR. QUERY: Your Honor, the plaintiff calls
15 Dr. James S. Garner, IV, by deposition. The
16 deposition was taken on August 14th, 2013, 11:06
17 a.m., at the McLeod Family Practice in Mullins,
18 South Carolina.

19 THE COURT: All right. Ladies and gentlemen,
20 the same thing I have told you about all the other
21 depositions obviously apply to this one also, the
22 recorded testimony of Dr. Garner under oath.

23 You may proceed.

24 (The deposition of Dr. James Garner was read
25 to the jury).

1 ANN GREEN,

2 after being first duly sworn, testified as follows:

3 THE CLERK: Have a seat, state your name,
4 spell your last name.

5 THE WITNESS: Ann Green, G-r-e-e-n.

6 DIRECT EXAMINATION BY MR. MARTIN:

7 Q All right, Ann, you're the wife of Randy
8 Green, right?

9 A Yes, sir.

10 Q And you live where?

11 A 287 Bubba Road, Marion.

12 Q Marion, South Carolina, and let me ask you
13 before I forget, there has been some testimony you
14 are not in a neighborhood but if you would,
15 describe for the jury where your house is located
16 with regard to neighbors and roads and things of
17 that sort.

18 A Well, we're on a dirt road, we're a quarter
19 of a mile from the main Highway 76.

20 Q Do you have any immediate neighbors?

21 A At the top of the hill, a quarter of a mile.

22 Q A quarter of a mile away?

23 A Yes.

24 Q How about past your house?

25 A Past the house is two or three miles.

1 guess?

2 A Yes, sir.

3 Q But, you know, do you have an option on what
4 you do or how you do it?

5 A Well, we visited family, I was very active
6 with my family, mostly over in Florence, we always
7 had something going on, and now I'm home, I can't
8 go far, I don't go far, time is my enemy now.

9 Q Say that again?

10 A Time is my enemy.

11 Q How do you mean that?

12 A I'm on a schedule, I can't leave him too
13 long.

14 Q All right. I understand that. And with that
15 in mind, I want to talk with you about a typical
16 day that you have now.

17 MR. MARTIN: Your Honor, may she step down
18 from the witness stand?

19 THE COURT: Certainly.

20 MR. MARTIN: And talk a bit?

21 Ann, if you would, come down.

22 THE COURT: If you would, make sure she gets
23 right next to that box over there so that we can
24 hear. Maybe move that a little closer to the jury
25 box.

1 he is occupying himself?

2 A Washing dishes, cleaning.

3 Q So you've got him, it's about 9:00 o'clock,
4 on the bed now?

5 A Well, a lot of times he's still awake, he
6 reads a lot, so supper is over, I can get my shower
7 and I come in, if I make it that long, 9:00 or
8 9:30, "Do you need anything else," and I set the
9 alarm for 11:30. If I'm not watching TV I'm passed
10 out.

11 So, 11:30 the clock goes off, I go back in,
12 cath again and then about 15 after, 20 after 12:00
13 I go back in, we don't do the legs but we check the
14 bowel and I clean him up and I give him medicine.
15 I forgot all about the medicine. He gets his last
16 pills for the day, I go back in the kitchen, fix
17 his drink, he usually gets a drink, and peanut
18 butter is the midnight snack. I take that and take
19 it to him and it's usually about 1:00 o'clock by
20 now, 1:00 or 1:20, I'm through, "Night, night," and
21 I go back to bed until the alarm goes off at 6:00.

22 Q Where do you sleep?

23 A About five steps down the hall.

24 Q So, it is in another bedroom in your home?

25 A Yes, sir. He's in a hospital bed, manual,

1 to go.

2 One thing I wanted to ask you, the
3 catheterization, you keep saying you have to cath
4 him. That has to happen, I believe you said five
5 or six times a day usually?

6 A Yes, sir.

7 Q And your understanding of why that's
8 important is what?

9 A If he does not, it is pure and simple, he
10 dies. Everything builds up, it's called AD, he
11 gets night sweats, which we would call them, but it
12 would be different, blurred vision. It's real,
13 pure and simple, it's real. If he does not get
14 cathed, if his bowels cannot move he dies.

15 Q And it's your responsibility to do the caths?

16 A Yes.

17 Q Does anybody do it but you for him?

18 A No, sir.

19 Q Other than the time when he might have been
20 in the hospital during this period of time, when
21 they would have done it, has anybody cathed him
22 besides you?

23 A No, sir.

24 Q And that process, without you having to get
25 too graphic, I know they have these throw away

1 bed. When he's in the bed I keep a medical pad
2 under him just in case. He hasn't really had
3 accidents but he's paranoid, so it is not a
4 pressure pad but a washable hospital pad under him,
5 okay, so when we do the bowel, the cathing, we use
6 the puppy pad which we can throw away and that
7 helps.

8 Q And you stimulate the bowels on the bed?

9 A Yes, sir.

10 Q With the puppy pad under him?

11 A Yes, sir, after I do the legs.

12 Q The leg exercises?

13 A Yes, sir.

14 Q You exercise the legs?

15 A That helps.

16 Q That helps with the bowel movement?

17 A Yes, sir.

18 Q Of course that is triggered when you take
19 your finger and insert it into his rectum to jiggle
20 it around and stimulate the bowels?

21 A Uh-huh (Affirmative).

22 Q And then when that occurs you throw that out
23 and you're good to go for awhile?

24 A Yes.

25 Q Is there, one thing I wanted to ask you, is

- 1 there an emergency room exit from Randy's room?
- 2 A No, sir. Just the doorway to get out of the
- 3 room.
- 4 Q Okay. Let me go back and make sure I cover
- 5 with you, Ann, one of the claims that we have here
- 6 for Randy is his loss of maintenance around the
- 7 house. I think you commented earlier on the things
- 8 that Randy would do around the house but if you
- 9 would very quickly do that for me again. Before he
- 10 became paralyzed what things would he do around the
- 11 house to help with the house?
- 12 A All the gardening, all the yard work. I do
- 13 my flowers but he would do all the gardening,
- 14 grass.
- 15 Q Take out the trash sometimes?
- 16 A Oh, yes, and --
- 17 Q Wash the dishes once in awhile?
- 18 A Once in awhile. Like I said --
- 19 Q Repair things around the house?
- 20 A Repair.
- 21 Q Change lightbulbs?
- 22 A It got repaired. Jack of all trades, I call
- 23 him.
- 24 Q I got you.
- 25 A He can do it all.

1 Q And let me talk a minute with you about
2 yourself and obviously the loss of consortium
3 claim, if you would, and I know all this is
4 difficult for you but if you would, kind of explain
5 to the jury how his paralysis has changed the
6 relationship that you and Randy enjoyed from your
7 marriage before in any facets that it has changed?

8 A My babies are in court but I will say it
9 anyway. We were very happy, I was very satisfied.

10 Q You and Randy had a good sexual relationship?

11 A Yes, sir.

12 Q In addition to that, did you and -- well, let
13 me just ask you what I guess is obvious. Do you
14 have that relationship since his paraplegia?

15 A No, sir.

16 Q How about other than that, your sleeping
17 arrangements, how has that changed?

18 A I'm in one room and he's in the other.

19 Q Do you get to hold him anymore?

20 A No, sir.

21 Q Can he help you around the house anymore?

22 A Not a lot. He does what he can. He's in the
23 yard and he takes a weedeater and in the winter
24 time he picks up pine cones and drags the little
25 cart behind him. He's not an inside person, never

1 was. He does not sit around watching TV.
2 Q Does he try to do what he can now?
3 A Yes, sir.
4 Q There are many things he can't do that he
5 could before?
6 A Yes, sir.
7 A Yes. My son and I came home with our
8 injuries and he should have, too, he had a hurt hip
9 and hand. At least he could walk, I have no doubt
10 in my mind.
11 Q You were in the same accident, right?
12 A Yes, sir.
13 Q Have you had any trouble walking since then?
14 A No, sir.
15 Q Any damage to your spinal cord that you're
16 aware of?
17 A No, sir.
18 Q Tell me, though, about now, in the years
19 following, how in your opinion in any manner has
20 this affected your health, both physical and
21 mental?
22 A I'm tired. I try to stay healthy, try to
23 stay, I have three great kids and they keep me
24 grounded and they come and we have a good time. I
25 don't have time for pity, I don't have the luxury.

1 You do what you have to do. He's a good person, a
2 good father and that's the bottom line. He would
3 do the same for me and I will do it until I die and
4 that's all I want for him, is to make sure he's
5 taken care of because when you say I do you don't
6 say I'll do this, I'm not going to do this. You do
7 it, and it is my turn to take care of him. He has
8 taken care of me all these years, it's my turn and
9 I will do it until I can't.

10 MR. MARTIN: That's all the questions I have
11 for this witness.

12 THE COURT: Cross-examination.

13 MR. McCUTCHEON: We have no questions, Your
14 Honor.

15 THE WITNESS: Thank you.

16 THE COURT: All right, you may step down.
17 Thank you.

18 (Witness excused).

19 THE COURT: All right. Mr. Martin, the next
20 witness, please, sir.

21 MR. McCUTCHEON: Your Honor, before you do
22 that, if we can approach?

23 THE COURT: Certainly.

24 (Unrecorded bench conference).

25 THE COURT: All right, ladies and gentlemen,

1 DR. RICHARD MATZA,

2 after being first duly sworn, testified as follows:

3 THE CLERK: Please have a seat. State your
4 name for the Court, spell your last name.

5 THE WITNESS: Richard Matza, M-a-t-z-a.

6 THE COURT: Go ahead.

7 DIRECT EXAMINATION BY MR. QUERY:

8 Q Good morning, Dr. Matza.

9 A Good morning, sir.

10 Q Dr. Matza, tell us where you're from.

11 A I'm from Connecticut.

12 Q Dr. Matza, could you tell us about your
13 education and your work background?

14 A Certainly. I originally came from New York
15 and went to college in Maryland. After that I went
16 to Georgetown University School of Medicine,
17 graduated there and did a post medical school
18 training as an MD, one year general surgical
19 residency in Boston, and following that one year I
20 did one year of general surgery residency.

21 Following that I did an orthopedic residency. I
22 spent roughly a year at Baptist Hospital in Boston
23 and did hands training in Baptist Hospital after my
24 orthopedic training was complete.

25 Subsequent to that I came to Connecticut to

1 opinions to a reasonable degree of medical
2 certainty?

3 A Yes, sir.

4 Q And will you offer those opinions by the
5 standard that it is more probable than not?

6 A Yes, sir.

7 Q And can you assure me that you will be
8 careful each opinion is restricted in that manner?

9 A Yes, I can.

10 Q Doctor, based upon your review of the medical
11 records and the deposition testimony that you have
12 described, based upon that review do you have
13 opinions as to the standard of care for orthopedic
14 surgeons and any breaches of that standard of care
15 by Dr. Bauerle --

16 A Yes, I do.

17 Q -- in this case with regard to his treatment
18 of Mr. Randall Green?

19 A Yes, I do.

20 Q And what are those opinions, Doctor?

21 A The treatment rendered by Dr. Bauerle, he was
22 brought in as an orthopedic surgeon because of
23 fracture/dislocation of the right hip in Randall
24 Green and originally he didn't know about the
25 dislocation, he thought it was just fractured and

1 subsequent found out that it was also dislocated.
2 The hip which was reduced by the emergency room
3 doctor, Dr. Lintz, was taken care of in a timely
4 fashion, not really under the direction of Dr.
5 Bauerle, but he wasn't involved with the reduction.

6 When Dr. Bauerle first saw the patient was
7 when the patient had been in the pre-operative area
8 in the operating room and the reason he was in the
9 pre-operative area of the operating room was
10 because he sustained a rather significant
11 laceration to the right upper extremity and it was
12 of the forearm of that extremity and so severe that
13 it cut two of the vital arteries that go to the
14 hand.

15 From the time of the incident, which was at
16 11:31 in the morning, until he got to the operating
17 room, which was about 2:00 o'clock in the
18 afternoon, he had been bleeding from that arm and
19 there were, there was documentation of low blood
20 pressure even at the original time he came to the
21 emergency room, and Dr. Bauerle came to the
22 operating room, pre-operative area, met the
23 patient, with the patient and demanded that the
24 patient be CAT scanned a second time.

25 A CAT scan was performed of the hip the first

1 time but it was not done subsequent to the closed
2 reduction of the hip. I believe Dr. Bauerle wanted
3 to get another CAT scan to see if there were
4 fragments in the hip joint itself and to evaluate
5 it further in case any other surgery had to be
6 done. He really didn't confer with any of the
7 treating physicians, Dr. Cozart who was the plastic
8 surgeon or other doctors that were involved, Dr.
9 Nicholson specifically, to discuss whether it was
10 prudent to have the patient leave the operating
11 arena and go to the CAT scan room which was not
12 very far away but still would take him away from
13 the monitoring that could be done of his vital
14 signs in the operating room.

15 And Dr. Bauerle ordered that the patient be
16 transferred to the CAT scan machine to get that CAT
17 scan done on his own and it was done. It is my
18 opinion the patient then came back to the operating
19 room some 15 minutes later, it seems like a short
20 period of time but in medicine, over the 35 years I
21 have been practicing there are critical moments in
22 everything we do and this happens to be one of
23 them.

24 The patient came back, was not monitored as
25 far as vital signs were concerned in the CAT scan

1 room and was under some duress respiratory wise in
2 the CAT scan room. The CAT scan was done and he
3 was rushed back to the emergency room, not back to
4 the operating room, pre-operative area.

5 He arrived at the emergency room, the patient
6 who was compensating for his blood loss up until
7 that period of time decompensated and what was
8 called crashed in trauma business, which means his
9 blood pressure gave out and he arrested, which
10 means his heart stopped.

11 At the time that he first came in his blood
12 pressure was 90 over 63, that was in the emergency
13 room about a half hour after the accident. And at
14 that time the first blood count that was taken was
15 41, which was pretty normal for somebody this age,
16 hematic count.

17 When he came back from the CAT scan to the
18 emergency room where he then crashed his hemoglobin
19 was then retaken, blood pressure was zero, went
20 down to zero, his pulse went down to zero, he
21 actually suffocated and his blood count at that
22 point in time was went down from 41 to 17, that was
23 a period of about two and a half hours, roughly two
24 and a half hours after the accident, the hematicrat
25 went from 41.9 down to 17. Every three metric

1 points is a unit of blood, so if you take that
2 difference of 24 points you're talking about eight
3 units of blood that was lost. That is a sizeable
4 amount of blood. So, that was the cause, the
5 direct cause for his decompensation, crashing,
6 arresting and the need to be resussitated.

7 Now, back to your question, the question was
8 was there a breach of the standard of care. We as
9 orthopedic surgeons through our training, as I
10 mentioned before, go through medical school and in
11 that training you are taught to take care of the
12 whole patient, no special kinds of training, and
13 that includes working people up, their vital signs
14 and different type injuries such as the multiple
15 trauma this was, and we're taught that the vital
16 signs have to be stable before you do any
17 procedures on people.

18 When you go through residency programs like I
19 did my first year of general surgery, internship
20 and then general surgery residency you're taught
21 that you don't perform procedures on people that
22 aren't stable and you need to stabilize them first
23 in a reasonable amount of time before going ahead
24 and doing any kind of elective or definitive
25 treatment. That was not done in this case.

1 It is my opinion to this Court that Dr.
2 Bauerle was not, was not in the standard of care in
3 ordering this patient to go from the pre-op area to
4 the CAT scan without knowing what his vital signs
5 were doing, knowing for sure, communicating with
6 the other doctors that were taking care of him to
7 see if he was stable, and in ordering that CAT scan
8 usurped the powers of Dr. Cozart who wanted to stop
9 the bleeding and treat the patient for the blood
10 loss. So, that is the standard of care that was
11 breached by Dr. Bauerle.

12 Q And, Doctor, if I understand correctly, is it
13 the fact that that interrupted that treatment
14 sequence or delayed the repair of the arm?

15 A Yes. It did two things. It put the patient
16 in jeopardy of not being monitored, his vital signs
17 not being monitored while he was in transit to the
18 CAT scan room and while he was in the CAT scan room
19 and in transit on the way back, so you really had
20 no way of controlling his vital signs. And it
21 certainly did cause a delay in stopping the
22 bleeding that was continuous since the injury
23 because he was in CAT scan instead of being in the
24 operating room where he could be monitored and
25 where it could be repaired, the bleeding could be

1 stopped.

2 Q Doctor, in your review of the materials that
3 you described, did you see in those materials
4 whether or not Dr. Bauerle acquainted himself with
5 the vital signs of this patient when he saw him in
6 pre-op?

7 A It is my understanding from the review of Dr.
8 Bauerle's deposition in which he said he did not
9 review or wasn't cognizant of the vital signs at
10 that time and the review of the other records,
11 there was no documentation that he was cognizant or
12 aware of what the exact vital signs were at the
13 time.

14 Q And do you have an opinion as to whether or
15 not that is a departure from the standard of care?

16 A Yes, I do.

17 Q And what is that opinion?

18 A That opinion is, as I stated before, that the
19 ordering of the CAT scan without knowing what the
20 vital signs were or the stability of the patient is
21 a breach of the standard of care.

22 Q And do you have an opinion to a reasonable
23 degree of medical certainty, Dr. Matza, as to
24 whether or not that delay in the sequence of
25 treatment was a direct or proximate cause of Mr.

1 Green's paraplegia?

2 A I do.

3 Q And what is that opinion?

4 A I have reviewed two depositions of experts in
5 this field and concur with their findings and
6 opinions. That is Dr. Chariker and Dr. Cranberg,
7 Dr. Cranberg being a neurologist and Chariker a
8 surgical expert, and in their depositions which I
9 recently reviewed they both opine that the delay of
10 treatment of the bleeding which led to the arrest,
11 which led to a zero blood pressure for a period of
12 time, at least a half hour to 40 minutes, led to
13 decreased blood flow or no blood flow to the
14 arteries in the spine and it is through the lack of
15 blood supply to the spine that the ultimate injury
16 to the spine occurred between the mid thoracic
17 region of T6 to T12, somewhere in that area where
18 the artery resides and directly led to the
19 paraplegia or the paralysis of both Mr. Green's
20 lower extremities and I concur with those opinions.

21 Q Doctor, I want to ask you if you would -- may
22 I approach?

23 A Yes, sir.

24 Q I'm going to

25 bring it over there rather than have you come to

1 the jury box, if that works okay.

2 THE COURT: You all make sure you move the
3 microphone over, please. Speak up so everybody can
4 hear you.

5 A Okay.

6 THE COURT: Thank you.

7 BY MR. QUERY:

8 Q Tell us what we're looking at here, Dr.
9 Matza.

10 A This is a model of a human spine, including
11 spinal cord and nerve endings that go in the base
12 of the skull, down to and including the pelvis.

13 Q And could you show us, Dr. Matza, what area
14 we're talking about where the death of the spinal
15 cord occurred in Mr. Green?

16 A Yes, I can. This is the cervical area, this
17 is the thoracic area going from T7 down to, or T1
18 down to T12. Then the lumbar region down here.
19 The artery resides between T6 and T12, which is the
20 region where my hand is.

21 Q And the area that you described from I
22 believe T6, down to L1 or L2, show us where that is
23 on that.

24 A L5, 4, 3, 2, 1, T12, 11, 10, 9, 8, 7, 6, so
25 that is T6, T12.

1 Q And it is through that entire area, according
2 to the medical records, that his spinal cord died?

3 A That's correct, that's where the injury
4 occurred.

5 Q Doctor, is there a medical term for that
6 tissue death or death of cells as a result of
7 blood, lack of blood?

8 A I don't know what term you're looking at.
9 Necrosis is what occurs, which is death of tissue.

10 Q What is an infarct?

11 A An infarct is where the blood supply is cut
12 off from a tissue and the tissue then dies, that is
13 the act, that is what it is called.

14 MR. QUERY: Beg your indulgence for a moment,
15 Your Honor.

16 Thank you, Doctor. Please answer any
17 questions counsel may have.

18 MR. McCUTCHEON: May it please the Court.

19 THE COURT: Cross-examination.

20 CROSS EXAMINATION BY MR. McCUTCHEON:

21 Q Doctor, so I don't get it wrong, would you
22 pronounce your last name for me one more time?

23 A My name is Matza.

24 Q Matza?

25 A Matza.

- 1 Q Now, what do you charge for coming down to
2 Horry County and testifying in this courtroom?
3 A \$12,500 for testimony.
4 Q Per day?
5 A That's for the whole event.
6 Q The whole event?
7 A That's correct.
8 Q \$12,500?
9 A That's correct.
10 Q Plus expenses?
11 A Yes, sir.
12 Q And then as I understand, Doctor, you correct
13 me if I'm wrong, but based upon a reading of the
14 medical records, Dr. Lintz then had a conversation
15 with the radiologist after the initial call to Dr.
16 Bauerle. Is that your understanding?
17 A Yes.
18 Q And at that time he informed Dr. Bauerle that
19 not only did he have an acetabulum fracture, but he
20 also had a dislocated hip. Would you agree with
21 that?
22 A Yes, sir.
23 Q Would you also agree, Doctor, in the
24 orthopedic surgery field a dislocated hip is an
25 orthopedic emergency?

- 1 A Yes.
- 2 Q And why is it an orthopedic emergency?
- 3 A When you dislocate your hip it tears blood
4 vessels that nourish the head of the femur and also
5 the bag or capsule that surrounds and supports the
6 hip joint and when that is out of place for a
7 period of six hours, that is, dislocated, not in
8 place for six hours, then the degrees of what we
9 call of death of the bone, vascular necrosis of the
10 bone goes way up, so that makes it kind of an
11 emergency to get that hip back in place.
- 12 Q All right, sir. And that means it needs to
13 be fixed?
- 14 A Needs to be reduced.
- 15 Q Needs to be reduced and according to your
16 review of the records it was reduced not by Dr.
17 Bauerle, but by Dr. Lintz. Is that correct?
- 18 A Yes, sir.
- 19 Q All right. And was it satisfactorily reduced
20 or do you know?
- 21 A I don't know. I don't know.
- 22 Q Okay.
- 23 A He didn't know at that time.
- 24 Q Does the standard of care also require, Dr.
25 Matza, that in addition to reducing that fracture

1 you need to take a CAT scan to make sure that it is
2 properly reduced?

3 A No, that is not the standard.

4 Q That is not standard care?

5 A No, sir.

6 Q That is not the standard of care where you
7 come from?

8 A Anywhere for orthopedics.

9 Q Anywhere, even down here?

10 A Even down here.

11 Q Well, suppose, Doctor, that there are bone
12 fragments in the socket when it is reduced and you
13 don't know about that. How are you going to find
14 that out if you don't do a CT scan?

15 A Well, we are talking, your first statement
16 was is it the standard of care to do a CAT scan to
17 see if a dislocated hip is reduced. And the answer
18 is no. Is the standard of care to do a CAT scan if
19 a fractured dislocation of the hip is reduced, to
20 ensure there are no fragments, the answer is yes.
21 So, I answered your question correctly the first
22 time.

23 Q This guy had a fracture/dislocation?

24 A I understand but you didn't say that. You
25 just said dislocation.

1 Q I thank you for correcting me. Let me say it
2 the right way. In a case where you have a
3 fracture/dislocation of the hip does not the
4 standard of care require that you get a CT scan to
5 make sure, number one, it is reduced and to make
6 sure that there are no fragments in the socket?

7 A Yes, that there are no fragments in the
8 socket, yes.

9 Q And that is what Dr. Bauerle was doing, was
10 he not?

11 A Yes.

12 Q He was getting a CAT scan to make those
13 determinations according to what the standard of
14 care requires, is that correct?

15 A That's correct.

16 Q All right. But it's your opinion in this
17 case that it wasn't necessary that he do that until
18 the man's arm got fixed?

19 A That's correct.

20 Q Okay. Which means that not only is this guy
21 going to have to go to surgery to get his arm fixed
22 and be subjected to anesthesia, he's then going to
23 have to go a second time to the OR and be subject
24 to anesthesia again to fix, if there are any bone
25 fragments this would mean that he would be subject

1 to two surgeries instead of one?

2 A They are two different surgeries, sir, at
3 anytime, whether they are done at the same time or
4 separately, two separate surgeries.

5 Q Would you agree that it is much better to get
6 it done at the same time so you don't have to
7 subject the individual to anesthesia again?

8 A Are we talking about this patient or are we
9 talking about in general?

10 Q I'm talking about in general.

11 A Okay, so now we're talking in general. In
12 general you like to do one anesthesia versus two.

13 Q Yes.

14 A In general, that's correct, I would agree
15 with that.

16 Q Okay. And why is that?

17 A Because there are risks with anesthesia.

18 Q What risk?

19 A The risk of pneumonia, infection, aspiration
20 what can occur just from the anesthesia, reactions
21 to the drugs.

22 Q And if I understand your testimony in this
23 case is that Dr. Bauerle deviated from the standard
24 of care by sending him to the CAT scan unit and not
25 talking to the other doctors?

1 Q All right. Did they stop the bleeding in
2 this case?

3 A They slowed the bleeding, they did not stop
4 the bleeding.

5 Q All right.

6 A Until the arteries were repaired.

7 Q So you're saying, Doctor, that applying the
8 dressing and that kind of stuff doesn't stop the
9 bleeding, he still continued to bleed?

10 A I'm saying that pressure -- we're talking
11 this case now, right?

12 Q Yes, sir.

13 A Okay. These bandages that were applied to
14 this arm with these injuries did not stop the
15 bleeding. It slowed the bleeding, at best.

16 Q How about the tourniquet?

17 A There was one mention of a tourniquet and that
18 was not substantiated by any of the records I
19 looked at.

20 Q You didn't see it in the records, Doctor?

21 A I didn't see it in any of the records that a
22 tourniquet was applied to stop the bleeding.

23 Q All right. Let's assume that it was. Would
24 that stop the bleeding?

25 A A tourniquet, if it was higher than the

1 pressure dressing, it would stop the bleeding, yes.

2 Q It would stop the bleeding if a tourniquet
3 was used?

4 A That's correct.

5 Q So if a tourniquet was used in this case along
6 with the pressure dressing it would have stopped
7 the bleeding?

8 A That's correct.

9 Q Okay. Now, what is the next blood pressure?

10 A 1330, 72 over 42.

11 Q His blood pressure was down and then was
12 going down and then it would go up, correct, and
13 then it would come back down?

14 A It didn't go back up, really. I mean, the
15 systolic went back up but that could be from pain.
16 The diastolic never really rose, it kept going down.

17 Q Which one of those numbers is the most
18 important, Doctor?

19 A The second.

20 Q The top or bottom?

21 A The bottom one.

22 Q What was the bottom -- what is the next one?

23 A 1345, 60 over 42, continuously dropping.

24 Q What is the next one?

25 A 1345.

1 would be, 1330 is an hour and ten minutes later.

2 Q You meant to say 1450?

3 A I'm sorry.

4 Q That's okay. Now, based on that, Doctor,

5 would you agree with me that this guy's blood

6 pressure would go up and down on an intermittent

7 basis?

8 A No, I wouldn't really agree with that.

9 Q You wouldn't agree with that?

10 A I wouldn't agree with that.

11 Q And it is your testimony in this case,

12 Doctor, or is it your testimony in this case that

13 the bleeding never stopped until it was repaired

14 after the code?

15 A There were two sources of bleeding in this

16 case. One was the acetabular fracture and the

17 second one was from the arm.

18 Q Okay.

19 A The one from the arm was slowed by the

20 dressing until the repair was incurred, until the

21 repair occurred.

22 Q Go ahead, I'm sorry.

23 A There was one mention of a tourniquet by Dr.

24 Lintz but not substantiated by any of the records

25 that the tourniquet was applied.

1 Q Okay.

2 A Blood pressure cuff was applied to the other
3 arm but not to the injured arm.

4 Q But you would agree with me that if they were
5 using a tourniquet in this case it would have
6 stopped the bleeding?

7 A I would agree with that. That's not the
8 issue but I would agree with that.

9 Q Well, it might not be the issue to you but it
10 may be to us because if they were using that
11 tourniquet and it was on there until Dr. Bauerle
12 ordered him to the CT scan it would not have been
13 bleeding?

14 A From the arm, yes.

15 Q Okay. And what information do you have that
16 he was bleeding in the pelvis?

17 A Thirty-five years of experience. Every
18 fracture bleeds until the pressure outside, the
19 outside tissue pressure equals the pressure of the
20 bleeding vessels, then it will stop. And it will
21 continue to bleed until it stops. You can get two,
22 three units of blood from a fracture/dislocation.

23 Q My question is, Doctor, is there anything in
24 this record that indicates that he had blood loss
25 from anywhere other than his forearm?

1 A We don't document pelvic fracture bleeding.
2 I mean, there is no way to document it. We don't
3 aspirate, there is no way to tell how much blood is
4 in there other than to clinically look at the
5 patient but you know it is going to bleed, you know
6 there is blood loss there, it's a source of blood
7 loss, you can't ignore it, it's significant. It is
8 a major trauma to the biggest joint in the body, it
9 bleeds.

10 Q And as you say, it's a major injury to a
11 major component and joint of the bones in a body
12 that is essential to proper ambulation and
13 everything else and it needs to be fixed correctly?

14 A Yes, it does.

15 Q It does?

16 A Yes.

17 Q And that is what Dr. Bauerle was attempting,
18 to make sure that it was correctly fixed, right?

19 A We're not talking about whether he knows what
20 he's doing. He's an excellent orthopedic surgeon,
21 the timing is what we're talking about.

22 Q Now, when did you read Dr. Cozart's
23 deposition?

24 A That was one of the initial ones that was
25 sent to me by email.

1 Q Well, Doctor, if you pull out a gun and shoot
2 me that's going to harm me, right?

3 A Yes, in a way, yes.

4 Q In a way? It might kill me?

5 A Might?

6 Q And the fact you pulled the trigger
7 proximately caused the harm that you caused me?

8 A I'm not understanding harm, I'm sorry.

9 It's not a medical term, it really isn't.

10 Q Well, it's an English language term, isn't
11 it, harm means harm?

12 THE COURT: Let's move along, Mr. McCutcheon,
13 please.

14 Q All right. Go to line 24, Doctor. This is
15 another part of your answer. "He put him in
16 jeopardy, there is no question about that, by doing
17 what he did, he put him in jeopardy but he lucked
18 out that nothing happened, nothing, that he didn't
19 die, really." So, you just said that nothing
20 happened by his actions, is that what you said?

21 A What I meant was, no, what I said was that he
22 was lucky that he got intubated in a timely fashion
23 and saved his life, that is basically where I was
24 coming from there, that is what I said, that is
25 what all that means, that he didn't die, he was

1 very lucky he didn't die.

2 Q Didn't you say in this case, Doctor, that it
3 was not inevitable but what he was going to have a
4 cardiac arrest? He was going to have one, wasn't
5 he?

6 A I have no way, there is nobody can tell that.

7 MR. McCUTCHEON: Thank you, Doctor, I have no
8 further questions.

9 THE COURT: Redirect?

10 MR. QUERY: If it please the Court, Your
11 Honor.

12 REDIRECT EXAMINATION BY MR. QUERY:

13 Q Doctor, would the fact that a bandage
14 covering Randy Green's arm had become saturated
15 with blood since it had last been changed be an
16 indication to you one way or the other as to
17 whether, by whatever means, the blood loss had been
18 stopped?

19 A Yes.

20 Q What would it indicate?

21 A The fact there was unaccounted for blood on
22 the floor, on the gurney, on the bandages and the
23 bandages were being changed and saturated, because
24 they were saturated indicates there is continuous
25 blood loss and it is verified by all the blood

1 pressures, sequential blood pressures and we
2 haven't really been queried about, I haven't been
3 queried about the pulse rate in this case which
4 went from low to high as time went on, all
5 indication of blood loss and instability.

6 Q And at that time at 2:15 in the afternoon,
7 1415 fancy time, in the ER room waiting to go to
8 the CAT scan, Dr. Bauerle is there, blood pressure
9 goes to 72 over 46 -- I'm sorry, did I read that
10 right? No, I'm sorry, 72 over 56, heart rate, do
11 you see it in the note?

12 A 135.

13 Q 135? Could Dr. Bauerle have sent him back to
14 the operating room then instead of continuing to
15 send him to the CAT scan?

16 A Yes, that was an option.

17 Q Would that have been a good idea?

18 A That would have been the right thing to do.

19 Q Was it a departure from the standard of care
20 not to?

21 A Yes, in my opinion it is.

22 Q In your opinion was it urgent to have that
23 CAT scan done then before the arm was repaired, to
24 determine whether or not that reduction had been
25 successful?

1 A And if there were fragments in the hip, no,
2 it was absolutely not urgent, emergent.

3 Q Doctor, when you go, I think from your
4 testimony if you found yourself in somewhat similar
5 certain situations, faced with a patient who had
6 been in an accident, there are other doctors
7 involved, there are nurses involved, I presume, in
8 virtually every case, there were in this case, as
9 we have been referring almost throughout your
10 cross-examination to nurses' notes, could you look
11 at those notes if you wanted to?

12 A Yes.

13 Q And would you?

14 A Yes.

15 Q And would they give you the information that
16 blood pressure had gone from some 106 over 59 at
17 12:15 when he came in, dropped to, with a heart
18 rate of 69, it looks like, 12:25 drops to 80 over
19 60, 66 heart rate. 12:40 seems to go back up to
20 130 over 57. Am I reading those accurately from
21 those same nurses' notes that you're looking at?

22 A Yes.

23 Q 1305 112 over 54 with 60 heart rate. Then at
24 1:30 it's at 72 over 42?

25 A Yes.

1 Q And 85?
2 A Yes.
3 Q 1345, about 1:45?
4 A Yes.
5 Q 128 over 59?
6 A Yes.
7 Q Heart rate is, though, where now?
8 A 115?
9 Q Still going up?
10 A Yes.
11 Q And then at 1352 we're all the way to 151 at
12 the top, but what is the bottom blood pressure?
13 A 40.
14 Q And the heart rate?
15 A 110.
16 Q And now finally we get to that time at 2:15,
17 he has still not gone into the CAT scan, he is
18 there in the ER, I believe your testimony is he
19 could have gone back to the OR if Dr. Bauerle had
20 said so, he was there at bedside and it's 72 over
21 56. What is the heart rate then?
22 A 135.
23 MR. QUERY: Beg your indulgence just a
24 movement, Your Honor.
25 THE COURT: Yes.

1 MR. QUERY: Thank you, Doctor.

2 THE COURT: Anything on those questions?

3 MR. McCUTCHEON: Yes, Your Honor.

4 RE-CROSS EXAMINATION BY MR. McCUTCHEON:

5 Q Dr. Matzu, Mr. Query asked you about the
6 notations in the nurses' notes at 2:15. Do you
7 recall that?

8 A Which notation, sir, which ones, sir?

9 Q Sir?

10 A Which ones specifically?

11 Q The questions concerning the blood pressure
12 that was recorded at 2:15 by the nurse. Do you
13 remember him asking you about that?

14 A Yes.

15 Q All right. Have you reviewed the first
16 addendum by Dr. Lintz which is Plaintiff's Exhibit
17 Number 3 in this record?

18 A I don't recall.

19 Q Would you take a look at that, please, sir?

20 A Sure.

21 Q And this recorded blood pressure is at 2:15,
22 is that correct, this one right here, the one at
23 2:15?

24 A Yes.

25 Q The one he asked about, 72 over 56?

1 RANDALL M. GREEN,

2 after being first duly sworn, testified as follows:

3 THE CLERK: Okay, say your full name and
4 spell your last name for the Court.

5 THE WITNESS: Randall M. Green, G-r-e-e-n.

6 THE COURT: All right, Mr. Query.

7 DIRECT EXAMINATION BY MR. QUERY:

8 Q Where do you live, Randy?

9 A About seven miles west of Marion, off of
10 Highway 76, almost in the Pee Dee community but not
11 quite, just on the Marion side of Big Pee Dee River
12 about two miles.

13 Q That would be that same Bubba Road and house
14 we have been talking about?

15 A Yes, sir, 287 Bubba Road.

16 Q Tell us where you grew up, where you went to
17 school.

18 A I grew up in Marion, Marion County, went to
19 school at Marion, all twelve years of schooling in
20 Marion. Went, at that time it was the University
21 of South Carolina Florence Extension, for two or
22 three semesters, couldn't afford much more than that
23 and that was the end of it.

24 Q What kind of work did your daddy do, Randy?

25 A Daddy was a farmer until, really until the

1 Q And you went home then back to Bubba Road
2 after you left the hospital?
3 A That's correct.
4 Q And you were in a wheelchair?
5 A That's correct.
6 Q Had the house been changed?
7 A Yes, sir.
8 Q And do you know who did it?
9 A Yes, sir. My brother and two of my wife's
10 brothers with a little bit of help from some
11 friends.
12 Q And could you -- you were in a manual
13 wheelchair?
14 A Tried to be.
15 Q Could you operate that?
16 A No, sir. I can't make a fist with this hand
17 and I can't grip the wheel.
18 Q Did you eventually, then, some short time
19 after that get an electric chair?
20 A Yes, sir. I had two or three or four of them
21 I think over the period of time.
22 Q And the first one was a small chair similar
23 to the one we saw in that video?
24 A Yes, sir. It was actually a poorer quality
25 than the one that you saw in the video.

1 Q Did that one meet all of your needs?

2 A No, sir. I couldn't get out the door without
3 it bogging down. I live on a sand hill, it is
4 comparable to beach sand except there is not no
5 ocean there, but it is real soft and if you get off
6 the boards or cement or a heavy grass it just bogs
7 right down, somebody has to come get me.

8 Q Tell us about the chair you're in. What are
9 the things you have with that chair that were not
10 necessarily there with the smaller chair?

11 A Well, this one has got a little bit wider
12 tires, it will go better in the yard than the
13 smaller chair, and it is also easier to show you
14 than tell you. It's got all kind of facilities.
15 The back will go back, the whole thing will tilt up
16 and down, the whole thing will go up and down.

17 I would say that the most important part of
18 it is the feet pieces are separated to allow my
19 feet individually more or less control mechanical
20 adjustment on that. I can't do it but I can get
21 somebody else to do it for me but it picks my feet
22 up to alleviate the pressure sores on the balls of
23 my feet, they call them ulcers, but my foot doctor,
24 Dr. Meyers in Conway, and he's treated me I believe
25 three separate times over the last six or seven

1 years from wounds, bleeding wounds under the
2 bottoms of my feet for failure to keep the pressure
3 either steady on them or off of them completely.

4 Q There was, have there been times,
5 interruptions in the time when you had a chair that
6 would do those things?

7 A Yes, sir. I was fortunate enough to have
8 actually a four wheel drive wheelchair that cost an
9 awful lot and took an awful lot of maintenance. It
10 cost more to keep it up than it was worth but --

11 Q But that one could go all around out in the
12 yard?

13 A Oh, yes. Oh, yes, that would go where I
14 didn't have any business going.

15 Q Okay. Were there other aspects of it that
16 were more important than the four wheel drive?

17 A Well, it had the individual foot pieces on it
18 as well and the seat back would tilt back to allow
19 me to get what they call pressure breaks.

20 Q And so that is important that the seat move,
21 as well as the legs?

22 A Very important.

23 Q And the four wheel drive chair, you finally
24 just hung it up?

25 A Gave up the ghost.

1 Q And did you have a chair with all these
2 movements after it?

3 A No, sir, no, sir. This is the first one.

4 Q Okay. And this is the first one since the
5 four wheel drive one?

6 A It's the first chair that has had any other
7 controls other than just falling backwards. You
8 can buy them on the computer, off the trader
9 magazines and stuff for two to seven hundred
10 dollars, these --

11 Q And did you have those ulcers on your feet,
12 those came about during the times that you were in
13 those smaller chairs?

14 A That's correct.

15 Q And between the four wheel drive and getting
16 this chair how long were you in that smaller chair?

17 A Probably two or three years, maybe more. The
18 four wheel drive chair would break down. The
19 motors for the four wheel drive chair were made in
20 Ireland, I didn't know this going in, the bottom
21 part of the chair was sent to Australia, Australia
22 shipped that part of to Canada, Canada sent it to
23 Nebraska, a dealer in Florence got it from the
24 wholeseller in Nebraska. That is where I got it
25 from. I found all this out by buying pieces.

1 Q But --

2 A That chair would break down and have to have
3 a part from somewhere. While it was down I would
4 use the little chair.

5 Q Okay. And then once it gave up completely,
6 though, how long were you in a little chair
7 continuously?

8 A Two to three years.

9 Q Okay. And that is when you had the foot
10 problems, during that?

11 A Very bad.

12 Q And did you, were there any other
13 disadvantages to that chair, did you ever have any
14 accidents with that chair?

15 A Oh, yes, sir. I would bog down in the yard
16 trying to go where I didn't, where the chair
17 wouldn't go, somebody, most of the time my wife
18 would come get me. One time --

19 Q How could she come get you?

20 A There again, I live way out in the country, I
21 tell people I have to pipe daylight in, and I don't
22 normally go very far out of the door without
23 something to tend to a snake because we have bad
24 rattlesnakes, others as well, but they are bad.
25 I'm talking huge, too, I ain't talking about no

1 little two foot. I very seldom go out of my door
2 very far anyway without at least a pistol. I can't
3 use a hoe or bush axe or shovel anymore, so, yes,
4 if I bogged down out there and shoot three times
5 she would come running.

6 Q How about injuries with that chair other than
7 your foot ulcers?

8 A Uh-huh (Affirmative). Yes, I was shelling
9 peas in the living room, den area of my house. I
10 had a sunken area in the house before this
11 happened, it was in front of the fireplace, stick
12 out a piece and of course that was part of the
13 repairs that was made, was to level it out because
14 a wheelchair don't go up and down humps in the
15 house or outside too well.

16 But anyway, that area is tiled now and that
17 is where I was trying to help my wife shell peas.
18 I would take my reacher thing and put peas in it,
19 my little dish pan, and pick my dish pan up and put
20 it in my lap. When I got those peas shelled, which
21 I was slow, I would put the dish pan back down on
22 the floor and get some more peas. Well, I leaned
23 over to pick up the dish pan and I fell out on my
24 head and I broke my hip.

25 Q Literally broke it?

1 A Literally broke it. I spent five days in
2 McLeod getting it bolted back together.

3 Q And is the falling thing something that the
4 health care people have cautioned you about and
5 having to watch out for?

6 A Oh, yes. I don't have any, very little
7 muscle capabilities from the lower bottom side of
8 the rib cage, down. If I get over balanced, yes,
9 I'm in trouble.

10 Q Where are you staying during the trial?

11 A During the middle of the day when we leave we
12 run right down here to the Cypress Inn or something
13 like that for me to get cathed in the middle of the
14 day and in the evenings and in the mornings. At
15 night we go back to Marion.

16 Q Back to your home?

17 A Yes. My bed there has got rails and I got
18 the trapeze up over it that I can halfway deal with
19 myself and as you saw in the video, the sink is
20 where I can kind of get to it to do as much as I
21 can tending to myself.

22 MR. QUERY: Let's go ahead and start this.
23 I'm going to ask you to look, Randy --

24 Can you all see that?

25 THE COURT: You're probably going to have to

- 1 A That's correct.
- 2 Q Randy, what in the world would you all do if
- 3 there was a fire in the den or in that hallway?
- 4 A Die.
- 5 Q There is not a way out for you back there, is
- 6 there?
- 7 A No, sir.
- 8 Q How long do these -- is that wheelchair a
- 9 likely -- tell me, is that one new?
- 10 A This one?
- 11 Q Yes, sir.
- 12 A Oh, no, sir. This was purchased from a widow
- 13 lady in Charleston whose husband had died. They
- 14 paid \$24,000 for this chair in 2001. He passed on
- 15 in 2005. The chair had been sitting in her, she
- 16 thought they might be going to need a chair but
- 17 decided it was too big and I got a chance to buy it
- 18 and made arrangements to get the chair for \$4,500.
- 19 It is definitely not new but it beats the dickens
- 20 out of what I did have.
- 21 Q It took you two or three years to find one
- 22 for that price?
- 23 A You don't find them for that price if it
- 24 wasn't for her, no. She could have gotten three
- 25 times that out of it without any problem.

1 GEORGE B. NICHOLSON, JR.,
2 after being first duly sworn, testified as follows:

3 THE CLERK: Please have a seat, state your
4 film name for the record.

5 THE WITNESS: George B. Nicholson, Jr.,
6 N-i-c-h-o-l-s-o-n.

7 DIRECT EXAMINATION BY MR. McCUTCHEON:

8 Q Dr. Nicholson, how are you today?

9 A Fine, thank you.

10 Q And we appreciate you taking the time away
11 from your office to come over here and you received
12 a subpoena from my office, did you not?

13 A Yes, sir.

14 Q To appear in court?

15 A Yes, sir.

16 Q And you're here at the request of that
17 subpoena?

18 A Yes, sir.

19 Q Now, Dr. Nicholson, you're George Nicholson?

20 A Yes, sir.

21 Q Where do you live, Dr. Nicholson?

22 A I live in Myrtle Beach.

23 Q How long have you lived in Murrells Inlet?

24 A Myrtle Beach.

25 Q Myrtle Beach.

1 MR. McCUTCHEON: Number 4.

2 THE COURT: All right, Defendant's 4 is in
3 evidence without objection.

4 (Resume marked and received in evidence as
5 Defendant's Exhibit Number 4).

6 BY MR. McCUTCHEON:

7 Q Now, Doctor, you told us generally what
8 general surgery is. Orthopedic surgery would be an
9 offshoot or specialty out of general surgery?

10 A A specialty.

11 Q Those folks have to go through the general
12 surgery training that you go through?

13 A They do but they also --

14 Q Then they go additional?

15 A That's right.

16 Q Okay. And as I understand, you were one of
17 the treating physicians of Mr. Green on April 17th
18 of 2004?

19 A Yes, sir.

20 Q Is that correct?

21 A Yes, sir.

22 Q And you became familiar with his condition
23 when you saw him?

24 A That's correct.

25 MR. McCUTCHEON: Your Honor, at this time I

1 would offer Dr. Nicholson as an expert in the field
2 of general surgery.

3 MR. MARTIN: Without objection.

4 THE COURT: All right, he is qualified to
5 give his opinion. You may proceed.

6 BY MR. McCUTCHEON:

7 Q Now, Dr. Nicholson, how did you become
8 involved in the care of Randall Green?

9 A I was consulted by the emergency room
10 physician Dr. Lintz to come see Mr. Green.

11 Q All right, and --

12 A He had been involved in an automobile
13 accident.

14 Q Now, we heard the term call used. Were you
15 on call?

16 A I was on call that day.

17 Q Do you recall what day of the week this was?

18 A That was on Saturday.

19 Q It was on a Saturday, and you had gotten the
20 call from where? Do you remember who called you?

21 A I do not remember exactly but I probably was
22 in the hospital making rounds on that day.

23 Q All right. Now, you told us that you joined
24 Surgical Associates in 1984 and you have been there
25 ever since?

- 1 A Yes, sir.
- 2 Q And his pulse rate or heart rate was 112?
- 3 A Yes, sir, slightly up, yes, sir.
- 4 Q Now, what is a normal heart rate, Doctor?
- 5 A Normal heart rate is around 80 to 90. Some
- 6 folks who are very good athletes they are lower,
- 7 50, 60 range.
- 8 Q How would you classify a heart rate of 110?
- 9 A Slightly elevated.
- 10 Q Okay. And what can cause an elevated heart
- 11 rate?
- 12 A Pain. Stress can cause that.
- 13 Q What do you mean by stress? Is that like me
- 14 when I get stressed out or does that stress mean
- 15 something else?
- 16 A If someone is in pain and they are not
- 17 relaxed, that it can make their pulse rate go up.
- 18 Q Okay. And do you recall what is, what his
- 19 WBC was, white blood count?
- 20 A White blood count?
- 21 Q Hemoglobin is what?
- 22 A Hemoglobin is red blood cell concentration in
- 23 your bloodstream. I remember his was 14.4.
- 24 Q Is that --
- 25 A That is normal, that's normal.

1 to see what their overall condition is?

2 A Usually xrays, lab work, physical exams, all
3 the specialists.

4 Q So, those would be one of the things that you
5 would look at but not the only thing?

6 A Yes, sir.

7 Q And I believe you told me you didn't recall
8 anything unusual about Mr. Green's exam?

9 A No, sir.

10 Q Now, although you did not take the dressing
11 off, was there any active bleeding or blood loss at
12 the time you examined him?

13 A There was no active blood loss on the
14 clinical exam. In reviewing all the studies I did
15 not see any source of blood loss in the chest,
16 abdomen or the pelvis. There was a small amount of
17 blood in the socket where the femoral head had been
18 displaced from the socket in the hip but there was
19 no intra-abdominal blood and there was no sign of
20 any external blood loss.

21 Q Now, in the arm, Doctor, there are arteries
22 and veins?

23 A That's correct.

24 Q How many arteries?

25 A A couple main arteries.

1 Q What are the main arteries?

2 A You've got the axillary brachial to the elbow,
3 that goes into the ulnar and radial arteries that
4 go down to the wrist.

5 Q It is my understanding from looking at the
6 records in this case that both of those arteries in
7 this gentleman had been severed, is that your
8 understanding?

9 A The records indicate that, yes, sir.

10 Q When an artery like that is severed what
11 response, if any, does the body or the brain and so
12 forth have in regards to that artery being severed?

13 A It is a natural mechanism of the body if a
14 vessel is completely transected it goes into spasm
15 and so the blood flow stops and then it will back
16 up to the next open branch and then go around by
17 collateral circulation to diffuse the hand.

18 Q You used a term that I'm not familiar with.
19 Can you tell me what transect means? Does that
20 mean cut?

21 A That means cut..

22 Q That is just medical lingo for being cut?

23 A Well, a complete transection. If you had a
24 partial transection, just had an opening in it,
25 sometimes those stay open and continue to bleed but

1 his were completely transected.

2 Q What is your understanding as to whether they
3 were complete in this case or partial?

4 A Complete is in the records, yes.

5 Q Based upon your review of the records is it
6 your understanding that at some point in time he
7 was going to have to have those repaired?

8 A That's right, to maintain viability of the
9 hand.

10 Q Are you familiar with the standard, Doctor,
11 as to what the time frame is within which you need
12 to repair those arteries?

13 A You like to re-establish flow within six to
14 eight hours to maintain viability.

15 Q Six to eight hours?

16 A Yes.

17 Q Now, the CT of the hip, did you look at that
18 or either the report?

19 A Yes, sir.

20 Q What did it show?

21 A It showed a dislocated right femoral head
22 that was out of the socket, had gone back behind
23 the natural opening and there was multiple fracture
24 fragments of the cup that the femoral head would go
25 into, we call it comminuted, it means multiple

1 pieces, where the femoral head had been jammed into
2 that cup in the pelvis and fractured it.

3 Q Now, what is a Doppler study?

4 A A Doppler is an instrument that you can put
5 over a blood vessel and chart the flow. It detects
6 the flow in the blood vessel.

7 Q All right. In your examination of this
8 gentleman -- did you examine him more than the one
9 time?

10 A That was the one time I examined him, then
11 turned him over to Dr. Cozart and Dr. Bauerle.

12 Q Now, is it your understanding, Dr. Nicholson,
13 that at some point in time, I think it was around
14 2:48 in the afternoon, that Mr. Green suffered a
15 heart attack or arrest?

16 A Yes, sir.

17 Q Also known as coded?

18 A Yes, sir.

19 Q And are you familiar, Doctor, with the causes
20 of cardiac arrests and so forth?

21 A Yes, sir.

22 Q Are you also familiar with things that might
23 come from that, including is it your understanding
24 Mr. Green is now a paraplegic?

25 A Yes.

1 Q And are you familiar with the mechanisms of
2 what can cause paraplegia?

3 A You have to have trauma to the spinal cord,
4 that can cause paraplegia.

5 Q What about loss of blood and an infarct?

6 A Loss of blood and infarct have been reported,
7 it is called infarct of the spine but I felt like
8 his was due to the trauma he had.

9 Q All right. And why do you hold -- do you
10 hold that opinion to a reasonable degree of medical
11 certainty?

12 A Yes, sir.

13 Q And when you say it was caused by the trauma,
14 what are you talking about?

15 A He had trauma to the right anterior chest.
16 The right third, fourth, fifth, and seventh ribs
17 were all fractured.

18 Q Okay. Now, when did you learn that, Doctor,
19 that the five ribs had been fractured?

20 A In review of the records from the Medical
21 University of South Carolina.

22 Q Would that have been the CT scan of the chest
23 that was done on 4/19/2004?

24 A Yes, sir.

25 Q Have you seen and reviewed this document

1 before?

2 A Yes, sir.

3 Q Does that reflect the five ribs that were
4 fractured?

5 A Yes, sir.

6 Q Which ribs were they?

7 A Fractures to the right third through seven
8 ribs.

9 Q Where was the infarct?

10 A The infarct was at the level of the sixth and
11 seventh rib, where it attached in the back.

12 Q Right below those?

13 A That's right. So, the trauma you get to that
14 chest, the ribs hinged in the front on the breast
15 bone and the back of the spine, getting that sort
16 of trauma and torquing of the spine is right where
17 you see the infarct in the spinal cord.

18 MR. McCUTCHEON: Your Honor, we would move to
19 introduce what has been previously marked as
20 Defendant's Exhibit Number 2.

21 THE COURT: Any objection?

22 MR. MARTIN: No, sir, I don't think so. Let
23 me look.

24 No objection.

25 THE COURT: In evidence without objection.

1 MR. MARTIN: Okay.

2 (CT scan marked and received in evidence as
3 Defendant's Exhibit Number 2).

4 BY MR. McCUTCHEON:

5 Q Do you have an opinion, Doctor, to a
6 reasonable degree of medical certainty as to what
7 caused the infarct?

8 A I feel that the trauma to the spinal cord
9 caused the damage to the spinal cord at that level
10 where you had a torquing and twisted spine, I feel
11 like it had bruised the spinal cord. The spinal
12 cord is contained in a bony canal. When you get
13 that swelling in those tissues and it stays swollen
14 like that, you cut off the blood supply and you can
15 get death of the tissue.

16 Q Does it take some time for that to occur?

17 A This can be a slow process, likely to be
18 different than having a stab wound or gunshot wound
19 that went straight through the tissues and
20 immediately cuts the tissue, but swelling, it can
21 take several hours, sometimes several days with
22 progress of loss of function due to death of the
23 tissue in the spinal cord.

24 Q Now, the term edema means swelling, does it
25 not?

1 A Sir?

2 Q The term swelling is called edema?

3 A That's right, swelling and edema, that is
4 fluid in the tissues.

5 Q Can you have such a mechanism, Doctor, when
6 you don't see any bony involvement of the spine,
7 fractures or dislocations or those kind of things?

8 A You can. You can see those just with a twist
9 and turn of the body at that level.

10 Q What happens in and around the spine itself?

11 A With the twisting and turning of the spine it
12 can put pressure on the blood vessels that supply
13 the blood flow to the spinal cord and that can be
14 disrupted or interrupted or cause it to thrombose.
15 If it doesn't get the oxygen and blood flow, then
16 the tissues will die.

17 Q That is what an infarct means?

18 A Infarct means death of the tissue. On the
19 spinal cord there is one spinal artery that comes
20 down the front and there are two posterior spinal
21 arteries on the back and they, as you get farther
22 down the cord then the vessels get more tenuous.
23 He received the spinal infarct from that level of
24 the lowest rib fracture, T6 down to T12.

25 Q Doctor, what is neurogenic shock?

1 A Neurogenic shock is shock that occurs when it
2 affects the nervous system that controls the blood
3 vessels. Ordinarily if you go into shock and you
4 lose blood your pulse rate will go up. In his
5 particular case his pulse rate went down and that
6 just --

7 Q What does that indicate to you?

8 A That indicates there was that disruption in
9 the sympathetic output to his blood vessels in the
10 lower half of his body which makes them constrict
11 to keep the blood flowing back to the heart. When
12 you lose that sympathetic control and they dilate,
13 then the blood pools in the veins and tissues and
14 does not return to the heart.

15 Q Now, when we use the term neurogenic shock
16 are there other kind of shock? In laymen's
17 terminology you might hear us lay people refer to
18 somebody being in shock. Does that include a
19 multiple of things or just one thing or what?

20 A There are different types of shock. You have
21 sepsis, septic shock, you can have shock from blood
22 loss, volume depletion.

23 Q What do you call the one from blood loss?

24 A I call that hypovolemia shock.

25 Q Hypovolemia means what?

1 A Decreased volume of blood in your system.

2 Q All right. In your opinion to a reasonable
3 degree of medical certainty in this case he was
4 suffering from which one?

5 A Neurogenic shock.

6 Q Which you have just explained to us?

7 A That's right. All the studies he had on
8 admission, there was no sign of any significant
9 internal blood loss, blood escaping in the chest,
10 abdomen, the pelvis, other than the blood with the
11 pelvic fracture.

12 Q And would you agree, Doctor, and to a
13 reasonable degree of medical certainty that in this
14 case the spinal infarct was caused by the initial
15 trauma which resulted in swelling of the cord in
16 the enclosed spinal column and spinal cord?

17 A Yes, sir.

18 Q All right. Doctor, did you also have an
19 occasion to, I think you have already told me about
20 one, you reviewed the MUSC records, did you not?

21 A Yes, sir.

22 Q I want to hand you what has been previously
23 marked as Defendant's Exhibit Number 3 and ask if you
24 can identify it?

25 A This is an MRI scan of the thoracic spine

1 dated April 21st, 2004.

2 Q And what does it show?

3 A This shows diffused cord edema from the level
4 of T6-7 to T12, without having some hemorrhage.

5 Q What does that mean?

6 A It means that there is swelling of the spinal
7 cord within the bony canal without any signs of any
8 bleeding or hemorrhage there but just the swelling,
9 edema, and they said this was a spinal cord
10 infarction that could be directly related to trauma
11 and also mentioned related to cardiac arrest but I
12 feel that his particular trauma, the rib fractures
13 at that same level, that there is one to one
14 correlation.

15 Q Do you have an opinion to a reasonable degree
16 of medical certainty as to whether or not those
17 findings are consistent with a neurogenic shock
18 caused by trauma?

19 A Yes. I feel they are consistent.

20 MR. McCUTCHEON: Your Honor, we move to
21 introduce what was previously marked as Defendant's
22 Exhibit Number 3.

23 MR. MARTIN: Absolutely no objection.

24 THE COURT: Exhibit 3 is in evidence without
25 objection.

1 (MRI marked and received in evidence as
2 Defendant's Exhibit Number 3).

3 BY MR. McCUTCHEON:

4 Q Doctor, have you also reviewed the ambulance
5 run report?

6 A Yes, sir.

7 Q From Grand Strand to MUSC which has
8 previously been marked as Defendant's Exhibit
9 Number 1?

10 A Yes, sir.

11 Q An that is the ambulance run report?

12 A Yes, sir.

13 Q And does it say on there what the status of
14 his lower extremities are, or extremities were
15 during his transport to MUSC?

16 A It says the patient is able to move all
17 extremities.

18 MR. McCUTCHEON: Your Honor, we move to
19 introduce what has previously been marked as
20 Exhibit 1.

21 MR. MARTIN: No objection.

22 THE COURT: Defendant's 1 is in evidence
23 without objection.

24 (Ambulance run report marked and received
25 in evidence as Defendant's Exhibit Number 1).

1 MR. McCUTCHEON: Thank you, Dr. Nicholson.

2 That is all the questions I have. Please answer
3 any questions these gentlemen may have.

4 THE COURT: Mr. Martin.

5 MR. MARTIN: Just one second, Judge.

6 CROSS EXAMINATION BY MR. MARTIN:

7 Q Let me ask, Dr. Nicholson, how are you?

8 A Fine, thank you.

9 Q Let me ask a couple questions to get started
10 here. You say that you saw Mr. Green initially at
11 what time?

12 A 1:59, I believe I had a written note there,
13 somewhere around in that time period.

14 Q And that is a written note?

15 A There is a written note and there is also a
16 transcribed note, the same time corresponds.

17 Q Well, let me ask you another question. The
18 testimony that you had today, is it based on your
19 recall of what happened on April 17th of 2004, or
20 is it based upon the notes and medical records at
21 Grand Strand Hospital?

22 A This occurred about nine years ago and I had
23 to review these records. I had given a previous
24 deposition in this case in 2009 as well.

25 Q So it was actually 2009 before anybody ever

1 took your deposition in the case?

2 A That's correct.

3 Q Okay.

4 MR. MARTIN: Could I get this marked.

5 BY MR. MARTIN:

6 Q Dr. Nicholson, I know it has been a long time
7 but I want to show you the medical records here,
8 the nurses' flow sheet. I'm assuming these medical
9 records are kept by the nurses as they go along?

10 A Uh-huh.

11 Q It has there, as I read that, 1:45 that you
12 are there with Mr. Green?

13 A Yes, sir.

14 Q So it might have been 1:45 as opposed to 1:59
15 or somewhere in that range is what you're saying?

16 A That's right.

17 Q But the nurse, what I have got here, the
18 nurses' flow sheet there indicates that a fourth
19 liter of saline solution at 1:35, Dr. Nicholson is
20 bedside 1:45, he prescribed some medicine?

21 A Morphine, morphine at that point.

22 Q Morphine?

23 THE COURT: Doctor, if you don't mind, stay
24 behind the microphone, they can't hardly hear.

25 Okay, thank you.

1 Q And the records indicate, though, at that
2 time you gave him morphine, right?

3 A This is what the records indicate, yes, sir.

4 Q And as well as Verced?

5 A I did not order Verced. If it is down there
6 Dr. Lintz ordered that but I didn't order the
7 Verced.

8 Q Let me get, it says Dr. Nicholson gave him
9 Verced, then the next line is Dr. Lintz reduced it,
10 one of you gave him Verced?

11 A He gave that I'm sure to relax him.

12 Q And you gave him morphine?

13 A I think he gave both of those in order to
14 reduce the hip pain.

15 Q He was given those about the time -- his hip
16 was reduced, according to the medical records, at
17 1:52, is that right?

18 A Yes.

19 Q So you are there probably at 1:45 and you see
20 him one time?

21 THE COURT: Did you want to introduce that in
22 evidence?

23 MR. MARTIN: I do. it may already be in.

24 MR. McCUTCHEON: It is already in, Your
25 Honor, Plaintiff's Exhibit Number 8.

1 MR. MARTIN: I used it instead of trying to
2 drag something out.

3 THE COURT: Very good. Plaintiff's 8 at this
4 point so we know what you're talking about.

5 BY MR. MARTIN:

6 Q You saw him once and would you agree with me
7 at the time you saw him that he was not paralyzed
8 in the legs, was he?

9 A No, sir.

10 Q It is clear from the medical records, isn't
11 it?

12 A Yes, sir.

13 Q And at that time you did not see any injury
14 to the spine at all, did you?

15 A No, sir.

16 Q And as a matter of fact there were xrays, CAT
17 scans taken to determine if there were any
18 fractures to the bones of Mr. Green's back and
19 ribs, wasn't there?

20 A That's right.

21 Q And the records at Grand Strand Hospital
22 showed that there were no fractures to the spine or
23 the ribs, were there?

24 A Not on those initial studies.

25 Q That's right. So when he came -- so, these

1 medical records that show some rib fractures were
2 actually taken at the Medical University some how
3 long would you say after this wreck?

4 A The dates on the xrays were April 19th.

5 Q All right. And the best record of that is
6 that the Grand Strand Hospital took those xrays on
7 April 17th after he was brought into the hospital,
8 correct?

9 A That's correct.

10 Q And you're aware that those records show no
11 fractures to the bones or the ribs, do they?

12 A Not at that time, yes, sir.

13 Q That xray machine over at Grand Strand was a
14 properly functioning machine at the time as far as
15 you know, I guess?

16 A Yes, sir.

17 Q All right. Now, we also know that at 2:48 he
18 coded and for a period of some 20 minutes or more
19 they worked on him to resuscitate him, didn't they?

20 A I don't know the exact amount of time. He
21 was resuscitated, yes.

22 Q And in that process they go through mouth to
23 mouth and chest compressions and intubation and a
24 lot of things, don't they?

25 A Yes, sir.

1 Q And it has been known that ribs can be
2 fractured in the process of CPR, hasn't it?

3 A Yes, sir.

4 Q That is reported repeatedly in the documents,
5 is it not?

6 A That's right.

7 Q So, to say that those xrays at the Medical
8 University of South Carolina done two days later
9 after the CPR had been done and after he was taken
10 there are not good evidence as to whether or not
11 his ribs were fractured at the time he came in to
12 Myrtle Beach hospital, are they?

13 A They were not evident on initial xrays.

14 Q All right. Now, we do know, again I think
15 something you and I can agree on is that he wasn't
16 paralyzed when he came in and he is paralyzed now.
17 Right?

18 A Yes, sir.

19 Q The question is how did that happen. Right?

20 A That's correct.

21 Q You have opined that it happened through
22 neurogenic shock and that somehow the spinal cord
23 got bruised within the spinal column without any
24 damage to the spinal column?

25 A That's correct.

1 Q No fractures to the spinal column, that is
2 not a possibility, right?

3 A Yes, sir.

4 Q All right. But there are certainly other
5 ways that the damage to Mr. Green's spinal cord
6 could have occurred, is there not?

7 A There are other ways.

8 Q All right. One of them is if you cut off the
9 blood supply to the spinal cord long enough the
10 spinal cord is going to die, isn't it?

11 A Yes, sir.

12 Q And there is an artery called the artery of
13 adamkiewicz which provides blood directly from the
14 heart to the spinal cord, is that correct?

15 A Yes, sir.

16 Q That artery hooks up to the spinal cord right
17 in the area where Mr. Green's damage to the spinal
18 cord occurred, did it not?

19 A Yes, sir.

20 Q Now, we also know that there was, according
21 to your records and I believe your earlier
22 testimony, there was no real evidence of any loss
23 of blood other than from the arm itself?

24 A That's correct.

25 Q And of course when you say no blood loss at

1 1:45 or 1:59 or whenever it was, you don't know at
2 that time really how much blood he had lost, do
3 you?

4 A There was no ongoing blood loss when I saw
5 him.

6 Q I understand that. It wasn't, you didn't see
7 any bleeding?

8 A I didn't see any bleeding.

9 Q Of course, while I'm on that, you didn't take
10 the bandage off, did you?

11 A I did not inspect the wound.

12 Q So, you don't know whether the thing was
13 oozing or not oozing underneath the bandage at the
14 very time you examined him, do you?

15 A I did not examine the wound.

16 Q And you also know that the medical records
17 has referenced to the fact the dressing is changed
18 on more than one occasion, don't you?

19 A I don't know how many times it was changed.

20 Q Well, let me ask you this. If they did
21 change the dressing more than one time that in and
22 of itself would be a pretty good indicator it was
23 continuing to at least ooze blood, right?

24 A If they were changing it.

25 Q They wouldn't change it just for the heck of

1 MR. MARTIN: Just one minute.

2 let's mark this one exhibit.

3 THE COURT: Just so we clear up the record,
4 Plaintiff's Exhibit 18 has been admitted into
5 evidence before. Mr. Martin, you want it in
6 evidence, correct?

7 MR. MARTIN: Yes, sir, I do.

8 THE COURT: Any objection to that, Mr.
9 McCutcheon?

10 MR. McCUTCHEON: No, sir.

11 THE COURT: It's in evidence without
12 objection.

13 (Nurses' flow sheets received in evidence as
14 Plaintiff's Exhibit 18).

15 BY MR. MARTIN:

16 Q Let me show you what is marked as Plaintiff's
17 Exhibit 19 which I would say to you is a report
18 from the Medical University of South Carolina dated
19 April 18th, 2004, which is the date that Mr. Green
20 was taken to MUSC, was it not?

21 A Yes, sir.

22 Q You see the date of April 18th right up at
23 the top?

24 A Yes, sir.

25 Q Over on the side it has a time entry there.

1 What is that?
2 A 2232.
3 Q Which would be?
4 A 10:30.
5 Q What does the first line on that say there?
6 A Received patient by stretcher from Grand
7 Strand Hospital intubated, patient alert, follows
8 commands, unable to wiggle toes.
9 Q Thank you, sir.
10 MR. MARTIN: I move Number 19 into evidence.
11 THE COURT: Any objection?
12 MR. McCUTCHEON: No, sir.
13 THE COURT: In evidence without objection.
14 (MUSC admittance report marked and received
15 in evidence as Plaintiff's Exhibit 19).
16 MR. MARTIN: Those are all the questions I
17 have. Thank you..
18 THE COURT: Redirect?
19 MR. McCUTCHEON: Yes, sir, just couple.
20 REDIRECT EXAMINATIO BY MR. McCUTCHEON:
21 Q Dr. Nicholson, this accident occurred in
22 2004, correct?
23 A Yes, sir.
24 Q And back in 2004 we didn't have the benefit
25 of the now electronic records that we do now?

1 count up about 120,000. The next check his
2 platlete count was back up to normal with 270,000,
3 so I think this is a suspicious result there with
4 the platlete count as well.

5 Q Now, was there something that might have
6 caused --

7 A I feel this, without any other signs of loss
8 from the time I saw him when I came in the door,
9 four liters of normal saline would have a
10 dillutional effect. The blood is drawn and put
11 into a tube and has an anticoagulant in there to
12 keep it from clotting so you can get a normal red
13 blood cell count there. If it is clotted it is
14 using up some of those red blood cells and you will
15 get an erratic result.

16 Q Do you feel that occurred here?

17 A I feel that occurred here.

18 Q The clots?

19 A The clots in the tube, I feel like the
20 platlete count is not a correct determination.

21 MR. McCUTCHEON: Thank you, Doctor.

22 MR. MARTIN: One brief question.

23 RECROSS EXAMINATION BY MR. MARTIN:

24 Q About that very point, alert and awake, does
25 that coincide with 5.5 hemoglobin but let's be

1 DR. RALPH FOSTER COZART,
2 after being first duly sworn, testified as follows:
3 THE CLERK: Please state your name, spell
4 your last.
5 THE WITNESS: Ralph Foster Cozart, last name
6 spelled C-o-z-a-r-t.
7 DIRECT EXAMINATION BY MR. McCUTCHEON:
8 Q Good afternoon, Dr. Cozart.
9 A Good afternoon.
10 Q How are you today?
11 A Fine, thank you.
12 Q We appreciate you taking your time to come
13 in. Did you also receive a subpoena from my office
14 in this case to appear in trial?
15 A Yes, sir, I did.
16 Q All right, sir. Now, Dr. Cozart, where do
17 you live?
18 A I live in Myrtle Beach.
19 Q And are you married?
20 A I'm married.
21 Q Do you have children?
22 A I do.
23 Q How many?
24 A Four.
25 Q And what do you do for a living, sir?

1 Q When was the last time you recertified?

2 A I initially got my certificate in 1999 and I
3 had to recertify again in 2009. It is every ten
4 years.

5 Q Okay,

6 A Similar to general surgery.

7 Q Doctor, let me show you this document and ask
8 you if you can identify that, please, sir?

9 A Yes, sir.

10 Q And what is that?

11 A This is my curriculum vitae or my c.v.

12 Q Is it current?

13 A It's current and up to date, yes, sir.

14 MR. McCUTCHEON: Your Honor, we move to
15 introduce what has previously been marked as
16 Defendant's Exhibit Number 5 into evidence.

17 THE COURT: Any objection?

18 MR. MARTIN: No objection.

19 THE COURT: Defendant's 5 is in evidence
20 without objection.

21 (C.V. marked and received in evidence as
22 Defendant's Exhibit Number 5).

23 MR. McCUTCHEON: At this time, Your Honor, we
24 would like to qualify this witness as an expert in
25 the field of general and/or plastic surgery, like

1 to offer him in those fields.

2 THE COURT: Do you wish to voir dire the
3 witness, challenge his qualifications, Mr. Martin?

4 MR. MARTIN: Judge, I have no objection.
5 What was the field of qualification?

6 MR. McCUTCHEON: General surgery and plastic
7 surgery.

8 MR. MARTIN: I have no objection.

9 THE COURT: All right. He's qualified to
10 give his opinions.

11 You made proceed.

12 BY MR. McCUTCHEON:

13 Q Now, Dr. Cozart, I want to ask you about a
14 couple documents so I don't forget it. The xray
15 that Mr. -- were you in the courtroom when Dr.
16 Nicholson testified?

17 A Yes, sir.

18 Q And do you remember when Mr. Martin handed
19 him a document and asked him, asked him about the
20 xray that was done at Conway, I mean done at Grand
21 Strand Regional Medical Center?

22 A Yes, sir.

23 Q And have you reviewed the records in this
24 case?

25 A I have reviewed the records.

- 1 Q Are you familiar with this document?
- 2 A I'm familiar with this.
- 3 Q And what is that?
- 4 A This is a chest xray and the radiologist does
- 5 not see an acute finding in just a single view,
- 6 frontal view of the chest. That means it's
- 7 limited.
- 8 Q Okay. It's a chest xray, right?
- 9 A Just a front view, it's a limited study, it
- 10 doesn't show a side view. Most xrays have both.
- 11 Q It's not a CT?
- 12 A It's not a CAT scan, which is much more
- 13 accurate.
- 14 Q It's not an MRI?
- 15 A Not at all.
- 16 Q What is your understanding as to what the
- 17 study was at MUSC two days later on the 19th which
- 18 is Defendant's Exhibit Number 3?
- 19 A This is a MUSC MRI of the thoracic spine.
- 20 Q MRI?
- 21 A MRI.
- 22 Q Was there also a CT scan done?
- 23 A There was a CAT scan done.
- 24 Q And that CT scan showed what?
- 25 A The CT scan done at MUSC showed fractures

1 from ribs three through seven on the right side.

2 MR. McCUTCHEON: Your Honor, I would like to
3 offer this as the next defendant's exhibit, it
4 hadn't been marked yet.

5 THE COURT: All right. Have it marked first,
6 pleas.

7 MR. McCUTCHEON: Your Honor, as to
8 Defendant's Exhibit Number 6 --

9 THE COURT: I'm sorry, that was which number?

10 MR. McCUTCHEON: Exhibit 6, Your Honor.

11 THE COURT: Go ahead and look at that.

12 MR. MARTIN: Okay.

13 THE COURT: Any objection?

14 MR. MARTIN: No objection.

15 THE COURT: All right, so Defendant's 6 is in
16 evidence without objection.

17 (CT scan marked and received in evidence as
18 Defendant's Exhibit Number 6.

19 THE COURT: You may proceed.

20 BY MR. McCUTCHEON:

21 Q It says on here, does it not, Doctor, "I do
22 not see direct signs of displaced rib fracture,
23 however lower ribs are beyond the field of view"?

24 A Correct.

25 Q Now, I have one other one.

1 Q Any other doctors there at the time, that you
2 recall?

3 A I believe Dr. Lintz was there, too.

4 Q Now, when you got there what did you do?

5 A The first thing I did was just evaluate him.

6 I was called to see him for an arm injury, an
7 arterial injury, he had a pressure dressing on and
8 a tourniquet on his right arm.

9 Q All right. So he had -- did you see the
10 tourniquet?

11 A I saw a tourniquet.

12 Q There was a tourniquet on him?

13 A Every time there is an arterial injury, there
14 is a tourniquet fits on the arm, it is a blood
15 pressure cuff pumped up like a tourniquet on that
16 arm to stop the arterial bleeding.

17 Q That was on him?

18 A Yes.

19 Q You saw it?

20 A I did.

21 Q You called it a tourniquet?

22 A It's a blood pressure cuff but a tourniquet,
23 in addition to a pressure dressing.

24 Q Did you have occasion to examine him at that
25 time?

- 1 A I did.
- 2 Q And what did you observe about him?
- 3 A He had a laceration on his right arm, just
- 4 below the elbow, with complete transection of the
- 5 muscle, nerves and two arteries that were cut.
- 6 Q Transection, that means cut?
- 7 A They were cut down to the bone, completely in
- 8 two.
- 9 Q It was a bad wound, was it not?
- 10 A It was a complex arm injury.
- 11 Q And it was on this part --
- 12 A It was just below the elbow.
- 13 Q Okay.
- 14 A Where the bifurcation of the brachial artery
- 15 goes to the radial artery.
- 16 Q Were you able to converse with Mr. Green?
- 17 A Yes. He was awake and talking at the time.
- 18 Q Are you familiar with A and O times three?
- 19 A I am. Alert and oriented times three means
- 20 the patient is awake and tells you who they are,
- 21 where they are, what time it is and that they know
- 22 where they are at.
- 23 Q And Mr. Green was able to do that?
- 24 A Yes.
- 25 Q And you then, as I understand, you examined

1 the arm wound and what did you find?

2 A I found muscle and tendon injuries, muscle
3 injuries, arterial injuries and nerve injuries.

4 Q All right.

5 A And venous injuries, too, of course.

6 Q I believe you stated a minute ago that the
7 two, two of the main arteries were cut?

8 A Correct.

9 Q The ulnar and the radial?

10 A Correct.

11 Q And when that happens to an artery, Doctor,
12 what response, if any, does the body have to that?

13 A The artery contracts and it spasms shut and
14 so it doesn't always, very rarely bleeds from a
15 complete cut artery. Now, the veins don't, the
16 veins don't have that much muscle in them so they
17 will tend to ooze sometimes.

18 Q When you say ooze, that just means seep out?

19 A Seep out. It's a low pressure system, the
20 blood pressure in the veins is very low.

21 Q All right. Did you actually remove the
22 pressure dressing on his arm?

23 A I removed it to examine the wound.

24 Q And what exactly was there, dressing wise?

25 A The dressing was a four by four gauze and ace

- 1 wrap.
- 2 Q And an ace wrap around it?
- 3 A An ace wrap puts pressure on it.
- 4 Q That pressure is on it to keep it from what?
- 5 A To press the veins to minimize the bleeding.
- 6 The arterial bleeding is prevented from opening up
- 7 from the tourniquet.
- 8 Q You then removed the ace wrap and the
- 9 dressing?
- 10 A And the dressing to evaluate the wound.
- 11 Q What did you see?
- 12 A I saw cut arteries, cut muscle and cut
- 13 nerves.
- 14 Q Were the arteries bleeding?
- 15 A They weren't bleeding.
- 16 Q What about the veins?
- 17 A The veins were oozing a little bit.
- 18 Q Okay. And was he still able to converse with
- 19 you?
- 20 A Yes.
- 21 Q All right. And after you observed that, even
- 22 at that point in time was he still able to converse
- 23 with you?
- 24 A Yes.
- 25 Q Was he still stable, in your opinion?

1 A He was.

2 Q At anytime that you actually observed Mr.
3 Green at Grand Strand Regional Medical Center prior
4 to 2:48 in the afternoon did he ever appear
5 unstable to you?

6 A No.

7 Q Now, after you removed the dressing what did
8 you do?

9 A Well, when I removed the dressing to evaluate
10 the wound I had to make a decision of how to manage
11 the wound so I replaced the dressing until we could
12 get him completely worked up and go to the
13 operating room to fix it.

14 Q All right. You actually put that back on
15 yourself?

16 A I with the nurse.

17 Q Sir?

18 A With the nurse.

19 Q Okay. And then you said you had to make a
20 decision as to what you were going to do about the
21 injuries that you saw?

22 A Right.

23 Q All right. And what did you determine that
24 you were going to do?

25 A I was going to have to re-establish blood

- 1 flow to his hand, repair both arteries but I would
2 also have to repair the nerves and the muscles.
- 3 Q All right. And your plan was to do that?
- 4 A Yes.
- 5 Q And your plan was to do it where?
- 6 A At Grand Strand.
- 7 Q Now, we're talking about a Saturday, are we
8 not, Dr. Cozart?
- 9 A Yes.
- 10 Q So, you would have had to do what in order to
11 be able to get this man through surgery?
- 12 A I would have to call the anesthesiologist in,
13 I would have to call the operating room team in
14 from home.
- 15 Q What is the required, what is the usual
16 response time unless they are already there?
- 17 A Thirty minutes.
- 18 Q Thirty minutes?
- 19 A They have to be within 30 minutes.
- 20 Q In this particular case, Doctor, do you
21 recall when you called in the OR team?
- 22 A I called right at 2:00 o'clock.
- 23 Q 2:00 o'clock?
- 24 A The OR team.
- 25 Q And was Mr. Green at the same time

- 1 transported to the pre-op or holding area?
- 2 A He was transported to the pre-operative area
- 3 shortly after that.
- 4 Q And would you have seen him there?
- 5 A Yes, I would have gone to see him.
- 6 Q Okay. And when you saw him was he still able
- 7 to converse with you?
- 8 A Yes.
- 9 Q Was he still all right?
- 10 A Yes.
- 11 Q Oriented?
- 12 A Oriented, yes.
- 13 Q And at that time when you saw him would have
- 14 been sometime after 2:00 p.m.?
- 15 A Sometime after 2:00 p.m.
- 16 Q And did he appear stable, or unstable to you
- 17 at that time?
- 18 A He appeared stable.
- 19 Q Now, when you got down there, Dr. Cozart, did
- 20 you learn that a CT scan had been requested?
- 21 A I found out later that he had another CAT
- 22 scan to check the post reduction films from the
- 23 hip.
- 24 Q You found that out after he had --
- 25 A After he had gone to pre-operative area.

1 lot worse.

2 Q At this time, Doctor, were you still well
3 within your window to fix the arm?

4 A Yes. We have generally four to six hours.

5 Q Okay.

6 A To repair it.

7 Q And we heard the terms used routine,
8 emergent, urgent. How would you classify this
9 gentleman as far as the repair to his arm?

10 A I would say it was urgent to be done within
11 four to six hours.

12 Q Four to six hours? And did you just tell us
13 also that, you know, to have the CT scan would mean
14 that he would only have to have one surgery as
15 opposed to two?

16 A Yes. If the CT scan showed that it was not
17 reduced, then he would have it reduced before going
18 to the operating room.

19 Q Why would that be advantageous to have one
20 surgery rather than two?

21 A So you won't have to go through two
22 anesthetics.

23 Q Why is that?

24 A Anesthetics can cause cardiac depression and
25 you want to get him black to the ICU as soon as you

1 perspective and your examination and your treatment
2 of this individual, do you have an opinion whether
3 or not there was anything that could have been done
4 between 2:00 o'clock and 2:48 to prevent the arrest
5 or the code?

6 A No.

7 Q Why do you say that?

8 A I think he had a spinal injury, too, even
9 though he didn't have a fracture, I think he was,
10 his heart rate was going down instead of going up
11 like it should have with a blood loss shock. In
12 fact it is probably fortuitous it happened there
13 and not in the operating room under anesthesia
14 because he might not have survived an operation
15 with cardiac arrest.

16 Q Is what you're telling us, that it would have
17 been worse if he had coded in the OR?

18 A It could have been worse. Under anesthesia
19 the cardiac function is depressed and we might not
20 have been able to resuscitate.

21 Q What is better about handling the cardiac
22 function and volume diminished in the OR as opposed
23 to outside the OR?

24 A Actually it is better to be outside the OR
25 awake and not under anesthetic because the

1 anesthetic will drop blood pressure, too. They

2 also have more manpower in the ER than the OR.

3 Q Is it your understanding, Doctor, that his

4 vitals became unstable before or after the CT?

5 A It was after CT.

6 Q Now, based upon the record that I just showed

7 you a moment ago and if Dr. Lintz's dictation is

8 correct at 2:05, this gentleman at 2:05 was already

9 in the CAT scan?

10 A Correct.

11 Q And would have been, would have come back

12 from the CAT scan to the ER?

13 A Right.

14 Q Correct?

15 A Correct.

16 Q After that?

17 A After the CAT scan.

18 Q Do you have an opinion, Doctor, to a

19 reasonable degree of medical certainty as to

20 whether or not this gentleman's bleeding was

21 controlled or uncontrolled?

22 A I think it was controlled by the tourniquet.

23 Q Okay. Did you have an opportunity to review

24 the nurses' flow sheet?

25 A I did.

- 1 Q In regards to the blood pressures?
- 2 A I did.
- 3 Q And based upon your review were they going up
- 4 and down or were they staying the same or what were
- 5 they doing?
- 6 A They were inconsistent, they were normal at
- 7 first and going down and then back to normal during
- 8 different times.
- 9 Q And according to the records there was a
- 10 blood pressure taken at 2:15?
- 11 A Right.
- 12 Q 72 over 56. Is that correct?
- 13 A Correct.
- 14 Q Were you aware of that?
- 15 A I saw that in the chart.
- 16 Q Okay. Did that concern you?
- 17 A Well, I think that would be low but then
- 18 again I would have to see what his heart rate was
- 19 at the same time.
- 20 Q 135?
- 21 A Heart rate 135, blood pressure 70.
- 22 Q That notation says it was at 2:15?
- 23 A Right.
- 24 Q Correct?
- 25 A Correct.

1 Q And if Dr. Lintz's record is correct, he was
2 in the CT scan prior to that?

3 A At 2:05.

4 Q Sir?

5 A Dr. Lintz's note is 2:05.

6 Q And then he had come back to the ER?

7 A He had come back to the ER.

8 Q At 2:15?

9 A It would probably take longer than that to
10 come back to the ER.

11 Q Now, do you know whether or not Dr. Bauerle
12 accompanied Mr. Green?

13 A I don't know. I wasn't at the CAT scan.

14 Q Okay.

15 MR. McCUTCHEON: Excuse me one moment, Your
16 Honor.

17 Thank you, Dr. Cozart, I have no further
18 questions.

19 THE COURT: Cross-examination.

20 CROSS EXAMINATION BY MR. MARTIN:

21 Q Dr. Cozart, how are you?

22 A Fine.

23 Q Let me ask you. Now, this event occurred, as
24 we all know, sometime nine years ago. Are you
25 testifying today from your memory of those events

1 or from the medical records of the events?

2 A Both my memory and the medical records.

3 Q So, you have some independent recollection?

4 A I do.

5 Q Tell me, then, before we even start, what is
6 your independent recollection, what details of the
7 medical records do you remember independent?

8 A I remember seeing the patient and evaluating
9 him and I also remember repairing the wound in the
10 emergency room, repairing the artery in the
11 emergency room.

12 Q Seeing him, evaluating him, repairing him?

13 A I remember repairing him in the emergency
14 room..

15 Q In the emergency room? And so you did get a
16 chance to repair the arteries in the emergency room
17 during or immediately after the code?

18 A After the code I was able to repair one
19 artery.

20 Q Now, you arrived, I believe the medical
21 records show about 1:05. Is that correct?

22 A That's correct.

23 Q And you determined at that time, I believe
24 you said you undressed it, you looked and you saw
25 the damage to his arm, correct?

1 A Yes.

2 Q All right. That is an operating room or
3 pre-op form, right?

4 A It's a form that the operating room uses.

5 Q All right. And it talks about Dr. Peters
6 being with you, doesn't it?

7 A We never made it into the operating room.

8 Q I understand that but doesn't that talk about
9 Dr. Peters being there with you, down at the
10 bottom?

11 A Dr. Ballow, not Peters.

12 Q Dr. Peters is there, right?

13 A Right.

14 Q Okay. And that is the operating, there is a
15 nurse there, too?

16 A There is none listed there.

17 Q Joyce Connor, electronic signature by Joyce
18 Connor.

19 A Electronic signature, Joyce Connor. That is
20 who would have been in the operating room.

21 Q That is who would have been in the operating
22 room. So, at that point in time we have --

23 MR. MARTIN: I would move to enter this into
24 evidence.

25 THE COURT: Any objection?

1 MR. McCUTCHEON: No, sir.

2 MR. MARTIN: 22.

3 THE COURT: Just a second. Without
4 objection.

5 (Nurse's note marked and received in evidence
6 as Plaintiff's Exhibit Number 22).

7 BY MR. MARTIN:

8 Q At that point we have the anesthesiologist
9 there, we have the operating room nurse there,
10 right?

11 A Correct.

12 Q Correct?

13 A Yes.

14 Q So, to say that you didn't call that group
15 until 2:00 o'clock is just a faulty memory on your
16 part, is it not?

17 A I would have called as soon as I evaluated
18 the wound.

19 Q All right. Now, on that accord you say, I
20 believe your testimony was, going back to these
21 fractured ribs, Mr. McCutcheon showed you some
22 exhibits from, an exhibit from Grand Strand
23 Hospital that I believe you looked at and you said
24 that it didn't tell you whether or not there were
25 any rib fractures?

1 A No gross fracture.

2 Q And in other words, that vertebrae that wraps
3 around that protects the spinal cord was not
4 damaged at all, was it?

5 A The vertebrae wasn't fractured but it doesn't
6 mean the cord wasn't contused from the trauma.

7 Q I agree with that but wouldn't you agree with
8 me that the first thing you think about if you've
9 got a spinal cord injury is oftentimes it is
10 accompanied by damage to the bony structure
11 surrounding it, is it not?

12 A Many times it is.

13 Q Yes. As a matter of fact that finding one
14 without damage to the bony structure is categorized
15 in the literature as rare, isn't it?

16 A It is rare.

17 Q Extremely rare in the literature, isn't it?

18 A It is in adults.

19 Q And would you agree with me further in the
20 medical records and examination you did that day at
21 the hospital that there was absolutely no evidence
22 whatsoever that there was injury to the spinal cord
23 from the wreck itself, was there?

24 A The only thing I can say is there was no
25 injury to the vertebral bodies.

1 Q So --

2 A I can't talk about the cord.

3 Q So, what has happened is you and Dr.

4 Nicholson, in your opinion, without any evidence of

5 it, that it was one of those extremely rare cases

6 in an adult where he suffered a spinal cord injury

7 from trauma when there was no evidence of bony

8 structure damage with it at all. Right?

9 A I think that it is he possibly could have had

10 a spine injury. Many head injuries have brain

11 injuries and no fractured skull.

12 Q Well, anything is possible.

13 A Sure. This is a deceleration injury, there

14 is traction on the spine.

15 Q Well, anything is possible and that is

16 essentially what you're testifying to, anything is

17 possible.

18 A No, I'm saying he possibly could have a spine

19 injury that didn't show up because the mechanism of

20 injury, the amount of force he was hit with, it is

21 like running into a brick wall at 60 miles an hour.

22 Q If that's the case the issue is every time

23 somebody gets in a bad car wreck they are going to

24 be paralyzed from injury to the spinal cord, right?

25 A No, that is not what I'm saying at all.

1 get a CAT scan?

2 A Correct.

3 Q All right, and the records reflect that they

4 took him back to the emergency room and he was

5 there at 2:15 in the emergency room with Dr.

6 Bauerle by his bedside. Are you aware of that?

7 A According to the nurses' notes.

8 Q At that time his blood pressure was 72 over

9 56 with a heart rate of 135. Are you aware of

10 that?

11 A Yes.

12 Q Okay. And then the nurses' notes say he took

13 him to CAT scan, right, he goes to CAT scan, then

14 he comes back to the ER? My point to you is you

15 don't know what time he actually was taken to the

16 CAT scan room yourself, all you can rely on is the

17 record, right?

18 A Right.

19 Q All right, and if anybody was going to

20 explain what Dr. Lintz meant by his notes it ought

21 to be Dr. Lintz, right?

22 A Yes.

23 Q Okay. And if Dr. Lintz writes here that he

24 noted -- these notes are electronically signed at

25 2:05. Are you aware his testimony is he had talked

1 to Dr. Bauerle before Bauerle came in and Dr.
2 Bauerle was adamant that they get a second scan,
3 right?

4 A I found that out later.

5 Q Okay. And that Dr. Bauerle comes in
6 somewhere around 2:00 o'clock, 2:05, sees him in
7 the pre-op holding area. Are you aware of that?

8 A Yes.

9 Q Okay. You didn't talk to him there?

10 A No. I was probably getting scrubs on.

11 Q So, when Bauerle, when Dr. Lintz was
12 transcribing these notes they are trying to hang
13 their hat on about the fact he had already gone to
14 the CAT scan at that 2:15 blood pressure reading,
15 Lintz dictated that because he already knows that
16 Dr. Bauerle is coming in and insisting on the CAT
17 scan and he is simply saying Dr. Bauerle had come
18 in and patient was currently in CAT scan. We don't
19 know whether he was actually in CAT scan or just
20 that Lintz knew he was going to be sent to CAT
21 scan, do we, you don't know?

22 A I don't know. I mean, I wasn't there.

23 Q Now, the emergency room and the CAT scan room
24 are two different rooms, right?

25 A Yes, separated by some distance.

1 Q But we do, what we don't know is, and I mean
2 you don't know, and I guess this is key, when the
3 nurses wrote these notes down, I guess you say it
4 is possible anything could have occurred but that
5 is what we have to go by, isn't it, the medical
6 records?

7 A Yes.

8 Q And what we do know is, then, according to
9 the nurses' notes at 2:15 he is in the ER with a
10 blood pressure of 72 over 56 and a heart rate of
11 135. Correct?

12 A That's correct.

13 Q All right. And you would agree with me that
14 that is not a stable vital sign, is it?

15 A No, not at the time.

16 Q And you, if you had been there at that time
17 you would not have, you would have deferred the CAT
18 scan in order to do more vitals or resuscitating,
19 would you not?

20 A Well, at the CAT scan he was stable, he
21 didn't become unstable until he got back from CAT
22 scan.

23 Q Well, what I'm asking you is, and you have
24 given a deposition in the case, have you not?

25 A Yes.

1 Q And --

2 A Yes, sir.

3 Q And if one had a blood pressure of 72 over 56
4 with a heart rate of 135 you would have deferred
5 any CAT scan, had you been in charge of it at that
6 time, in order to evaluate further the patient?

7 A I would defer it if I had an unstable
8 patient. Again, that was after he got back. At
9 the time he had went to CAT scan, you know, he
10 didn't have that blood pressure.

11 Q You don't know what his blood pressure was
12 when he went to CAT scan, do you?

13 A I don't know, no.

14 Q You weren't there?

15 A I wasn't there.

16 Q Let's get that clear. When you saw him at
17 1:10, you didn't see him again until he coded in
18 the emergency room, did you?

19 A I saw him when he was coding in the emergency
20 room because I had come back.

21 Q Which was about 2:48, right?

22 A Roughly 2:48.

23 Q Okay. So my point to you is, just so we're
24 clear, from 2:00 o'clock to 2:48 you don't see him
25 anywhere, did you?

- 1 A I saw him in prep holding.
- 2 Q Pre-op holding around 2:00 o'clock?
- 3 A Around 2:00, after 2:00 o'clock, between
- 4 2:00, a little after.
- 5 Q I will give you this. Between 1:55 2:05,
- 6 2:08, from then until 2:48 there is about a 40
- 7 minute period while he's back to ER, over to scan,
- 8 back to ER, that you don't see him, do you?
- 9 A No, I didn't see him.
- 10 Q So you have absolutely no opinion whether he
- 11 is stable or not, do you?
- 12 A I couldn't tell you if he was stable or not
- 13 at that time.
- 14 Q The only thing you can go by is there was a
- 15 blood pressure taken at 2:15 according to the
- 16 medical records, it says the blood pressure was 72
- 17 over 56 with a heart rate of 135 and you yourself
- 18 believe that to be unstable?
- 19 A That is after he got back from CAT scan?
- 20 Q No, huh-uh, that is not what the records
- 21 reflect. Do you know what time the records reflect
- 22 he got back from CAT scan?
- 23 A It was a little after 3:00. I would have to
- 24 review it.
- 25 Q The point is you don't know, do you? Do you

1 know?

2 A I don't know exactly what time he got back
3 from CAT scan.

4 Q All right. You just told us when he got back
5 from CAT scan he had the 72 over 56 with 135. That
6 is not what the medical records say, is it?

7 A That is the part of the records I reviewed
8 prior to the code.

9 Q Well, refer you reviewed them, we've got
10 medical records in evidence, I don't want to take
11 time to find them but do you dispute that the
12 medical records say that at 2:15 his blood pressure
13 is 72 over 56 with a heart rate of 135, he is going
14 to CAT scan and then when he comes back from CAT
15 scan, according to the medical records at 2:25 to
16 2:30 and it is at that time he's coded, that it is
17 what the records say? Do you disagree with that?

18 A No.

19 Q Now, there has been your testimony several
20 times to establish he was alert, awake and stable
21 and that you talked to him and he seemed to be fine
22 and came in and you talked to him, I believe again,
23 we go back, that was about 1:09, 1:10, in the
24 emergency room?

25 A Yes.

1 Q Okay. And do you know whether or not that's
2 before they had given him morphine and Versa, or
3 Verced, or not?

4 A I don't know.

5 Q Morphine and Verced might have some impact on
6 how one is, wouldn't it?

7 A They might.

8 Q Might impact your opinion as to whether or
9 not they were alert, talkative or not, might it?
10 Do you have any medical records or notes of your
11 own that indicate that he was alert and talking
12 after 2:00 o'clock?

13 A Not in the records, no.

14 Q Now I want to ask you again, they are taking
15 his blood pressure all the time, right,
16 intermittently?

17 A Okay.

18 Q Are they taking it with that blood pressure
19 cuff that you're calling the tourniquet?

20 A They are taking it with a different blood
21 pressure cuff.

22 Q So, he's got --

23 A Different arm.

24 Q Different arm? And did you make a note of
25 that tourniquet in your medical records?

1 A I think in my operative note.

2 Q Do what?

3 A In my consultation note.

4 Q You did, in your consultation note you made a
5 note of the tourniquet?

6 A Uh-huh.

7 Q Okay. Are you sure about that?

8 A As far as I can remember, yes, he had a
9 tourniquet on.

10 Q As far as you can remember? Well, let me ask
11 you this. If he had it you would have put it in
12 your medical record, wouldn't you?

13 A Not always.

14 Q You don't remember now nine years ago whether
15 he had one on or not, do you?

16 A Well, I do remember he had one on because
17 every time I go in there and they have an injury
18 like that there is a tourniquet on.

19 Q You saw him one time nine and a half years
20 ago in the emergency room and you think you
21 remember he had one on?

22 A Yes.

23 Q Now, arteries spasm and that is a natural
24 reaction of the body, right?

25 A Yes.

1 Q And that either stops or curtails bleeding?

2 A Generally stops bleeding.

3 Q All right. And of course eventually those
4 arteries are going to relax, aren't they?

5 A Yes.

6 Q And of course this accident happened 11:30
7 and we're around about 2:00 o'clock here with Mr.
8 Green. It would be fair to say those arteries, at
9 some point in time they have began to relax,
10 wouldn't it?

11 A When I took the dressing off they weren't
12 bleeding at all.

13 Q If you give a patient morphine and Verced
14 that would tend to relax the arteries, would it
15 not?

16 A It relaxes the patient but not necessarily
17 relax the artery.

18 Q So, the arteries operate separately from the
19 rest of the body when it came to the effects of
20 morphine?

21 A Smooth muscle may be affected differently. I
22 have seen arteries spasm for a week and then open
23 up.

24 Q Let me ask you this. When you, of course
25 eventually at some point in time they are going to

1 start bleeding, right?

2 A Yes.

3 Q if I cut my arm real bad and I just say, "I
4 ain't got time to go to the emergency room, those
5 arteries, they will stop bleeding, I will be okay,"
6 that is not necessarily true, is it?

7 A No, that is not necessarily true. Eventually
8 they will open up but you also have to re-establish
9 flow to the hand.

10 Q That or lose my hand, or going to bleed to
11 death, those things, right?

12 A Well, you can hemorrhage out and you can lose
13 a hand if you don't repair them in six hours.

14 Q Sure. And one thing that we can agree on is
15 if I cut the arteries in my arm and I bleed long
16 enough I will lose enough blood until I will
17 arrest, have a cardiac arrest, will I not?

18 A Not necessarily.

19 Q No?

20 A Not necessarily. I have seen arteries,
21 traumatic injuries and the accident take a leg off
22 and they weren't bleeding.

23 Q Well, my question, the premise of my question
24 was if I bleed enough, if I lose enough blood from
25 whatever injury I will, eventually enough blood

1 will flow out of my body that my heart can't find
2 enough to pump on through it, isn't that correct?

3 A If you lost enough blood.

4 Q Right. And what happens is I have a cardiac
5 arrest, right?

6 A That can happen.

7 Q And it's a code, right?

8 A Yes.

9 Q And we do know that Mr. Green had a cardiac
10 arrest and a code there in the emergency room or
11 either the CAT scan room that day?

12 A He had it in the emergency room.

13 Q And you were there, weren't you?

14 A Yes.

15 Q And there was everything done that could be
16 done to save his life?

17 A Yes, his life was saved.

18 Q CPR involves compression, the whole nine
19 yards, right, intubation?

20 A Yes.

21 Q Thankfully he was resuscitated, was he not?

22 A Yes.

23 Q It was a prolonged period without any blood
24 flow through his body?

25 A I would say eight minutes, based on the

1 Q You talked a little bit about the dislocation
2 of the hip and the impact that had on what happened
3 here today. Would you agree with me that the hip
4 had been reduced by Dr. Lintz at 1:52?

5 A It was reduced.

6 Q And would you agree with me that you can
7 determine whether or not a hip has been reduced
8 with a portable xray right in the operating room?

9 A It can't be.

10 Q What?

11 A You can't tell by xray whether it's reduced.

12 Q Now, the reason for a CAT scan is to
13 determine if there was any bony fragments in the
14 joint, right?

15 A Right.

16 Q And the bony, if there are bony fragments in
17 the joint after the hip has been reduced, which Dr.
18 Lintz's record showed it hadn't and that you could
19 show it through a portable xray right there in the
20 operating room, you don't need a CAT scan, do you?

21 A Well, I'm not an orthopedic surgeon. CAT
22 scans are certainly more accurate than a normal
23 xray for reduction, hip post reduction.

24 Q Well, the worst thing that is going to
25 happen, the worst is going to happen to you if you

1 do have bony fragments in there and they don't get
2 them out is you might develop arthritis from that,
3 correct?

4 A I'm not an orthopedic surgeon, I can't give
5 an opinion on that.

6 Q Well, you know, you have opined about a lot
7 of things here today and I'm asking you do you not
8 know that the problem that might come from leaving
9 a few tiny fragments in a hip is going to be
10 arthritis and nothing more?

11 A Well, if the hip is still dislocated you
12 might lose blood supply to the femoral head.

13 Q If he lost blood supply to the femoral head
14 he is likely to have his hip replaced?

15 A Yes.

16 Q He will not be paralyzed, would he?

17 A No.

18 Q So what we're talking about here is paralysis
19 or arthritis of the hip, right?

20 A I don't see any comparison of the two.

21 Q Okay. And by the way, if Dr. Bauerle knew he
22 wasn't going to do any surgery on the hip that day,
23 then certainly he wouldn't have needed a CAT scan,
24 would he?

25 A I can't speak for Dr. Bauerle.

1 MR. MARTIN: One second.

2 Q I just ask you, I'll hand you Exhibit Number
3 23, Dr. Cozart, and ask you if that is the
4 consultation report you made in this case?

5 A That is.

6 Q That's it, right?

7 A Yes, sir.

8 Q Any more or other you made?

9 A Just a handwritten note in the chart.

10 Q That's in this chart, too?

11 A Yes.

12 MR. MARTIN: I move to enter into evidence
13 Number 23.

14 THE COURT: Any objection?

15 MR. McCUTCHEON: No, sir.

16 THE COURT: In evidence without objection.

17 (Consultation report marked and received in
18 evidence as Plaintiff's Exhibit 23)

19 BY MR. MARTIN:

20 Q Now I'll show you Plaintiff's Exhibit 24.

21 MR. McCUTCHEON: Can I see it, please?

22 MR. MARTIN: I'm sorry.

23 MR. McCUTCHEON: No objection, Your Honor.

24 THE COURT: Plaintiff's 24 is in evidence
25 without objection.

1 MR. MARTIN: Well, I don't want to offer it
2 at this time for a specific reason. I just want to
3 get him to identify it.

4 BY MR. MARTIN:

5 Q Is that the handwritten notes from your
6 records?

7 A One of my notes.

8 Q What?

9 A One of my notes.

10 Q Do you have anything other than that?

11 A I have notes from the ICU after he was
12 resuscitated.

13 Q Anything before?

14 A Not before.

15 Q So those are the only two documents you would
16 have written about your time before he coded?

17 A Yes.

18 MR. MARTIN: That is all that I have at this
19 time, Your Honor.

20 THE COURT: All right.

21 Redirect?

22 REDIRECT EXAMINATION BY MR. McCUTCHEON:

23 Q Dr. Cozart, Mr. Martin asked you a bunch of
24 questions about what the record shows, what the
25 record shows, what does the record show. He didn't

1 WAYNE B. BAUERLE,

2 after being first duly sworn, testified as follows:

3 THE CLERK: State your full name for the
4 court, spell your last.

5 THE WITNESS: Wayne Brian Bauerle,
6 B-a-u-e-r-l-e.

7 DIRECT EXAMINATION BY MR. McCUTCHEON:

8 Q Good afternoon, Dr. Bauerle.

9 A Good afternoon.

10 Q How are you?

11 A I'm fine, thanks.

12 Q Who are these two lovely young ladies sitting
13 back over here?

14 A Those beautiful young ladies, the one with
15 the dark hair is my wife Cheryl, and the other one
16 with the blonde hair is my daughter Summer.

17 Q And we're thanking the Lord she looks like
18 her mama, right?

19 A Yes, sir.

20 Q Now, Dr. Bauerle, obviously I need to ask you
21 some questions --

22 A Yes, sir.

23 Q -- about this case. You are one of the
24 defendants in this case, is that correct?

25 A I think I'm the only defendant.

1 femoral head can die, it is called a vascular
2 necrosis and can lead to arthritis, can lead to a
3 total hip.

4 But something else wasn't mentioned. When
5 that femoral head is out the back of the hip joint,
6 we call it posterior hip dislocation, what hasn't
7 been mentioned yet, there is the siatic nerve
8 sitting right there. That femoral head is pushing
9 on the sciatic nerve, that can cause the nerves to
10 die and that can lead to paralysis, that leg on
11 that side would not be able to function.

12 Q All right, sir. You wanted a CAT scan and
13 you just told us why you wanted a CAT scan?

14 A Yes.

15 Q And there has been some mention of the fact
16 that there may have been some disagreement between
17 you and Dr. Lintz about whether it needed to be
18 done or not?

19 A I had no disagreement, I knew exactly what
20 needed to be done, it's what I did.

21 Q Okay. Now, I would assume you immediately
22 went to Grand Strand Hospital?

23 A Yes.

24 Q And where was Mr. Green when you first saw
25 him?

- 1 A When I first encountered Mr. Green he was in
2 the holding area, the waiting area of the operating
3 room.
- 4 Q The pre-op holding area?
- 5 A Pre-op holding area, yes.
- 6 Q Okay. And was there anyone with him?
- 7 A Yes. Dr. Cozart was sitting at the nurses'
8 station.
- 9 Q He was what?
- 10 A Sitting at the nurses' station.
- 11 Q Okay. And did you have an occasion to
12 examine Mr. Green at that time?
- 13 A Yes.
- 14 Q Tell me what you did?
- 15 A First of all I introduced myself to him.
- 16 Q Okay.
- 17 A And then I did the usual examination just to
18 make sure he was awake and alert, knew where he
19 was, what was going on. I noticed that obviously
20 his left forearm was -- excuse me.
- 21 Q Right forearm?
- 22 A Excuse me, right forearm was bandaged and his
23 wrist limp. I didn't see where the lower extremity
24 was grossly out of alignment, which was a good sign
25 because that gave me some indication that Dr. Lintz

1 had more than likely reduced the hip, but he was
2 moving all four extremities.

3 Q Then based on that examination, what about
4 his ability to converse? Was he awake, was he
5 alert?

6 A He was awake and alert, oriented.

7 Q He was able to converse with you?

8 A Yes.

9 Q And based upon your -- of course that would
10 have been a limited exam, would it not?

11 A Yes.

12 Q To a certain degree?

13 A It was a cursory orthopedic exam.

14 Q All right. And based on that exam, Doctor,
15 was this gentleman stable or was he unstable?

16 A At that moment in time my opinion from an
17 orthopedic surgeon standpoint he was stable. If I
18 can talk to you and can you answer my questions and
19 I can examine you you're stable until somebody
20 tells me otherwise.

21 Q Okay. And then as a result, after you
22 examined him where did you send him?

23 A He went to get a CAT scan.

24 Q Did he go back to the ER first or did he go
25 to the CAT scan?

1 we call it, back to the emergency room, less
2 distance than it would have been to the OR, I will
3 say 50 feet.

4 Q How about from the OR to the ER?

5 A Back then, basically the distance from the
6 OR, or from CT to OR was about the same, 50 to 100
7 feet.

8 Q Then as I understand, after you left the CT
9 reading room you went back to the emergency room?

10 A That's correct.

11 Q And Mr. Green was in the emergency room?

12 A And he wasn't doing very well.

13 Q And by that what do you mean?

14 A His pressures, from what I can recall, his
15 pressures was dropped, they were concerned about
16 his vital signs and were basically getting ready to
17 start resuscitation.

18 Q Do you know approximately what time we're
19 talking?

20 A No, I don't.

21 Q Okay. And who all -- were any other
22 physicians there when you got there?

23 A I believe Dr. Lintz was there, I believe Dr.
24 Cozart was there, and then once they got further
25 into the resuscitation process I believe that Dr.

1 Peters, the anesthesiologist, came over. I don't
2 know if they called him or he heard code blue over
3 the speakers but he ended up coming in and
4 assisting with the resuscitation.

5 Q And this gentleman did in fact, did he not,
6 suffer a cardiac arrest?

7 A As an orthopedic surgeon I'm probably not the
8 best one to ask about cardiac arrest but if he
9 didn't I think he was doggone close to it.

10 Q Okay. And he had to be resuscitated?

11 A Yes, sir.

12 Q And by resuscitated, you mean what?

13 A Basically they were coding him, compressions,
14 i.v. fluids, I believe they hung blood, whatever
15 they deemed necessary. Once again, as an
16 orthopedic surgeon I don't run code, I haven't in
17 twenty years.

18 Q You have participated in them?

19 A Excuse me?

20 Q You have participated in them?

21 A No. I stay away. That is not what I do as
22 an orthopedic surgeon, I don't run code.

23 Q Did you stay while they were?

24 A I watched.

25 Q But you were there?

1 pulseless?

2 A If he's pulseless -- well if he's pulseless
3 he has no pulse, I assume it's an arrest.

4 Q Then what does number four say?

5 A Number four, 1456, CPR ceased, pulse present,
6 femoral dopplerable.

7 Q That means that the pulse has been restored,
8 correct?

9 A Yes.

10 Q And how long was that, 1448 to 1456?

11 A Eight minutes if my math is correct.

12 Q Eight minutes?

13 A Yes.

14 Q Doctor, if in fact Dr. Lintz's dictation is
15 correct and --

16 A It is correct.

17 Q Okay. At 2:05?

18 A Yes.

19 Q According to the other records, to include
20 the nurses' notes, you assume it's accurate?

21 A Yes.

22 Q Is that the pulse of 72 over 56 --

23 A Blood pressure.

24 Q Blood pressure. In other words, you would
25 have been downstairs, or not downstairs --

1 A We were already, he was somewhere in CAT scan
2 or finishing CAT scan, obviously you can't get a
3 blood pressure when you're in the CAT scan machine,
4 that I know of.

5 Q When you went to the, or when you came to the
6 holding area, you said Dr. Cozart was there?

7 A Yes.

8 Q You have already told us that this gentleman
9 looked stable to you, is that correct?

10 A Yes.

11 Q Did you talk with Dr. Cozart?

12 A Yes.

13 Q What did you ask him, what happened?

14 A I asked him if it would be appropriate for me
15 to take the patient to get the CAT scan that I
16 needed.

17 Q What did he say?

18 A He didn't say no.

19 Q He didn't say, "No, you can't take him"?

20 A No, he did not, because if he had of I
21 wouldn't have taken him and I would have documented
22 that in my dictation.

23 Q So is my information correct, based on what
24 you told me, you were not aware of the blood
25 pressure 72 over 56 at 2:15?

1 MR. McCUTCHEON: Thank you, Dr. Bauerle.
2 Please answer any questions these gentlemen may
3 have.

4 THE COURT: Cross-examination.

5 MR. MARTIN: If it please the Court.

6 CROSS EXAMINATION BY MR. MARTIN:

7 Q Dr. Bauerle, how are you?

8 A I'm fine.

9 Q Give me one second, Dr. Bauerle.

10 A Yes, sir.

11 Q Let me ask you some questions to be sure I
12 understand what is happening here. First of all
13 with this dictation we have talked about, where do
14 you do that?

15 A There are multiple dictation, we call them
16 physician dictation areas in the hospital. The
17 emergency room, holding area, doctors' dictating
18 area and the operating room. You can, basically,
19 any phone in the hospital that the physicians can
20 access we can access the dictation system. You can
21 access it from home if you want.

22 Q So, they've got them all over?

23 A Got it all over, scattered all around the
24 hospital.

25 Q One in the ER, one in the operating room?

1 A Where there is a phone jack, basically.

2 Q Okay. And I think that between your -- let
3 me ask you this.

4 A Uh-huh.

5 Q Your testimony today is primarily from the
6 medical records as opposed to your independent
7 recollection?

8 A Both.

9 Q Some of both?

10 A Some of both, that's correct.

11 Q And to your recollection you got to the
12 hospital shortly before or around 2:00 o'clock?

13 A That's correct.

14 Q And you went straight to the OR pre-op area?

15 A Went straight to the pre-operative holding
16 area, correct.

17 Q All right. And you knew to go there I guess
18 because somewhere along the line you had been told
19 he had been sent there?

20 A Yes.

21 Q Before you got to the hospital, I guess in
22 your --

23 A Dr. Lintz had told me when he called me the
24 second time that the patient would be going for
25 repair, whatever needed to be repaired in that

1 A That's fine.

2 Q It says the patient had gone to CAT scan.

3 A I could have sworn it said Dr. Bauerle was
4 with the patient.

5 Q I won't argue about it. Anyway, it says
6 something about either you or the patient or you
7 and the patient had gone to scan?

8 A Yes.

9 Q Of course he knew when he got off the
10 telephone with you that you were going to send him
11 to scan, did he not?

12 A He knew I was adamant about getting the CAT
13 scan.

14 Q You were adamant he was going to get a CAT
15 scan?

16 A I think there is a difference in being
17 adamant and knowing what this patient needs to get.

18 Q Now you're assuming?

19 A We don't assume that.

20 Q Well, sometimes people have to assume some
21 things.

22 A Yes. I don't.

23 Q What we do here, what we do here is, there is
24 no question when you get off the telephone with
25 him, the conversation that you had had, that he has

1 you have read it recently?

2 A Yes.

3 Q You said, "I don't do that kind of surgery
4 and nobody there at the hospital that day would
5 have done that kind of surgery."

6 A That's correct. The surgery to fix the
7 posterior acetabular wall fracture, that is totally
8 different than doing surgery to remove small bone
9 fragments from the hip joint that would cause
10 cartilage degradation and lead to arthritis.
11 Apples and oranges.

12 Q Apples and oranges?

13 A Yes, sir.

14 Q But I am correct and clear when I, when we
15 say that you would not have done the acetabular
16 fixation?

17 A That's correct.

18 Q No matter what?

19 A That's correct, I would not have.

20 Q And nobody at the hospital is going to do it
21 that day?

22 A There is nobody at the hospital, period, that
23 did that type surgery.

24 Q Did that type surgery? Now, the question is,
25 then, that is out of the question, so the only

1 thing at issue is, are you going to go in if it
2 hasn't been properly relocated, which it was?

3 A Yes, sir.

4 Q Are you going to go in and remove any bone
5 fragments from it?

6 A Yes.

7 Q Okay. And of course you never got around to
8 doing that because he had a cardiac arrest in
9 between?

10 A Unfortunately not.

11 Q But today, knowing what you know today, is
12 that a surgery that you would have done that day?

13 A And I have done it in the past, yes.

14 Q And you have done those?

15 A Yes.

16 Q And you were prepared to do those that day?

17 A Yes.

18 Q But by the same token, you know, if the hip
19 has been reduced there is no orthopedic emergency,
20 is there?

21 A No, there is not, once the hip is reduced.

22 Q All right. And the hip was reduced.

23 Correct?

24 A It was reduced and was confirmed reduced with
25 the CAT scan.

1 Q Confirmed reduced and you confirmed it by
2 actually looking at it as it was being --

3 A No, wait a minute, now.

4 Q Okay.

5 A As an orthopedic surgeon and the last time I
6 looked sitting in this room I'm the only one, as an
7 orthopedic surgeon the only way, the only way you
8 confirm a reduced dislocated joint is with xray
9 and/or CAT scan. You never can rely strictly on
10 the physical exam.

11 Q Well, my question to you -- I must have
12 misstated my question.

13 A Yes.

14 Q My question was, when you walked in the CAT
15 scan arena and Mr. Green was there where you had
16 sent him, you observed while they were checking
17 him, I guess the screen, you can see it as it's
18 happening?

19 A No, there is a delay because they have to
20 reformat them so they can scan the patient, then at
21 that point in time in 2004 the CAT scan machines
22 weren't as fast as they are now in 2013, so the
23 patient would go, literally move through the CAT
24 scanner and then you have to wait for the computer
25 to reformat and produce those images.

1 Q That's not true?

2 A No.

3 Q So you think it would have been advisable to
4 open up that hip twice, knowing that the fixation
5 had to be repaired within a few days and was going
6 to be repaired and it was repaired in Charleston?

7 A Now you're asking me to project what may have
8 happened from that point on.

9 Q I won't do that, then I'm just going to ask
10 you this way. Are you saying that it would be
11 beneficial to Mr. Green for you to have gone in
12 under that anesthesia to repair his forearm, to
13 remove those few small bony fragments you saw and
14 not do the fixation and do all the trauma that went
15 with that, and then turn around a day or two later,
16 if they did that, and repair the fixation?
17 Wouldn't it have been preferable to repair the
18 fracture and remove the few bony fragments all at
19 the same operation?

20 A No.

21 Q Okay. Now, what we do know is, the bony
22 fragments in the hip were not a big problem, were
23 they?

24 A Bony fragments in any joint are a problem.

25 Q Well, the problem is, the problem is

1 arthritis, right?

2 A Yes.

3 Q And even if you remove those fragments he's
4 likely to develop arthritis in that joint, right?

5 A Just because you -- so, what you're asking me
6 is, just because you have had fragments in a joint
7 and you remove them that person is more likely than
8 not to develop arthritis?

9 Q I understand he may develop arthritis. Any
10 of us can develop arthritis?

11 A That's right.

12 Q And even if you don't remove those small bony
13 fragments we had here he may develop arthritis from
14 them?

15 A There is definitely increased incidence of
16 developing arthritis.

17 Q He may not develop arthritis from that but
18 there is an increased incidence of that?

19 A That's correct.

20 Q But we are talking arthritis.

21 A Yes, we are.

22 Q We aren't talking even necrosis of the hip so
23 you have to have hip replacement?

24 A No, we're not.

25 Q So, the real dilemma we've got here is that

1 Mr. Green, whether you realize it or anybody else
2 realizes it, was minutes away from a cardiac
3 arrest, we know he had a cardiac arrest at 2:25,
4 plus, something like that?

5 A That's what the records reveal, yes.

6 Q Okay. And as a matter of fact -- well, your
7 report is dictated at 3:00 o'clock?

8 A Okay.

9 Q Do you know where you dictated it from?

10 A From the telephone in the hospital.

11 Q Do you know which one? I don't know, I'm
12 just asking you.

13 A No, I don't know.

14 Q They talk about you being, the medical
15 records indicate, the nurses' notes, Dr. Lintz,
16 Nicholson, Bauerle and Cozart all at bedside at
17 1452. So, you were at the bedside at some point in
18 time?

19 A Like I said earlier, I was watching.

20 Q And if you dictated your records at 3:00
21 o'clock, do you know why you dictated the records
22 that quickly in the middle of his code, so to
23 speak?

24 A There is not much an orthopedic surgeon can
25 do during a code, to be quite honest.

1 Q And you didn't do anything in that code and
2 then obviously you didn't go back in and do
3 anything to the hip afterward?

4 A I made sure the abduction pillow was on, I
5 took care of the orthopedic problem.

6 Q Now, what we do know is, though, in addition
7 to that is that you did not know what his vital
8 signs were, did you?

9 A Not that I can recall, no.

10 Q And we know that you did not check his
11 medical chart?

12 A I don't remember if I did or I didn't. I
13 don't remember.

14 Q You don't what?

15 A I don't remember checking his medical chart.

16 Q Well, you went straight to the pre-op holding
17 area?

18 A Correct.

19 Q You didn't examine his medical chart?

20 A I examined him and I asked Dr. Cozart was it
21 appropriate for him to go get the CAT scan.

22 Q And you say, and I heard you say, I said what
23 did he say, you said he didn't say no.

24 A Right. If he said no I wouldn't take him.

25 Q You don't remember what he said but you're

1 telling us if he had said no you wouldn't have
2 taken him?

3 A Right.

4 Q Olay. So, if he doesn't remember talking to
5 you, he already testified to that?

6 A That's fine, he can only remember what he
7 remembers.

8 Q But you didn't talk to Dr. Nicholson about
9 him?

10 A I have no recollection of talking to Dr.
11 Nicholson.

12 Q You talked about him to Lintz over the phone
13 but didn't talk to Lintz after you got to the
14 hospital?

15 A I didn't talk to Dr. Lintz again until
16 probably during the code. That would be the last
17 time I would have said anything to him.

18 Q And had you known, you say in your
19 deposition, that his blood pressure was 72 over 56
20 with a heart rate of 135 that you would have done
21 something besides take him to CAT scan?

22 A That's correct.

23 Q All right. Of course you didn't know what
24 any of his blood pressures were when you ordered
25 him to go to CAT scan?

1 A Not that I can recall, no.

2 Q He had been given morphine and Verced in
3 preparation for surgery. Could you tell that when
4 you were talking to him?

5 A According to the records he was given the
6 morphine and Verced to relax him for the hip
7 reduction Dr. Lintz did, which is pretty standard.

8 Q My question to you is could you discern that
9 as a physician at the time you talked to him?

10 A Discern he had been given morphine and
11 Verced.

12 Q Yes.

13 A He was awake, alert and oriented when I spoke
14 to him. Generally someone who has been medicated
15 with i.v. narcotics, they are significantly
16 influenced by those and aren't awake, alert and
17 oriented.

18 Q That's my point. If they are they generally
19 aren't, but then we know that from the medical
20 records that he had been given morphine and Verced,
21 if they're correct, but you didn't look at the
22 records?

23 A Not that I remember.

24 MR. MARTIN: One second.

25 Thank you, Dr. Bauerle, that's all the

1 CHARLIE DORN SMITH, III.,

2 after being first duly sworn, testified as follows:

3 THE CLERK: State your full name for the
4 Court, spell your last.

5 THE WITNESS: Okay. My name is Charlie Dorn
6 Smith, III., S-m-i-t-h.

7 THE COURT: Go ahead.

8 DIRECT EXAMINATION BY MR. McCUTCHEON:

9 Q Good morning, Dr. Smith, how are you this
10 morning?

11 A I'm well, thanks. How are you?

12 Q We appreciate you taking the time to come
13 down here and to testify for us.

14 First of all, Dr. Smith, I would like to get
15 a little background information from you and
16 acquaint you --

17 THE COURT: Deputy, seize that phone.

18 DEPUTY SHERIFF: Yes, sir.

19 MR. McCUTCHEON: Sorry, Your Honor.

20 BY MR. McCUTCHEON:

21 Q Go ahead.

22 A I grew up in the big city of Turbeville,
23 South Carolina, I went to Salem High School in New
24 Zion, went to Wofford College, I then matriculated
25 to the University of South Carolina School of

1 MR. McCUTCHEON: I hadn't got to that point.

2 THE COURT: Okay.

3 MR. McCUTCHEON: Thank you, but I will go
4 ahead and do it now so I won't forget later.

5 At this time, Your Honor, we would offer Dr.
6 Smith as an expert in the field of general surgery,
7 cardio, thoracic and vascular surgery.

8 THE COURT: Do you wish to voir dire the
9 witness or challenge the qualifications?

10 MR. MARTIN: I do not, no, sir.

11 THE COURT: All right, he's qualified to give
12 his opinions in those fields.

13 BY MR. McCUTCHEON:

14 Q Now I want to talk a little bit about the
15 vascular surgery part. What is your understanding
16 of the injury that was sustained by Mr. Green on
17 April 17th of 2004?

18 A Well, he had multiple injuries. Primarily a
19 laceration to his right arm, acetabular fracture,
20 dislocation of his right hip as well as just
21 general thoracic trauma, if you will.

22 Q What is your understanding of what caused
23 these injuries to Mr. Green?

24 A He was the unrestrained driver of a vehicle
25 that unfortunately someone crossed the centerline

1 A Yes, sir.

2 Q In this particular case, based upon your
3 review of the records, do you understand that both
4 of those were severed?

5 A Yes, sir.

6 Q Or cut?

7 A Yes, sir.

8 Q Now, as a vascular surgeon, Doctor, what is
9 your understanding of what the body's response is
10 to the cutting of those two arteries?

11 A Well, the tendency, the way the good Lord
12 made us, if you sever an artery the tendency is for
13 the blood vessel to, the medical term is vasospasm,
14 vaso for blood vessel and spasm means for it to
15 shrink down. But it is a protective mechanism that
16 you have where the body tries to stop the spigot,
17 if you will, from allowing all your blood to flow
18 out of your body.

19 Q Okay. And did that occur here, based on your
20 review?

21 A Yes, sir.

22 Q Based upon your review of the records,
23 Doctor, did you see any evidence in the record that
24 at anytime he was in the ER or the holding area or
25 the CAT scan unit that there was any evidence of

1 active bleeding?

2 A There was ooze but not arterial bleeding.

3 Q What is the difference?

4 A Well, arterial bleeding is pulsitized. If
5 you thought about it, when you feel someone's pulse
6 it's the heart beating and ejecting blood flow out,
7 or like if you wanted a drink of water, if you
8 will, where you turn on the spigot and it's
9 pressurized. Whereas to me it would mean if you
10 want a drink of water and you just sip what you
11 wanted, it is just a more controlled, if you will.

12 Q Okay. And based upon your review of the
13 records and once again asking you about the 2:15
14 notation in the nurses' record and the recorded
15 blood pressure 72 over 56, based upon your review
16 of the record and if you assume that this date
17 stamp is correct, then Dr. Bauerle could not have
18 been in the ER?

19 A That's correct.

20 Q Do you have an opinion, Doctor, as to whether
21 or not this gentleman was brought into the
22 emergency room and categorized as a stable
23 admission?

24 A Yes, sir.

25 Q And what do you mean by that? Is that to a

1 reasonable degree of medical certainty?

2 A Yes, sir.

3 Q And what does that mean?

4 A That means that when he came in that he was
5 not, again, emergent, someone that you were going
6 to rush off to the operating room immediately.

7 Q All right. And based upon, once again, and I
8 keep asking it this way but I have to base it on
9 the records, based upon your review of the records
10 what did you notice about this gentleman's blood
11 pressures from the time he arrived until the time
12 he coded?

13 A It was somewhat of a rollercoaster, it was up
14 and down as they resuscitated him, but it was
15 never, you know, horribly low, per se.

16 Q And then what is your understanding, once
17 again based upon that same review, as to whether or
18 not this gentleman was stable from the time he came
19 in, until the time he left the pre-op holding area
20 to go to the CT scan?

21 A He was awake and alert, talking, and that is
22 usually a pretty good sign that your brain is being
23 profused or has enough blood supply, if you think
24 about it, and people that are in shock, they are
25 not really responsive and can't really talk to you

1 or are confused, if you will.

2 Q Okay. Would you categorize that, do you have
3 an opinion to a reasonable degree of medical
4 certainty as to whether or not that was a stable
5 individual?

6 A Yes, sir.

7 Q Now, Doctor, I want to talk to you about one
8 other area, and do you have an opinion in this case
9 to a reasonable degree of medical certainty as to
10 what caused Mr. Green to arrest?

11 A Yes, sir.

12 Q And what is that opinion?

13 A It was --

14 Q To a reasonable degree of medical certainty?

15 A What caused his arrest was, is just
16 hypovolemia and the trauma of the whole event, if
17 you will.

18 Q Was it caused by trauma, or loss of blood?

19 A It was a combination of both. The trauma
20 caused the loss of blood, if you will, so --

21 Q Loss of blood where?

22 A Primarily from his arm.

23 Q Okay. Have you looked at the reports,
24 Doctor, from MUSC?

25 A Which one?

1 level of T6, T7. That means the thoracic spine
2 which is about the midway down, all the way down to
3 T12 without evidence of hemorrhage, which is
4 bleeding, and this could be directly, this could be
5 directly due to trauma or cord contusion, cord
6 infarction related to the cardiac arrest and also
7 be considered, number two says bilateral pleural
8 effusion, bilateral air space consolidation. And
9 Number three is, it says subcutaneous edema of some
10 of the issues of the back.

11 Q All right. Now, Doctor, are those two
12 reports, I think one of them even referred to a
13 cord contusion. What is that?

14 A A contusion is the medical term for a bruise.
15 In other words, if I popped you in the nose your
16 nose would swell and it would bruise, maybe even
17 bleed, maybe get black eyes but I would have
18 contused your face, if you will.

19 Q All right. And can you have injury to the
20 spinal cord to include infarct, based on trauma?

21 A Yes, sir.

22 Q And can it be based on trauma even aside from
23 the fact that you don't see any bony abnormalities?

24 A Yes, sir.

25 Q And that --

1 A Yes, sir.

2 Q And what happens to the spinal cord in
3 accidents or whatever where it causes a blow to or
4 defined bony involvement?

5 A The concern of the spinal cord and the brain
6 is they are both encased within a bony structure,
7 if you will, your skull or the spine itself, and
8 there is a limited amount of space in there, so if
9 I walked up and hit you in the head with a hammer,
10 even if I didn't fracture your skull, if I hit you
11 hard enough to cause swelling your brain would
12 swell over the next, you know, 24, 48, 72 hours,
13 and the thing that is dangerous about that both for
14 the head and the spinal cord is there is a limited
15 amount of space in there that you have available
16 for the brain or the spinal cord to swell and as it
17 swells it can get compressed and cuts off the blood
18 supply to the brain or even to the spinal cord.

19 Q And what happens to the spinal cord?

20 A The spinal cord dies.

21 Q Okay. Now, Doctor, in this particular case,
22 based upon your review of the medical records and
23 the depositions in this particular case --

24 A Yes, sir.

25 Q -- do you have an opinion whether this

1 gentleman's arrest was caused by hypovolemia, which
2 is loss of blood?

3 A Yes, sir.

4 Q Or blunt trauma to the spinal cord, do you
5 have an opinion to a reasonable degree of medical
6 certainty as to whether or not at the time that Dr.
7 Bauerle got involved in this case was there
8 anything that could have been done by Dr. Bauerle
9 or anyone else that would have changed the outcome
10 in this case?

11 A By the time Dr. Bauerle showed up I think the
12 die was cast.

13 Q Is that opinion to a reasonable degree of
14 medical certainty?

15 A Yes, sir.

16 MR. McCUTCHEON: If the court would bear with
17 me one moment, please?

18 THE COURT: Yes, sir.

19 MR. McCUTCHEON: Thank you, Doctor. Please
20 answer any questions these gentlemen may have.

21 THE WITNESS: Yes, sir.

22 THE COURT: Cross-examination.

23 MR. MARTIN: Yes, sir, If it please the
24 Court.

25 CROSS EXAMINATION BY MR. MARTIN:

1 A Yes, sir.

2 Q -- that there wasn't arterial bleeding
3 reported in the record but there was oozing
4 reported in the record?

5 A Yes, sir, oozing.

6 Q Is that right?

7 A Yes.

8 Q And that oozing, I'm trying to think what it
9 is like, if you took an hour glass?

10 A What?

11 Q An hour glass.

12 A Yes, sir.

13 Q And you turn it over it is not going to spurt
14 sand, is it?

15 A No, sir, it won't.

16 Q But it is going to ooze out of there, isn't
17 it?

18 A It will.

19 Q I've got an hour glass. That's oozing sand
20 as we talk, isn't it?

21 A Yes.

22 Q If you don't stop it you will eventually run
23 out of sand?

24 A Yes, sir.

25 Q And if you don't stop a bleed you will

1 eventually run out of what?

2 A Blood.

3 Q And if you run out of blood you're going to
4 suffer a cardiac arrest?

5 A Yes, sir.

6 Q Okay. Now, your basis for saying, if I
7 understand it correctly, that Mr. Green was stable
8 when Dr. Bauerle took him out of the pre-op and
9 sent him to CAT scan was Dr. Bauerle's testimony in
10 his deposition because you didn't hear him at the
11 trial yesterday?

12 A No, sir.

13 Q But that he was able to talk, communicate and
14 he appeared alert and all that kind of stuff?

15 A Yes, sir.

16 Q All right. But that's all that you have got
17 to base that on, isn't it?

18 A Yes, sir.

19 Q As a matter of fact, and I don't know if you
20 had a chance to review Dr. Bauerle's report that he
21 dictated about what he did in this case or not. It
22 was in the record and I'm sure you read it?

23 A Yes, sir.

24 Q But would you agree with me that it doesn't
25 say anything in there about having discussed Mr.

1 Green with Dr. Cozart after he arrived at the
2 hospital?

3 A Yes, sir.

4 Q It doesn't say anything about it?

5 A No, sir, it does not.

6 Q And as a matter of fact Dr. Cozart's report
7 doesn't say anything about having discussed Mr.
8 Green with Dr. Bauerle before he sent him to scan,
9 does it?

10 A That's correct.

11 Q All right.

12 A But he said he was fine with it.

13 Q But he said, he said he was fine with it?

14 A Yes, sir.

15 Q Of course now we know from, help me with
16 this, we know in Dr. Cozart's testimony yesterday
17 he's fine with it because he saw him at 1:10,
18 ordered in the operating apparatus and he didn't
19 see him again until in the code room, so 2:00, some
20 hour, hour and a half later?

21 A Yes, sir.

22 Q So, his condition could have changed from the
23 time Cozart saw him to the time Bauerle took him
24 out of scan, couldn't it?

25 A It certainly could have.

1 A Of course.

2 Q Okay. And am I right to say that that
3 increased blood pressure, not blood pressure, heart
4 rate going up is an indication that the heart is
5 having to work harder?

6 A Yes, sir.

7 Q And if the heart, if the blood in the body is
8 leaving and there is less and less of it the heart
9 has to do what to pump what is there?

10 A It increases its rate to compensate.

11 Q Yes. And every doctor who looks at the
12 record knows that, don't they?

13 A Yes, sir.

14 Q Now, I believe that you gave a deposition in
15 this case and you said in that deposition that,
16 when you were questioned about vital signs and
17 whether or not who knew them and didn't know them?

18 A Yes, sir.

19 Q That is the responsibility of the physician
20 examining the patient to make himself aware of the
21 condition of the patient, which includes the vital
22 signs of the patient?

23 A Yes, sir.

24 Q All right. And if a guy comes in like Mr.
25 Green, he has been there two hours and you come in

1 to check him, then the smart thing to do would be
2 to get his charts and take a look and see what had
3 occurred since he got there, wouldn't it?

4 A Yes, sir.

5 Q See what those vital signs were?

6 A Yes, sir.

7 Q All right. Do you realize Dr. Bauerle didn't
8 do that?

9 A Dr. Bauerle said he assessed the patient at
10 the time.

11 Q I agree. He said he assessed the patient but
12 he said, he testified in court he didn't pick up
13 the chart and look at it.

14 A Okay.

15 Q That would have been a good thing for him to
16 do?

17 A Yes, sir.

18 Q No question about that?

19 A Yes, sir.

20 Q He has also said that had he known his blood
21 pressure was 72 over 56 with a heart rate of 135 he
22 wouldn't have sent him to scan, he would have done
23 more checking on him?

24 A Yes, sir.

25 Q All right. Who's responsibility is it to

1 know the condition of the patient at the time you
2 issue orders about him?

3 A Well, the ordering physician, but in the
4 trauma scheme there are multiple people that are
5 taking care of the patient.

6 Q All right. But ultimately who's
7 responsibility is it?

8 A As far as in the grand scheme of things, I
9 mean, usually the trauma leader is the one that is
10 ultimately responsible for the patient but if you
11 are going to order something it is usually the
12 ordering physician.

13 Q That's right. And the trauma leaders, Dr.
14 Nicholson and Dr. Bauerle, agree they didn't talk
15 to each other, so he didn't talk to him?

16 A Yes, sir.

17 Q You don't see any indication different than
18 that in the record, do you?

19 A No, sir.

20 Q Okay. The old surgical adage, never argue
21 with a physician looking at the patient?

22 A Yes, sir.

23 Q Now, that in this case can also apply to Dr.
24 Lintz, can't it?

25 A Yes, sir.

1 Q Dr. Lintz was looking at him at a point in
2 time, wasn't he?

3 A Yes, sir.

4 Q And you remember reading in the medical
5 record where it says that Dr. Lintz put down that
6 he had talked to Dr. Bauerle who wanted scans and
7 that he thought it was better to repair an arm
8 first, that Dr. Lintz was adamant?

9 A Yes, sir.

10 Q Now, doesn't that indicate to you that in
11 that conversation it went just like that, "We need
12 to sew up the arm," "I need the CAT scan"?

13 A Yes, sir.

14 Q All right. Now at that point in time Lintz
15 is the one looking at him, isn't he?

16 A Yes, sir.

17 Q And he is saying, "We need to sew up that
18 arm"?

19 A Yes, sir.

20 Q And Dr. Bauerle comes in after that and
21 within minutes has checked him and sent him to
22 scan.

23 A He looked at the patient before sending him
24 to scan.

25 Q That's right.

1 MR. MARTIN: Bear with me just a minute.

2 Q Now let's go, let me talk to you a minute
3 about the cause of this damage to Randy's spinal
4 cord.

5 A Yes, sir.

6 Q Of course you know -- first of all you're not
7 a neurologist, are you?

8 A No, sir.

9 Q All right. And of course we have had the
10 doctors, Dr. Nicholson who is a surgeon over in
11 Myrtle Beach and Dr. Cozart who is a surgeon, and
12 they testified the same thing you did but they also
13 testified that they aren't neurologists and frankly
14 a neurologist is probably in a better position to
15 make the determination about the injury to the, the
16 cause of the injury to the spinal cord. Would you
17 agree with that?

18 A Well, that's true but it is also true that
19 this is certainly within the, my realm of practice
20 of medicine.

21 Q All right. But the practice of neurology
22 centers on the brain, the spinal cord and the
23 nervous system. Is that correct?

24 A Yes, sir, that's correct.

25 Q All right. Now, what we do know here is, and

1 surgeon is there, we know the anesthesiologist is
2 there, we know the CPR is there and we know that
3 the staff has been called approximately an hour in
4 advance of that in a place like Myrtle Beach and
5 you have got the people in place, then that would
6 be the best place to do such, if you were going to
7 have a cardiac arrest, to have it, would it not?

8 A It would certainly be one of the better
9 places to have it. It just depends, again, upon if
10 the support is there present in the OR versus the
11 ER.

12 Q That's right. And then the question is, and
13 what we're dealing with, that minutes can make the
14 difference between maybe, maybe seconds, between
15 Randy Green walking and not walking once he has
16 that cardiac arrest?

17 A It depends upon what you're determining as
18 the cause of his paraplegia was.

19 Q Well, if that is the cause of his paraplegia?

20 A If that is indeed true.

21 Q If the cardiac arrest and lack of blood flow
22 is the cause of his paraplegia?

23 A If that indeed is the case, yes, sir.

24 Q And lastly, once again, the damage to his
25 spinal cord is right there where that artery goes

1 into it, isn't it?

2 A Yes, sir.

3 MR. MARTIN: That's all the questions I have.

4 THE COURT: Redirect?

5 MR. McCUTCHEON: Yes, sir, Your Honor.

6 REDIRECT EXAMINATION BY MR. McCUTCHEON:

7 Q Doctor, in regards to the next to last
8 question, that assumes that the staff, including
9 the anesthesiologist, is in the OR?

10 A That's correct.

11 Q Is that correct?

12 A That is.

13 Q Now, Mr. Martin asked you earlier and he used
14 this time frame of 27 minutes without blood. Is
15 that your understanding?

16 A That is what he said, yes, sir.

17 Q All right. And I want to show you what has
18 been marked as Defendant's Exhibit Number 7.

19 A Yes, sir.

20 Q Which is the resuscitation record?

21 A Yes, sir.

22 Q Have you seen that resuscitation record?

23 A I have.

24 Q And the first time on there is what?

25 A 1448.

1 Q -- the canal?

2 A Yes, sir, that is correct.

3 Q And that causes an infarct?

4 A That's correct.

5 Q All right.

6 MR. McCUTCHEON: Thank you doctor. I have
7 nothing further.

8 THE COURT: Any questions on that?

9 MR. MARTIN: Just one other question.

10 RE-CROSS EXAMINATION BY MR. MARTIN:

11 Q Did you say you read Dr. Cozart's deposition?

12 A I'm sorry?

13 Q Did you say you read Dr. Cozart's deposition?

14 A Yes, sir, I did.

15 Q All right. And do you recall in there when
16 he asked Dr. Cozart where he was, that he says he
17 didn't know for sure, probably changing into his
18 scrubs?

19 A I don't recall. I thought he said he was
20 sitting at the nurses' station.

21 Q That is what Dr. Bauerle says, he was sitting
22 at the nurses' station.

23 A Okay.

24 Q You wouldn't disagree with me Cozart said he
25 was changing into his scrubs?

1 Q All right.

2 MR. MARTIN: Your Honor, I have talked to Mr.
3 McCutcheon, we move to enter exhibits 27, 28, 29
4 and 30 in the record.

5 THE COURT: 27 through 30. Any objection?

6 MR. McCUTCHEON: No, sir, Your Honor, there
7 is no objection to those three but I think, and I
8 think we can sort it out later, there is one of the
9 pages that is a duplicate.

10 THE COURT: All right, very good.
11 Plaintiff's 27 through 30 is in evidence without
12 objection. You may proceed.

13 (Dr. Bauerle's orders marked and received
14 in evidence as Plaintiff's Exhibits 27).

15 (Dr. Hyler consultation marked and received
16 in evidence as Plaintiff's Exhibit 28).

17 (Nurses' notes marked and received in
18 evidence as Plaintiff's Exhibit 29).

19 (Emergency room record marked and received
20 in evidence as Plaintiff's Exhibit 30).

21 MR. MARTIN: All right.

22 BY MR. MARTIN:

23 Q Dr. Haskin, without asking you exactly what
24 these are, I would ask you to just look through
25 them and see if you agree they are medical records

1 All right, let's go over, I guess we can
2 start off with the verdict form in this matter,
3 gentlemen. Regarding this, I have a verdict form I
4 will be glad for you all to look at in just a
5 second. It basically has the caption of the case,
6 there is a question, first question is do you find
7 that the defendant Wayne B. Bauerle, M.D., and
8 Wayne B. Bauerle, P.C., negligently did depart from
9 the standard of care in treating plaintiff Randall
10 M. Green and this negligence, and that this
11 negligent departure from the standard of care
12 proximately caused plaintiff Randall M. Green's
13 injury and has if yes go to question two. If the
14 answer is no stop deliberating and go no farther.
15 It basically tells them to stop and notify the
16 bailiff if the answer is no.

17 If yes, number two is please state the total
18 amount of damages, if any, sustained by plaintiff
19 Randall M. Green. There is a space for actual
20 damages. And then it says or for defendant. Down
21 at the bottom it has if you awarded actual damages
22 it says please continue to question three on page
23 three. If you do not award actual damages please
24 stop deliberating and notify the bailiff.

25 Question three is, do you find that defendant

1 Wayne B. Bauerle, M.D., and Wayne B. Bauerle M.D.,
2 P.C., was negligent and that such negligence
3 proximately caused the plaintiff Ann Green's loss
4 of consortium. And if the answer is yes go on to
5 question four. If no, deliberate no further,
6 notify the bailiff.

7 Question four is please state the total amount
8 of actual damages sustained by the plaintiff Ann
9 Green. Again it states for actual damages, or for
10 the defendant, and notify the bailiff when they're
11 done.

12 Do you all want to come up, I will be glad to
13 let you examine the verdict form.

14 (Unrecorded bench conference).

15 THE COURT: I appreciate the suggestion that
16 the plaintiffs have made as to the verdict form but
17 it would be my belief that if it was phrased in
18 that fashion I am at least implying, at least
19 suggesting to them that these damages be included.
20 I prefer for you to all to talk about that but I
21 don't think the verdict form is such that I'm
22 comfortable with submitting it to the jury in that
23 fashion.

24 MR. MARTIN: Okay, thank you, Your Honor.

25 THE COURT: Thank you.

1 MR. McCUTCHEON: I don't have any objection
2 to your verdict form.

3 MR. MARTIN: No objection.

4 THE COURT: All right, gentlemen, why don't
5 we go over the charge. I can tell you briefly my
6 intention is to charge the jury about the things
7 that we always talk to them about in any case,
8 credibility, believability, the verdict can't be
9 the result of any type of passion or sympathy,
10 speaks the truth, they decide it from the evidence
11 in the case, not any other extraneous or external
12 matters, they decide the case on the facts as
13 presented here and the law that I will give to
14 them.

15 We do have a corporation as a defendant so of
16 course I'll tell them that the corporation is
17 entitled to the same treatment as an individual, no
18 more, no less, the same consideration, and you can
19 sue, be sued, a corporation may be liable for the
20 acts of its officers, agents and employees when
21 they are acting in the scope of their authority or
22 in the course of their employment.

23 Didn't you all have two stipulations in this
24 case? I will tell them a stipulation is an
25 agreement, admission or stipulation made in a

1 but these are categories that you can look at to
2 compensate the plaintiff if you think that is the
3 right and the proper thing to do. Past and present
4 and future pain and suffering. Past, present and
5 future medical expenses, doctor bills, hospital
6 bills, rehabilitation expense, transportation
7 expense in connection with the medical treatment,
8 past and present and future loss of enjoyment of
9 life, past and present and future impairment of
10 health or bodily function, past, present and future
11 disability, past and present and future loss of
12 wages or loss of earnings, mental anguish brought
13 about by bodily injury or suffering, depression.
14 Those are all different types of categories. I
15 have given you a laundry list, they don't include
16 every possible thing but you understand when we
17 talk about damages they include a wide scope of
18 categories for your consideration.

19 Now, when I talk about things like maybe
20 earning capacity or wages that can be a
21 mathematical concept from which you might arrive at
22 a specific figure but when you're talking about
23 things such as permanent injury, pain and
24 suffering, loss of enjoyment of life, those types
25 of more nebulous ideas, the law doesn't require

1 only if you award actual damages to Mr. Green,
2 Randall M. Green, then you can consider actual
3 damages to his wife and that is under the theory
4 called loss of consortium and those are claims that
5 come about as a result of the injuries to your
6 spouse.

7 The companionship and society of a spouse are
8 not articles of commerce which can be weighed or
9 measured or bought and sold and no expert is
10 competent to testify to you about their value. The
11 consideration of which they are given is not
12 monetary but the plaintiff is entitled to monetary
13 compensation, that is, compensation in money for
14 their loss if it has occurred. The amount of
15 compensation is your determination, not from the
16 evidence of value, but from your own observation,
17 experience, knowledge conscientiously applied to
18 the facts and circumstances of this case. The
19 plaintiff, again, has to prove to you by the
20 greater weight or preponderance of the evidence
21 she is entitled to recover the value of those
22 services of their spouse which were lost, including
23 the loss of the spouse's society and companionship
24 in the home. The plaintiff is also entitled to
25 recover for any expenses incurred in the care and

1 treatment of their spouse because of the illness or
2 bodily harm suffered by the spouse.

3 In this particular matter the Court has had
4 prepared for you a verdict form to aid you in using
5 and arriving at your verdict. The verdict form has
6 the caption of the case, the very first page is do
7 you find that the defendant Wayne B. Bauerle, M.D.,
8 and Wayne B. Bauerle, M.D. P.C., negligently
9 departed from the standard of care in treating the
10 plaintiff Randall M. Green and that this negligent
11 departure from the standard of care proximately
12 caused plaintiff Randall M. Green's injuries. Two
13 answers to that question, yes or no.

14 If you find no, that's the end of the case,
15 you stop there, you knock on the door and you let
16 the bailiff know. If you answer yes to that
17 question you go on to the next question and the
18 next question being please state the total amount
19 of damages, actual damages, if any, sustained by
20 the plaintiff Randall M. Green, and there is a
21 space to write in just like you would on a check,
22 actual damages, whatever that amount is, based upon
23 your view of the facts of the evidence and proof
24 and if proven to you by the greater weight or
25 preponderance of the evidence. Or for the

1 MR. QUERY: None, Your Honor.

2 THE COURT: From the defendant?

3 MR. McCUTCHEON: No, sir.

4 THE COURT: Very good. All right, at this
5 point in time exceptions, deletions, additions to
6 the charge, by the plaintiff?

7 MR. MARTIN: Well, from the plaintiff, Judge,
8 none other than we did ask initially and I guess
9 re-ask that the jury be submitted by jury form a
10 list of the possible damages they could consider.

11 THE COURT: I appreciate that and I
12 respectfully decline to do so. You all do need to
13 make that a plaintiff's exhibit for identification
14 for the record so that if there is any future
15 consideration it can be looked at by the appellate
16 court, so you all make that an exhibit but I
17 respectfully decline to do that. I told you I felt
18 it might unduly influence or in some way might give
19 them the impression that the Court believes they
20 need to do that and that's solely their job and
21 responsibility and I respectfully decline to do so.

22 Thank you.

23 (Plaintiff's requested jury instructions
24 marked as Plaintiff's Exhibit Number 31
25 for Identification.)

1 matters I respectfully decline to grant the
2 defendant's motion for a judgment notwithstanding
3 the verdict or a new trial absolute.

4 Further matters and motions by the defense?

5 MR. McCUTCHEON: Yes, Your Honor. I don't
6 know whether we need to do this now but I want to
7 make sure that I do, or whether I have to petition
8 the Court at a later time to do this, this case
9 occurred in 2004 under the old statute and the old
10 law.

11 THE COURT: Yes, sir.

12 MR. McCUTCHEON: There were other defendants
13 in this case that my understanding have settled
14 with the plaintiff in this case and that under the
15 old law we would be entitled to an offset of those
16 amounts as against the verdict in this case. My
17 understanding is, and I don't know what the numbers
18 are because under the statute I'm not allowed to
19 inquire or find out what those numbers are unless
20 and until a verdict is rendered in the case, but if
21 there were it would be applicable, in my opinion,
22 as an offset as to the at fault driver in this case
23 as well as the ambulance company who was a
24 defendant and settled, as well as the Grand Strand
25 Regional Medical Center that also settled with the

1 plaintiff and I just want to make sure that I
2 protect my right. I don't know whether I'm
3 supposed to make that now in front of Your Honor as
4 the trial judge or subsequent thereto by way of
5 written motion.

6 THE COURT: Well, any response from the
7 plaintiff at this point in time?

8 MR. MARTIN: Will, we would think he is not
9 entitled to a set-off and protect ourself on the
10 record, we would object to any set-off.

11 THE COURT: All right. What I'm going to
12 allow, gentlemen, you to do, counsel, what I'm
13 going to allow you all to do is to file a written
14 argument with the Court. I find you have made your
15 motion for an offset at this time, Mr. McCutcheon,
16 but what I would like for you all to do is to send
17 to the Court by, I would appreciate it if you all
18 would do it by the close of business next Friday,
19 so a week from -- what date would that be?

20 MR. MARTIN: The 20th.

21 THE COURT: September 20, by the 20th
22 whatever written submission that you would make to
23 the Court at that point in time. As I indicated to
24 you, I'm not going to be here next week anyway, so
25 you all take that time, submit it to me by the

1 close of business on the 20th, and that will be for
2 the defense. You've got the general argument I
3 know you would be making anyway from the
4 Plaintiff's side as against an offset, so you all
5 can start working on that but the plaintiff --

6 MR. McCUTCHEON: Your Honor, could we request
7 until the Wednesday after that? I've got another
8 trial starting on September the 30th and I've got
9 two or three days of motions this coming week in
10 that same case.

11 THE COURT: All right. So you want it by
12 Wednesday the 25th?

13 MR. McCUTCHEON: Yes, sir.

14 THE COURT: Wednesday the 25th, by 12:00
15 noon. Any reply to that is by Monday the 30th,
16 Monday the 30th, by 5:00 p.m., so the defendant
17 Wednesday the 25th, write these things down,
18 Wednesday. I will write them down, Wednesday the
19 25th by 12:00 noon and then the plaintiff Monday
20 the 30th by 5:00 p.m. I want your responsive filing
21 with the Court on behalf of the plaintiff and then
22 I will address those as quickly as possible and
23 inform the parties as to the Court's ruling on
24 that.

25 All right, anything further from the defense?

STC

GRAND STRAND REGIONAL MEDICAL CENTER
Myrtle Beach, SC

PT: GREEN, RANDALL M
MR#: F000426717

CONSULT

PT: GREEN, RANDALL M
CON: 04/17/2004
DICT PHY: WAYNE B. BAUERLE, MD
CONS PHY: GEORGE B. NICHOLSON, MD

HPI: The patient is a 54-year-old white male who was involved in a motor vehicle accident. He was initially evaluated in the emergency room and was found to have a fracture/dislocation of the right hip. He was also found to have a significant soft tissue injury to the proximal volar aspect of his forearm with involvement of the ulnar artery. Please refer to the ER physician's assessment for pertinent past medical history and review of systems.

When I examined the patient initially he was over in the preoperative holding area and being readied to go back and have his right volar forearm laceration explored by Dr. Ralph Cozart. Prior to seeing the patient I reviewed the CT scan of the pelvis which revealed the right hip to be dislocated posteriorly with a comminuted posterior wall acetabular fracture. I was told by the emergency room physician that his hip had been reduced, but there were no postreduction x-rays or CT scans to confirm this. Therefore, the patient was urgently sent over to the CT scan suite where CT scan of the right acetabulum was performed, and this revealed a comminuted posterior wall acetabular fracture with articular surface impaction and involvement of the posterior column. There appeared to be some small fragments of bone within the hip joint itself.

After the CT scan the patient was sent back to the emergency room until the reading of the CT scan was performed. At most it was no more than half an hour from the time the patient left the preoperative holding area to the time he was back in the emergency room after having the CT scan performed of the right acetabulum. After reviewing the CT scan with the radiologist, Dr. Mencken, I was proceeding back to the emergency room to notify the emergency room staff and Dr. Cozart that the patient could be taken to the operating room to have exploration of the forearm when the patient went into extremis and full code was called. The code was run by the emergency room staff accordingly. Dr. Cozart will debride and explore the volar forearm wound in the emergency room. The patient will be maintained in an abduction pillow for the fracture/dislocation of the right hip. His hip is stable in the abduction pillow, but he will require operative intervention for the posterior wall acetabular fracture. He will need to be transferred to Medical University of South Carolina in Charleston for this procedure. I discussed this with the patient's son, who was in also in the emergency room at that time with friends and family members, and this will be done in appropriate medical time.

GSRMC

PT: GREEN, RANDALL M
MR#: F000426717

CONSULT

Of note the patient had no other obvious orthopedic injuries when I first assessed him in the preoperative holding area. He was actually moving all four extremities well and was awake, alert and oriented, and he complained of no other musculoskeletal injuries or discomfort other than the right hip.

D 04/17/2004 15:00:49

T 04/18/2004 10:31:12/360 Job #: 1974567/Doc #: 1404424

WAYNE B. BAUERLE, MD

GRAND STRAND REGIONAL MEDICAL CENTER

ER REPORT

NAME: GREEN, RANDALL M
MED REC #: F000426717

PHYSICIAN: SEEN, ERIC R
ACCOUNT #: F01011093196

PT: GREEN, RANDALL M
DOS: 04/17/2004
DICT PHY: SCOTT LINTZ, MD

CC: The patient presents status post motor vehicle crash.

HPI: The patient is a 54-year-old white male who was the unrestrained driver of a vehicle which was apparently struck in the front side of his vehicle. The car was laid on its side. The patient denies any loss of consciousness. He was brought in on a long spineboard with cervical collar in place to Room #12. History of the accident was obtained from the police officer. The patient complains of pain in his right arm along with his right lower chest and right hip. Primary survey reveals initial blood pressure to be in the 80-90s systolic. He had strong peripheral pulses with the exception of his right wrist which the pulse was only noted by Doppler. The patient denies any neck pain. He denies any headache. He denies any blurred vision.

MEDS: Only aspirin.

AL: No known allergies.

PMH: None.

PE: Primary survey reveals him to be awake and alert. He has no evidence of confusion. He has no evidence of any face or scalp trauma. His face is symmetric. HEART: Regular. LUNGS: Clear throughout. ABDOMEN: Soft and completely nontender. The patient has no pelvic tenderness until I ask him to straight leg raise which causes pain in the right femoral region. The patient has a strong dorsalis pedis and posterior tibial pulses. He has normal sensation. The patient has normal left upper extremity. Evaluation of his right arm reveals a significant wound to the right proximal forearm. The volar surface of the forearm reveals a significant wound, probably down to the bone. It is at least 6-7 cm in length and depth, most likely to the bone. There is chronic oozing of blood. There is no foreign body noted and the wound appears very clean. A sterile pressure dressing was applied over the wound. The patient could not flex his digits.

A STAT x-ray of the forearm was performed which revealed no obvious fracture. A portable C-spine, chest and pelvis x-ray was performed which revealed a probable fracture to the right acetabulum.

A CT scan of his chest and pelvis was performed which revealed an intraabdominal injury. He has most likely an acetabular fracture with a hematoma.

I contacted Dr. Dickinson for evaluation of the patient's wounds. He stated he does not operate below the elbow for vascular injuries.

Dr. Cozart was contacted and has arrived in the ER.

The patient was given a tetanus shot and Ancef for prophylaxis. He will be going to the operating room.

I discussed the case with Dr. Bauerle who eventually would like reconstructive CAT scan

ED REPORT

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GSRMC 14

GRAND STRAND REGIONAL MEDICAL CENTER

ATT. PHY SEHN, ERIC R

NAME: GREEN, RANDALL M
MED REC# F000426717

of the patient's acetabulum. The patient will need a complete C-spine film when he has post-op. He denied any neck pain and he was rolled with no mid or lower back pain. The patient was able to flex his right elbow normally. The patient was given a liter bolus of normal saline and his pressure came up to over 100 systolic. The patient had intermittent episodes of hypotension.

His labs revealed a white count of 13 with a normal HTH. His cardiac enzymes are normal. His coag studies are normal.

His liver function tests are mildly elevated. The patient did admit to drinking alcohol and smoking cigarettes on a regular basis.

EKG reveals a normal sinus rhythm at 87 beats a minute. He has nonspecific ST/T wave abnormalities with no evidence of acute ischemia.

The patient will be admitted most likely to Dr. Nicholson's service, trauma surgeon who is in the ER.

Critical care time spent with this patient was well over 1-1/2 hours.

D 04/17/2004 13:09:09
T 04/17/2004 14:13:56/353 Job #: 1974497/Doc #: 1403905

LINTZ, SCOTT

Electronically Signed by SCOTT LINTZ on 04/19/04 at 0721

ED REPORT

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GSRMC 15

Plaintiffs' Trial Exhibit #2

GRAND STRAND REGIONAL MEDICAL CENTER

XR REPORT

NAME: GREEN, RANDALL M
MRD REC #: F000426717

PHYSICIAN: NICHOLSON, GEORGE B.
ACCOUNT #: F01011093196

PT: GREEN, RANDALL M
DOS: 04/17/2004
DICT PHY: SCOTT LINTZ, MD

ADDEN: The radiologist confirmed a posterior hip dislocation. Prior to the patient going to the operating room for his forearm injury, he was given 4 mg of morphine and 1 mg of Versed IV. The hip was reduced without difficulty. There was a significant clunk heard in the hip. The patient had improvement of his discomfort. He had a persistent strong femoral pulse and dorsalis pedis pulse. He moves his toes normally. There is no color discrepancy between the two extremities.

However prior to the sedation, the patient's neck was palpated by myself and Dr. Nicholson. He denied any midline bony neck pain.

Portable lateral x-ray of his neck and swimmer's view of his neck revealed no malalignment or obvious fracture. The collar was then removed.

Dr. Bauerle was contacted regarding the patient's hip injury a second time. He had asked for reconstructive views, however due to the patient's injury to his right forearm requiring surgical intervention, I felt that was better warranted than holding the patient up to get the hip CAT scan. When I notified Dr. Bauerle, he was pretty adamant about getting the CAT scan of the hip first. Dr. Bauerle has come in and the patient is currently in CAT scan. Dr. Bauerle will follow up with the CAT scan and make sure there are no fragments in the hip joint itself.

Dr. Cozart will be repairing the forearm injury.

The patient continued to have a Dopplerable pulse in the right radial area.

PROC: Conscious sedation with reduction of closed hip dislocation.

D 04/17/2004 14:05:25
T 04/17/2004 15:40:04/353 Job #: 1974535/Doc #: 1403974

LINTZ, SCOTT

Electronically Signed by SCOTT LINTZ on 04/19/04 at 0721

ED REPORT

Page 1 of 1

GSRMC-16

Plaintiffs' Trial Exhibit #3

GRAND STRAND REGIONAL MEDICAL CENTER

MR REPORT

NAME: GREEN, RANDALL M
MED REC #: F000426717

PHYSICIAN: NICHOLSON, GEORGE B
ACCOUNT #: F01011093196

PT: GREEN, RANDALL M
DOS: 04/17/2004
DICT PHX: SCOTT LINTZ, MD

ADDEND: The patient is a 54-year-old male who was waiting to go to the operating room pending results of the x-ray of his right hip. Again Dr. Bauerle was adamant about the patient getting those prior to going to the operating room to make sure his hip is reduced. While waiting for the results of the CAT scan reading from the radiologist, I walked by the room and noted that the patient started to become bradycardic. His heart rate went from 60 to 50 to 40. The patient had just complained of some difficulty breathing. I auscultated somewhat rhonchial breath sounds bilaterally. The patient had only been given 4 of morphine and 1 mg of Versed. He had minimal response to sternal rub. We checked his pulse, and we could not palpate it. For this reason, the patient was intubated with an 8.0 endotracheal tube to 22 cm at the lip. CPR was initiated. We gave him a milligram of atropine and a milligram of epi IV. The patient's heart rate increased to over 100 in a wide complex fashion. I had paged anesthesia just prior to intubating the patient. The patient then had a dopplerable pulse over the femoral artery. Dr. Cozart, Dr. Nicholson and Dr. Bauerle were present at some time during the initial code. The patient appeared very pale on a repeat exam. CPR was performed for under a minute. The patient was bagged with 100% oxygen prior to my intubation. Dr. [Peters] performed a right IJ central line. Blood which was called for arrived from the blood bank and the patient was transfused 4 units of packed red blood cells.

We did repeat a H&H which revealed a hemoglobin of 5.5 and platelets of 5. The lab was unsure if this was normal, as there was a clot in the tube. This was ordered prior to the patient getting the blood. The patient had already received over 3 L of normal saline. Dr. Cozart began operating on the patient's forearm in the E.D. to stop the oozing from the patient's forearm injury.

There was no gross bleeding when he started that I could observe. A left arterial line was performed by Dr. Peters with very decreased blood pressure in the 50s to 60s. The patient had a second episode of bradycardia and hypotension and was given another milligram of atropine and epinephrine. The patient was started on epi and Levophed drip. The patient's son-in-law was outside the room, and I intermittently discussed the events with him.

I ordered 2 units of platelets for him. The patient's blood pressure had increased to over 100 systolic.

PROC: Endotracheal intubation.

Critical care time of the patient was over an hour again on top of what I had performed before. I also contacted the hospitalist service for a medical consult and called the echo tech for a STAT echocardiogram after discussing the case with Dr. Trask. The patient's hypotension and bradycardia appears to be most likely due to anemia and volume loss. The patient I believe is improving due to at least 3.5 to 4 L of normal saline in the packed red blood cells. Incidentally, the CAT scan of the right hip did reveal some small fragments in the right hip, but the hip reduction was successful.

ED REPORT

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GRAND STRAND REGIONAL MEDICAL CENTER

ATT. PHY NICHOLSON, GEORGE B

NAME: GREEN, RANDALL M
MED REC# F000426717

D 04/17/2004 15:31:20
T 04/17/2004 16:21:50/107 Job #: 1974593/Doc #: 1404003

LINTZ, SCOTT
Electronically Signed by SCOTT LINTZ on 04/19/04 at 0721

ED REPORT

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GSRMC 18

Plaintiffs' Trial Exhibit #4

MC MEDICAL CENTER
INFORMATION SERVICES
92-3881

Medical University Hospital Authority
P.O. Box 250349
Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

7W D794

Patient Name: GREEN, RANDALL M

ID: 001461441

DOB: 102759578

Admitted: 04/16/2004

Discharged: 05/12/2004

Physician:

Attending: Stuart M. Leon, MD

Referring:

REF COMPLAINT: Motor vehicle collision.

HISTORY OF PRESENT ILLNESS: Mr. Green is a 54-year-old gentleman who involved in a motor vehicle collision on about 04/16/2004. He was initially taken to Grand Strand Hospital for initial stabilization. Shortly while in the emergency department at the outside station, the patient arrested requiring ACLS protocol. He spent several hours in their intensive care unit and was transferred to the Medical University of South Carolina for further management once stabilized. His known injury complex on transfer included a right acetabular fracture, a complex right forearm fracture, acute and chronic versus chronic renal failure and lower extremity paralysis. The patient was transferred to the Medical University of South Carolina for definitive level 1 trauma care.

HOSPITAL COURSE: On presentation to IWest, the patient remained hemodynamically stable. He was initially brought to the scanner for radiographic studies. While in radiology, the patient acutely decompensated requiring emergent endotracheal intubation. CTs of his head, abdomen and pelvis were performed which revealed a little bit of intraperitoneal fluid in the right as well as some free fluid in the abdomen and thickening of the left colon with mesenteric stranding. On his acute decline in status and findings on CT abdomen and pelvis, the patient was brought to the operating room where he underwent exploratory laparotomy. The exploratory laparotomy was performed for intraabdominal injury. While in the operating room, the patient also underwent incision and drainage of his complex right



Page

1

3 MEDICAL CENTER
1 INFORMATION SERVICES
3) 722-3881

Medical University Hospital Authority
P.O. Box 250349
Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

001461441

MR: GREEN, RANDALL

saw soft tissue injury as well as a right femoral traction pin
action by Dr. Litts. There was also concern for aspiration when
patient arrested in radiology. A chest x-ray was suggestive of
infection pneumonia. The patient, therefore, also underwent
endoscopy while in the operating room. This was also found to be
evidence for purulent secretions.

patient was transferred to the PACU and subsequently to the STICU
stable but critical condition. He remained intubated. Given his
aplegia, the neurosurgery team was consulted. An MRI of the
spine was performed and the patient was found to have diffuse cord
injury from the level of T6 through L1 without evidence of hemorrhage.
This was felt to represent either cord contusion versus cord
compression. No surgical intervention was required. They also
reviewed the CT of his head and this was unremarkable.

patient was brought back to the operating room on 04/23/2004 under
direction of Dr. Litts with the hand surgery team. Here he
underwent repair with transposition of the right ulnar nerve, repair
his right median nerve, necrotic muscular debridement, and repair
multiple muscle soft tissue injuries. The patient tolerated this
without difficulty.

was brought back to the STICU and monitored closely. He was then
brought back to the operating room on 04/27/2004 with the orthopedic
surgery team where he underwent open reduction and internal fixation
his acetabular fracture. The patient tolerated these procedures
well. He was brought back to the STICU and monitored closely. He was
eventually weaned off the ventilator and tolerated this well. He was
eventually transferred to the floor where physical therapy and
occupational therapy were consulted. Speech consult was also obtained
for cognitive training. The patient's mental status continued to have
evidence of closed head injury, though this did progressively improve
during his hospitalization.

Page 2

C MEDICAL CENTER
INFORMATION SERVICES
3, /92-3881

Medical University Hospital Authority
P.O. Box 250349
Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

I 001461441
IDENT: GREEN, RANDALL

one point, his leukocytosis began to creep up. Pan-cultures were
ained. He was found to have Serratia in his sputum and he was
ated with cefepime for this.

patient was eventually started on a regular diet without
ficulty. His weightbearing status was nonweightbearing to the
ht lower extremity but range of motion exercise was okay. He was
o nonweightbearing to the right upper extremity though he was able
do range of motion exercises to the right shoulder but no range of
ion, active or passive, to the right elbow, wrist or fingers.

really progressed well after being transferred to the floor and
ntually his only issue became one of placement for continued
rnsive rehabilitative services. A bed at TCU eventually became
le and the patient was subsequently felt stable for transfer to
' On the date of transfer, the patient was eating and urinating
hout difficulty. He was continuing with aggressive physical
rapy for out of bed to chair exercises. Given his closed head
ury, he had difficulties maintaining commands but continued to
gress with physical therapy as well.

ASSESSMENT:

Status post motor vehicle collision with multiple injuries
luding closed head injury.

T6 to L2 spinal cord edema consistent with infarct versus spinal
d contusion, now paraplegic.

Right acetabular fracture, status post open reduction and internal
ation.

Complex soft tissue injury to the right forearm, status post
ridement of necrotic muscle as well as transposition and repair of
ht ulnar nerve and repair of right median nerve.

COMMENDATIONS/TREATMENT PLAN:

patient will be transferred to TCU.

His medications will include: Pepcid 20 mg p.o. b.i.d.; docusate

Page 3

3 MEDICAL CENTER
1 INFORMATION SERVICES
3, 92-3881

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Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

: 001461441
CENT: GREEN, RANDALL

lum 100 mg p.o. b.i.d.; heparin 5000 units subcu t.i.d.; magnesium
cate 296 mU p.o. daily p.r.n. constipation; milk of magnesium 30 mL
. b.i.d. p.r.n.; Senna 187 mg p.o. b.i.d. (hold for diarrhea);
lum bisphosphonate enema daily p.r.n. constipation; Tylenol 650 mg
. q.6h. p.r.n. pain; albuterol nebuliser treatment q.6h. p.r.n.;
atropium bromide nebuliser treatment q.6h. p.r.n. wheezing; Reglan
mg p.o. q.a.c. and at bedtime; oxycodone 5 to 10 mg p.o. q.4h.
.n. pain.

He will follow up with orthopedics at CMH in 1 week for staples.

He will follow up with Dr. Litts in hand clinic in 5 to 7 days
ce the splint to his right upper extremity will most likely be
oved. This splint is not to be removed but by the hand surgery

n.
Will follow up with Dr. Leon in surgery on a p.r.n. basis.

He will follow up with neurosurgery in 4 to 6 weeks.

He is to remain nonweightbearing to the right upper extremity
il further advised by the hand physicians. He should do no active
passive range of motion exercises to the right elbow, wrist or
jers. He can do right shoulder exercises.

He is to remain nonweightbearing to the right lower extremity for
stal of 4 more weeks (6 weeks from 04/27/2004).

Physical therapy is to continue range of motion exercises to
ateral lower extremities including to his right hip.

Out of bed to chair with assist daily with pressure relief q.20
ites.

Speech therapy consult for cognition.

PT/OT consult and treat.

He is to continue paraplegic bowel protocol with daily rectal
mulation.

Diet is regular.

Please feel free to page me at pager #13101. My name is Stefania
arski for any further questions regarding this patient.

Page 4

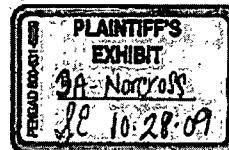
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(843) 792-3881

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P.O. Box 250349
Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

7W 0799

Patient Name: GREEN, RANDALL M
MRN: 001461441
Patcom: 102759578
Admitted: 04/18/2004
Discharged: 05/12/2004
Service:
Attending: Stuart M. Leon, MD



Referring:

CHIEF COMPLAINT: Motor vehicle collision.

HISTORY OF PRESENT ILLNESS: Mr. Green is a 54-year-old gentleman who was involved in a motor vehicle collision on about 04/16/2004. He was initially taken to Grand Strand Hospital for initial stabilization. Reportedly while in the emergency department at the outside institution, the patient arrested requiring ACLS protocol. He spent the next several hours in their intensive care unit and was transferred to the Medical University of South Carolina for further management once stabilized. His known injury complex on transfer included a right acetabular fracture, a complex right forearm laceration, acute and chronic versus chronic renal failure and lower extremity paralysis. The patient was transferred to the Medical University of South Carolina for definitive level 1 trauma care.

HOSPITAL COURSE: On presentation to IWest, the patient remained hemodynamically stable. He was initially brought to the scanner for radiographic studies. While in radiology, the patient acutely decompensated requiring emergent endotracheal intubation. CTs of his head, abdomen and pelvis were performed which revealed a little bit of perinephric fluid in the right as well as some free fluid in the abdomen and thickening of the left colon with mesenteric stranding. Given his acute decline in status and findings on CT abdomen and pelvis, the patient was brought to the operating room where he underwent exploratory laparotomy. The exploratory laparotomy was negative for intraabdominal injury. While in the operating room, the patient also underwent incision and drainage of his complex right

Page 1

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Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

MRN: 001461441

PATIENT: GREEN, RANDALL

forearm soft tissue injury as well as a right femoral traction pin insertion by Dr. Litts. There was also concern for aspiration when the patient arrested in radiology. A chest x-ray was suggestive of aspiration pneumonia. The patient, therefore, also underwent bronchoscopy while in the operating room. This was also found to be negative for purulent secretions.

The patient was transferred to the PACU and subsequently to the STICU in stable but critical condition. He remained intubated. Given his paraplegia, the neurosurgery team was consulted. An MRI of the T-spine was performed and the patient was found to have diffuse cord edema from the level of T6 through L1 without evidence of hemorrhage. This was felt to represent either cord contusion versus cord infarction. No surgical intervention was required. They also reviewed the CT of his head and this was unremarkable.

The patient was brought back to the operating room on 04/23/2004 under the direction of Dr. Litts with the hand surgery team. Here he underwent repair with transposition of the right ulnar nerve, repair of his right median nerve, necrotic muscular debridement, and repair of multiple muscle soft tissue injuries. The patient tolerated this without difficulty.

He was brought back to the STICU and monitored closely. He was then brought back to the operating room on 04/27/2004 with the orthopedic surgery team where he underwent open reduction and internal fixation of his acetabular fracture. The patient tolerated these procedures well. He was brought back to the STICU and monitored closely. He was eventually weaned off the ventilator and tolerated this well. He was eventually transferred to the floor where physical therapy and occupational therapy were consulted. Speech consult was also obtained for cognition training. The patient's mental status continued to have a picture of closed head injury, though this did progressively improve during this hospitalization.

Page 2

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HOSPITAL DISCHARGE SUMMARY

MRN: 001461441

PATIENT: GREEN, RANDALL

At one point, his leukocytosis began to creep up. Pan-cultures were obtained. He was found to have Serratia in his sputum and he was treated with cefepime for this.

The patient was eventually started on a regular diet without difficulty. His weightbearing status was nonweightbearing to the right lower extremity but range of motion exercise was okay. He was also nonweightbearing to the right upper extremity though he was able to do range of motion exercises to the right shoulder but no range of motion, active or passive, to the right elbow, wrist or fingers.

He really progressed well after being transferred to the floor and eventually his only issue became one of placement for continued aggressive rehabilitative services. A bed at TCU eventually became available and the patient was subsequently felt stable for transfer to TCU. On the date of transfer, the patient was eating and urinating without difficulty. He was continuing with aggressive physical therapy for out of bed to chair exercises. Given his closed head injury, he had difficulties maintaining commands but continued to progress with physical therapy as well.

ASSESSMENT:

1. Status post motor vehicle collision with multiple injuries including closed head injury.
2. T6 to L2 spinal cord edema consistent with infarct versus spinal cord contusion, now paraplegic.
3. Right acetabular fracture, status post open reduction and internal fixation.
4. Complex soft tissue injury to the right forearm, status post debridement of necrotic muscle as well as transposition and repair of right ulnar nerve and repair of right median nerve.

RECOMMENDATIONS/TREATMENT PLAN:

1. The patient will be transferred to TCU.
2. His medications will include: Pepcid 20 mg p.o. b.i.d., docosate

Page 3

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Medical University Hospital Authority
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Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

MRN: 001461441

PATIENT: GREEN, RANDALL

sodium 100 mg p.o. b.i.d.; heparin 5000 units subcu t.i.d.; magnesium citrate 296 mL p.o. daily p.r.n. constipation; milk of magnesium 30 mL p.o. b.i.d. p.r.n.; Senna 187 mg p.o. b.i.d. (hold for diarrhea); sodium bisphosphonate enema daily p.r.n. constipation; Tylenol 650 mg p.o. q.6h. p.r.n. pain; albuterol nebulizer treatment q.6h. p.r.n.; ipratropium bromide nebulizer treatment q.6h. p.r.n. wheezing; Reglan 10 mg p.o. q.a.c. and at bedtime; oxycodone 5 to 10 mg p.o. q.4h. p.r.n. pain.

3. He will follow up with orthopedics at CMH in 1 week for staples out.

4. He will follow up with Dr. Litts in hand clinic in 5 to 7 days where the splint to his right upper extremity will most likely be removed. This splint is not to be removed but by the hand surgery team.

5. He will follow up with Dr. Leon in surgery on a p.r.n. basis.

6. He will follow up with neurosurgery in 4 to 6 weeks.

7. He is to remain nonweightbearing to the right upper extremity until further advised by the hand physicians. He should do no active nor passive range of motion exercises to the right elbow, wrist or fingers. He can do right shoulder exercises.

8. He is to remain nonweightbearing to the right lower extremity for a total of 4 more weeks (6 weeks from 04/17/2004).

9. Physical therapy is to continue range of motion exercises to bilateral lower extremities including to his right hip.

10. Out of bed to chair with assist daily with pressure relief q.20 minutes.

11. Speech therapy consult for cognition.

12. PT/OT consult and treat.

13. He is to continue paraplegic bowel protocol with daily rectal stimulation.

14. Diet is regular.

15. Please feel free to page me at pager #13101. My name is Stefania Owczarski for any further questions regarding this patient.

Page 4

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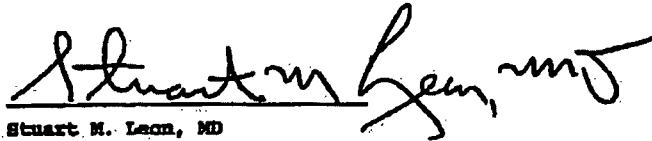
Medical University Hospital Authority
P.O. Box 250349
Charleston, SC 29425

HOSPITAL DISCHARGE SUMMARY

MRN: 001461441
PATIENT: GREEN, RANDALL

Dictated by: Stefanie M. Owczarski, PA

Stefanie M. Owczarski, PA


Stuart M. Leon, MD

Attending

581890 / 30028 /

JOB: 137047

DD: 05/11/04 02:28 PM

DT: 05/11/04 03:08 PM

Additional CC: _____

Page 5

Billing 843 915-5182
Fax: 843 915-6180

CAD # 0408081
Grid # 249

Horry County Fire/Rescue

Billing Dept.
PO Box 296
Conway, SC 29528

print date: Monday, October 11, 2004

Call Summary

Call received Apr 17, 2004
Nature Motor Vehicle Accident
Location HWY 22 AND 905
LONGS, SC, USA 29566

Outcome Hospital ER
Call completed by Howell, David
Level of care Medical Emergency
Destination 3016 Grandstrand Hospital
Reason Closest available
Delay to hosp reason No Delay

Location type Roadway
Response mode Emergency Changed to No Change
Respond with Other
Assist at scene
Response delay No Delay
Patient found Sitting Upright
Patient positioned Supine
Patient transported Main Stretcher
Patient returned

Call Received 11:14 Apr 17, 2004
Dispatch 11:14
Enroute 11:14

Scene 11:30
Patient Side 11:31
Depart 11:51

Destination 12:01
Clear 12:05

Patient Information

Name GREEN, RANDALL
SSN [REDACTED]
DOB [REDACTED]
SEX M

Home Phone [REDACTED]
Mailing Address [REDACTED]

Doctor
Pers. Effects

Employment:
Occupation
Employer
Phone
Address

Next of Kin:
Name
Relation
Address

Insurance:
Company
Address

Phone

History

Chief Complaint: Pain - Abdominal, Pain - Other
MOI / Present illness: MVA T-Bone
Trauma: Site of Trauma - Abdomen, Site of Trauma - Upper Extremities
Relevant Past History: None
Medications: None Currently
Allergies: as reported by Patient

Billing: 843 915-5182
Fax: 843 915-6180
CAD # 0408081
Grid # 249

Horry County Fire/Rescue

Billing Dept.
PO Box 296
Conway, SC 29528

print date: Monday, October 11, 2004

Time	Who	Body Area	Assessment
			Deformity
			Discoloration
			Fx / Dislocation
			Laceration(s)
			Mangling
			NOT
			Pain
			Numbness
		Upper Extremities, Right Hand	Assessed with No Abnormalities

Vital Signs

Time	BP	Pulse	SPO2	ETCO2	Cap Refill	ECG	Respiratory				
							GCS	Effort	Rate	Left	Right
00:00	110	Palp 72, Strong, Regular	97 %		Normal		E4 M6 VS=I	Normal	22	Clear	Clear
TEMP: 98.6 F SKIN TEMP: Cool SKIN COLOR: Pale SKIN MOISTURE: Dry ARM MOVEMENT: Left - Strong, Right - Strong LEG MOVEMENT: Left - Strong, Right - Strong											
PUPIL SIZE: Left - 3, Right - 3 PUPIL REACTS: Left - Reacts, Right - Reacts PUPIL DILATION: Left - Normal this eye, Right - Normal this eye											
LOC: Alert											
00:00	100	Palp 72, Strong, Regular	97 %		Normal		E4 M6 VS=I	Normal	22	Clear	Clear
TEMP: 98.6 F SKIN TEMP: Cool SKIN COLOR: Pale SKIN MOISTURE: Dry ARM MOVEMENT: Left - Strong, Right - Strong LEG MOVEMENT: Left - Strong, Right - Strong											
PUPIL SIZE: Left - 3, Right - 3 PUPIL REACTS: Left - Reacts, Right - Reacts PUPIL DILATION: Left - Normal this eye, Right - Normal this eye											
LOC: Alert											

Revised Trauma Score

Time	Score	Details
00:00	12	GCS = 13-15 (4); Resp. Rate = 10-29 (4); Systolic BP = >89 (4)

Interventions

Time	Treatment	Description	Further Details
PTA	IV Administered	Successful: Yes, Jelco Size: 16ga, Solution: normal saline, Tubing Size: macro, Rate: TKO, Site: right antecubital, By: Howell, David	
PTA	IV Administered	Jelco Size: 16ga, Solution: normal saline, Tubing Size: macro, Rate: TKO, Successful: Yes, Site: left antecubital, By: Howell, David	
PTA	Oxygen	LPM: 25 LPM, Indication: poor perfusion, Device: non-rebreather mask, By: Howell, David	

General Comments

pt CC R hip pain pt was driver in a MVA T-Bone

I was driving POV and stopped at the crash sight found there was no one in charge of pt care for two victims that had just been extricated I assumed pt care placed no neck collar on pt 1 and placed pt on LSB est. #16 IV county Vol. attempted to place head bed on but were grossly unsuccessful I was asked by B1 to ride in M17 who was also Tx the passenger of this vehicle pt 2. Pt 1 is multi trauma CAOx3 abd. was tender and rigid over URQ R forearm was mutilated and Fx, R hip has severe POP to iliac crest moved pt to M17 and established 2nd IV #16 Mon: NSR @ 72 BP 110P P2 Tx by FF/P Graham transported P2 to GSRMC

Billing: 843 915-5182
Fax: 843 915-6180

CAD # 0408081
Grid # 249

Horry County Fire/Rescue

Billing Dept.
PO Box 296
Conway, SC 29528

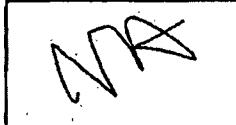
print date: Monday, October 11, 2004

Signatures

Time Type
13:53 Billing Signature

Disclaimer

I, GREEN, RANDALL, acknowledge receipt of Horry County Fire/Rescue service(s) and accept full responsibility of all charges. In the event that this service provider deems it necessary to seek other payment alternatives, I hereby consent and authorize payment of my medical benefits from Medicare or other insurance companies to the undersigned supplier. I authorize any holder of medical information about me to be release to the health care financing admin. and it's agents for purpose of determining payable benefits.



GREEN, RANDALL

Shift Information

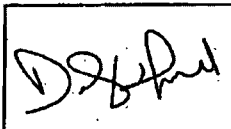
DHEC Permit 03701

15 Red Bluff Sta.17

Start Date/Time: 13:20 Apr 17, 2004

Crew # Name Certification
480 Howell, David 84207

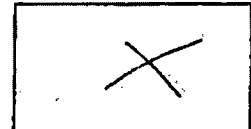
Signature



Crew # Name
504 Sandler, Charles

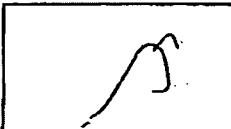
Certification
27284

Signature



Crew # Name Certification
426 Graham, Lee 83136

Signature



Miscellaneous

Misc Hierarchy 1: Required O2, Required IV, Required EKG

Misc Hierarchy 2:

Ready for billing Yes
ICD-9 Codes: Trauma (Multi) 958.4

T3118
Page 1 of 1

Date: 4/17/04 **Time:** 12:55 **Patient Name:** Kuen Mandal **DOB:** [redacted] **Age:** 35 **Sex:** M **Referral:** 12

ED Triage: **Chief Complaint:** [redacted] **History of Present Illness:** [redacted] **Physical Exam:** [redacted] **Vitals:** [redacted] **ECG:** [redacted] **Labs:** [redacted] **Imaging:** [redacted] **Disposition:** [redacted]

Physician's Orders: [redacted] **Medications:** [redacted] **Discharge Instructions:** [redacted]

Physician's Signature: [redacted] **Physician's Title:** [redacted] **Physician's Department:** [redacted]

Discharge Instructions: [redacted] **Discharge Date:** [redacted] **Discharge Time:** [redacted]

ED Core Encounter Record
T3118-0 12/03

WHITE - Chart CANARY - Department Copy PRNK - Physician Copy

PAGE 1

GSRMC 4

Baseline Nursing Examination						
Date	Time of Assessment	Initials	Bed	Page	of	
4/12/04	1300	SB	10	2	4	
Psychosocial Subordered Age/Dev. Approp. ☒ Yes ☐ No Eye Contact ☒ Yes ☐ No Affect ☒ Normal ☐ Abnormal Motor Behavior ☒ Cooperative ☐ Resistant ☒ Relaxed ☐ Agitated Speech ☒ Normal ☐ Abnormal Support System ☒ Lives Alone ☐ Family/Significant Other ☒ Other Suspect Neglect/Abuse Primary Language <u>English</u> Last Grade Completed	Skin ☐ Intact ☐ Lesions ☐ Warm ☐ Dry ☒ Cool ☐ Diaphanous Turgor ☒ Normal ☐ Occasional Edema ☒ Absent ☐ Present ☐ Mild/Degree Color ☒ Normal ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundice ☐ Flushed Mucous Membranes ☐ Moist ☐ Dry Ortho ☒ N/A ☐ Pain ☐ Swelling ☐ Deformity ☐ Limited Movement Size: _____ Color: _____ Sensation: ROM: ☐ Limb ☐ Full <u>Reflexes in relationship.</u>	Respiratory ☒ Normal ☐ Distress ☐ Dyspnea ☐ Nasal Flaring ☐ Retractions ☐ Stridor ☐ Cough ☐ Non-Productive ☐ Productive ☐ Color ☐ Bibas Accessory Murmurs ☐ Expiratory Grunt Breath Sounds ☐ Clear ☐ Crackles ☐ Wheezing ☐ Diminished ☐ Absent	Neurological ☒ Alert ☐ Drowsy ☒ Oriented ☐ Disoriented ☐ Alert ☐ Drowsy ☐ Confused ☐ Lethargic ☐ Unresponsive ☐ Comatose ☐ Unconscious/Dead Fontanelle ☐ Flat ☐ Depressed ☐ Bulging ☐ Crying ☐ Age Appropriate Responsive to Stimuli Verbal ☐ Painful Pupils ☐ Equal ☐ Unequal ☒ Reactive ☐ Non-Reactive	Cardiac ☒ N/A ☐ CP Chest ☐ Clear ☐ Crackles ☐ Interribal ☐ Rales ☐ Prolapsations ☐ Non-Flapping ☐ Radiating Arm ☐ R ☐ L ☐ Back ☐ Neck/Jaw ☐ Pain Scale (0-10) Heart Sounds ☐ Normal / Regular ☐ Irregular Pulses ☐ Radial ☐ Femoral ☐ Pedal ☐ A ☐ L ☐ Capillary Refill ☐ Normal ☐ Abnormal ☐ Delayed	GI ☒ N/A ☐ Distress Abdomen ☐ Normal ☐ Distended ☐ Guarding ☐ Rigid Tenderness ☐ LUO ☐ RUO ☐ UO ☐ RLO ☐ Epigastric Bowel Sounds ☐ Present ☐ Absent ☐ Hyper ☐ Hypo ☐ Last BM ☐ Vomiting ☐ Diarrhea ☐ Stool in Stool O.S. ☐ N/A ☐ Distress ☐ Pains ☐ Pain ☐ R ☐ L ☐ Dysuria ☐ Hematuria ☐ Frequency ☐ Oliguria ☐ Retention ☐ Foley	

TS Screen	Functional Screen	Nutritional Screen	Variables	Gyn./Pregnancy Screen
1. Do you have a cough? Yes No 2. How long have you been coughing? Days Weeks Months 3. Are you having night sweats? Yes No 4. Have you lost recent weight? Yes No	Asbestos Dusts 1. Home 2. Car 3. Crutches Inhalant Pneumonia Age ☒ Independent ☐ Dependent	Unintentional Weight Loss? Yes No Recalling accident / personal accident? Yes No Skin ulcer / Decubitus present? Yes No	☒ Glasses ☐ Hearing Aid ☒ Dentures / partial ☐ No ☐ Medications ☐ Money / Credit Cards Other _____	☐ PA ☐ Donks Preg. Dist. Gravidity ☐ PVD Discharge ☐ LMP Standing ☐ EDD No. pads per hour Soiling ☐ P A Conts Small Medium Large

Previous Medical History											
Have you had or do you have:		Yes	No	Have you had or do you have:		Yes	No	Have you had or do you have:		Yes	No
COPD				Pacemaker				Kidney Disease / UTI			
Asthma				Reaction to receiving blood				Other Disease			
Other lung problems				Sicklecell				Hypertension			
Hypertension				Hepatitis / Cirrhosis / Jaundice				Heartburn			
Heart Attack				Convulsions / Seizures				Bowel difficulties			
Chest Pain / Angina				Migraines				Cancer / type			
Heart Failure				Alzheimer / Dementia				Spotted Nursing Facility			
Heart Murmur				Stroke / TIA				Name of Facility			
Irregular Heart Beat				Diabetes, NIDDM, IDDM							

[illegible]

Initial	Signature / Title	PATIENT IDENTIFICATION
SB	Sander Basmajian	Green, Randall
		GREEN, RANDALL, M
		AGE 161 1993116 RPO CR
		DOB 04/17/74 SEX, CHIC R
		ED 18F00012571

ED Nursing Flow Sheet - Short

प्रा.सं.सं. सं.सं.

Wells - Chair Canary & Green - For Faculty Pre...

GSRMC 5

Page 3 of 4		Nurse's Interventions/Evaluations										Initials
Temp	BP	HR	RR	SpO ₂	O ₂ Device	Pain Scale 0-10	GCS	Rhythm	ATS			
1215	96/51	69	20			10	4-5/6	NSC	3-4-4	#16 F/dry inserted C clear yellow urine return, U/A sent - Pt A+OX3, NS infusing		SB
1225	97/60	66	20			10	4-5/6	NSC	3-4-4	Pt to CT Scan via stretcher - RN in attendance		SB
1241	98/71	67								Back from CT - Placed back in monitor bleed is thru dog in place		SB
1251						10	4-5/6	NSC	3-4-4	Dr. Dickson here to sept. Doppler used to obtain Rt radial pulse @ Rt ulnar		
1256	104/51	60	18							Pulse noted - Pt A+OX3 - Dr. Corat here to see pt. Present dog removed by Dr. Corat & re applied.		SB
1310										Tid O Sec IM Deleted #18 Haplock placed Chand. Dr. Corat removed @ AC Haplock EKG done		SB
1315 1330	94/42	65	22	99	100	10	4-5/6	NER	11	Ancef 1 gram IV NS in 10cc NS. Sutures removed + given to daughter + son + Jani		SB

Rt hand cool & pale
capillary refill 1-2 sec

Patient Identification

SB Sandra Baran

Green, Randall

GREEN, RANDALL H
Nurse, RN
UP 050

ED Nursing Flow Sheet - Continued

GSRMC 005

Time	Temp	BP	HR	RR	SpO ₂	O ₂	Pain Scale 0-10	C.C.S.	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials
1335											4th liter NST w/o.	SB
1345		108/59	115	24	100	100% O ₂					Dr. Nicholson @ bedside	
1347											Machine 4mg IV	
											C-collar removed by	
											Dr. Nicholson - Pt given	
1352		108/40	110	24	100	100% O ₂		4-6	ST		Verbal 9mg IV -	SS
											Dr. Litz reduced Pt	
1355											bp, pt alert @ time	SB
											Pt sleeping out of	
											awakens to verbal	
											stimuli	SS
1400											Pt to O.R. via	
											stretcher	SS

Initials	Signature / Title	PATIENT IDENTIFICATION
SB	Sandra Sandoz	Green, Randall

ED Nursing Flow Sheet - Continued

GSRMC 006

T3119C

03/01/01

P.

Plaintiffs' Trial Exhibit #8

Time	Temp	BP	HR	RR	SpO ₂	O ₂	Pain Scale 0-10	QCS	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials
1415		17/51	135								Pt back from C.R. per Dr. Bauerle, who is @ bedside. Pt to have CT hip Pt to CT Scan for CT hip	
1435											Pt back from CT Scan placed back on monitor to BP. Pt getting clammy map now showing. Di Lintz awake @ bedside	SB
1448											Pt brady & to 37 RR w/ pagers. Pt given Atropine 1 amp, Epi 1 amp IVP. Pt intubated by Dr Lintz #8 ET tube	
1452		53/32	135								Marked @ 22 @ lips - see code sheet, Dis Lintz, Nickelson, Bauerle & Corant @ bedside -	SB
1505		17/44									ET placed. Rt side of neck by Dr Peters from anesthesia. Blood 12 units up on pressure bag.	SB
1507							36 L 85553 FF24			36FF 18183 FF1	HR dropping brady & 37 Atropine 1 amp, Epi 1 amp IVP. Dr Corant @ bedside to repair & stop bleeding of Rt arm	
1512		64/31	140									
1514												
Initials		Signature / Title		PATIENT IDENTIFICATION								
SB		Sandra Bauerle		Green, Lendal								

ED Nursing Flow Sheet - Continued

GSRMC 007

Page _____ of _____													
Time	Temp	BP	HR	RR	SpO ₂	O ₂ On vent	Pain Scale 0-10	G.C.S.	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials	
1515											Anterior line @ wrist Blood units 3 + 4 ↑ on pressure bags - heparin started @ 15cc/hr = 1mg/min Epi. started @ 5mg = 1cc/hr. Epi. stopped per Dr. Pathto units 3 + 4 infused. Platelets 6 units ↑ on pressure bag - Report called to Heather on SICU, Echo completed. Called resp for transport to SICU Pt to SICU & Prep to bag pt, Jim + R. Fre.		
1530		72/50	143	14									S
1543		107/51	97	N									SS
1554		113/51	99	N									SS
1610		107/51	99	14	100	vent			SR				
1620		107/51	97		100%	vent.							
Initials SB Signature / Title Sandra Benson Patient Identification Green, Randal													

ED Nursing Flow Sheet - Continued

GSRMC 008

13119-C

white - CMA

03-0



H 1461441
GREEN RANDALL H
H/N
P102759578

INTERDISCIPLINARY PROGRESS NOTES

ATTENDING PHYSICIAN NOTE

MRN: 1461441
NAME: Randall Green

Date: 4/23/84 Service: Trauma
The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History: Upon examining the patient, it is my belief that a reliable history can not be obtained due to inability to communicate. Upon personally questioning the patient, I can confirm that the following are the key history factors:

MR Green at 4:00 am has been in the trauma bay. He is a 40-year-old male, single, with no significant medical history. He was last seen at 3:00 am when he was found by the house staff.

Physical Examination: Pulse: 100 BP: 120/80 Resp Rate: 18 T: 37.5 Input: 500 Output: 220
Neuro: Alert & oriented to person, place, and time.
Eyes: PERRL
ENT: No acute changes.
CV: No acute changes.

Resp: Lungs clear. Equalized V.E. +10 Kx +0.50.

GI/Ur: No acute changes.
GU/Renal: No acute changes. Creat 2.5 (longstanding) and no change in BUN. No acute changes in electrolytes.
HemoStat: No acute changes.

Skin: No acute changes.
Psych: Unable to assess but seems uncooperative.
Other: No acute changes.

GI have reviewed the results of pertinent laboratory tests as documented in the residents note.
GI have reviewed the results radiographs as documented in the resident's note.
GI have personally reviewed pertinent X-ray examinations.
GI have personally reviewed the results of additional medical testing and monitor output.
GI have personally discussed the case with the residents.

Management/Problems:
1. Hypotension
2. Hypoxemia
3. Head injury
4. Spinal cord injury - paraplegia
5. Fractured ribs
6. Fractured humerus
7. Fractured femur
8. Fractured tibia/fibula
9. Fractured pelvis
10. Fractured scapula
11. Fractured clavicle
12. Fractured radius/ulna
13. Fractured mandible
14. Fractured maxilla
15. Fractured zygomatic arch
16. Fractured orbital floor
17. Fractured nasal bone
18. Fractured lacrimal bone
19. Fractured maxillary sinus
20. Fractured mandibular body
21. Fractured mandibular angle
22. Fractured mandibular ramus
23. Fractured hyoid bone
24. Fractured thyroid cartilage
25. Fractured cricoid cartilage
26. Fractured trachea
27. Fractured larynx
28. Fractured pharynx
29. Fractured esophagus
30. Fractured stomach
31. Fractured small intestine
32. Fractured large intestine
33. Fractured rectum
34. Fractured sigmoid colon
35. Fractured descending colon
36. Fractured ascending colon
37. Fractured cecum
38. Fractured appendix
39. Fractured gallbladder
40. Fractured pancreas
41. Fractured spleen
42. Fractured liver
43. Fractured kidney
44. Fractured adrenal gland
45. Fractured ovary
46. Fractured uterus
47. Fractured vagina
48. Fractured vulva
49. Fractured clitoris
50. Fractured penis
51. Fractured testis
52. Fractured epididymis
53. Fractured vas deferens
54. Fractured ureter
55. Fractured bladder
56. Fractured prostate
57. Fractured urethra
58. Fractured penis
59. Fractured scrotum
60. Fractured perineum
61. Fractured rectum
62. Fractured sigmoid colon
63. Fractured descending colon
64. Fractured ascending colon
65. Fractured cecum
66. Fractured appendix
67. Fractured gallbladder
68. Fractured pancreas
69. Fractured spleen
70. Fractured liver
71. Fractured kidney
72. Fractured adrenal gland
73. Fractured ovary
74. Fractured uterus
75. Fractured vagina
76. Fractured vulva
77. Fractured clitoris
78. Fractured penis
79. Fractured testis
80. Fractured epididymis
81. Fractured vas deferens
82. Fractured ureter
83. Fractured bladder
84. Fractured prostate
85. Fractured urethra
86. Fractured penis
87. Fractured scrotum
88. Fractured perineum
89. Fractured rectum
90. Fractured sigmoid colon
91. Fractured descending colon
92. Fractured ascending colon
93. Fractured cecum
94. Fractured appendix
95. Fractured gallbladder
96. Fractured pancreas
97. Fractured spleen
98. Fractured liver
99. Fractured kidney
100. Fractured adrenal gland

☐ New	☐ Improved	☐ Unchanged	☐ Worsening
☐ New	☐ Improved	☐ Unchanged	☐ Worsening
☐ New	☐ Improved	☐ Unchanged	☐ Worsening
☐ New	☐ Improved	☐ Unchanged	☐ Worsening
☐ New	☐ Improved	☐ Unchanged	☐ Worsening
☐ New	☐ Improved	☐ Unchanged	☐ Worsening



Risk of complications/mortality: ☐ Minimal ☐ Low ☐ Moderate ☐ High
CPT is critically ill/injured. I spent 15 minutes providing critical care to this patient.
Overall Condition: ☒ Critical ☐ Serious ☐ Fair ☐ Good

Signature: [Signature]

UMA #18100-19

U.1804



MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

H 1461441
GREEN RANDALL
W/H
P102759578

ATTENDING PHYSICIAN NOTE

Sheet
Jewett
Reprint
H-2504-46
Terry
Hegler
Curtis
Labeled per
O'Donoghue
Adm. per
MRN: 1461441
NAME: Randall Green

Date: 4/25/04

Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to
Upon personally questioning the patient, I can confirm that the following are the key history factors:

Physical Examination: Pulse: 135 (45) BP: 120/80 Resp Rate: 13 T: 38.1°C Input: 5215 Output: 2000
Neuro: Alert, oriented, no focal deficits
Eyes: No conjunctival injection, no scleral icterus
ENT: No nasal discharge, no oral lesions
CV: No murmurs, no rales

Resp: CXR (B) 4/25/04 - 97%

GI/Heb: 50% ATNAD

Misc/Stat: incision 5/10/1

Skin: 12/11/12 12/11/12 12/11/12 110

Psych: 12/11/12 12/11/12 12/11/12 110

Other: 12/11/12 12/11/12 12/11/12 110

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☐ I have personally reviewed pertinent X-ray examinations.

☐ I have personally reviewed the results of additional medical testing and monitor output.

☐ I have personally discussed the case with Dr. Carter

Respiratory: 12/11/12 12/11/12 12/11/12 110
Cardiovascular: 12/11/12 12/11/12 12/11/12 110
Neurological: 12/11/12 12/11/12 12/11/12 110
Endocrine: 12/11/12 12/11/12 12/11/12 110
Hematology: 12/11/12 12/11/12 12/11/12 110
Immunology: 12/11/12 12/11/12 12/11/12 110
Infectious: 12/11/12 12/11/12 12/11/12 110
Nephrology: 12/11/12 12/11/12 12/11/12 110
Oncology: 12/11/12 12/11/12 12/11/12 110
Pediatrics: 12/11/12 12/11/12 12/11/12 110
Radiology: 12/11/12 12/11/12 12/11/12 110
Surgery: 12/11/12 12/11/12 12/11/12 110
Urology: 12/11/12 12/11/12 12/11/12 110
Vascular: 12/11/12 12/11/12 12/11/12 110
Other: 12/11/12 12/11/12 12/11/12 110

Respiratory: 12/11/12 12/11/12 12/11/12 110
Cardiovascular: 12/11/12 12/11/12 12/11/12 110
Neurological: 12/11/12 12/11/12 12/11/12 110
Endocrine: 12/11/12 12/11/12 12/11/12 110
Hematology: 12/11/12 12/11/12 12/11/12 110
Immunology: 12/11/12 12/11/12 12/11/12 110
Infectious: 12/11/12 12/11/12 12/11/12 110
Nephrology: 12/11/12 12/11/12 12/11/12 110
Oncology: 12/11/12 12/11/12 12/11/12 110
Pediatrics: 12/11/12 12/11/12 12/11/12 110
Radiology: 12/11/12 12/11/12 12/11/12 110
Surgery: 12/11/12 12/11/12 12/11/12 110
Urology: 12/11/12 12/11/12 12/11/12 110
Vascular: 12/11/12 12/11/12 12/11/12 110
Other: 12/11/12 12/11/12 12/11/12 110

Risk of complications/mortality: ☐ Minimal ☐ Low ☐ Moderate ☐ High
☐ Patient is critically ill/injured. I spent 20 minutes providing critical care to this patient.
Overall Condition: ☐ Critical ☐ Serious ☐ Fair ☐ Good

I.D. - Confirmed for 10/28/09
Still 6 for 10/28/09
2 police car. 600 = 10/28/09



UMA #19100-13

OTCI

Room 194

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA



STAMP PLATE AREA

P 146144
GREEN
P102759578

PHYSORDER
Standard Admission Orders Trauma Service
Page 1 of 2

Patient Name _____
MRN _____

DRUG SENSITIVITY: 1. NEOA 2. _____ 3. _____ 4. _____

(Instructions: Check or fill in Yes (Y) block for all applicable orders and fill in any blanks for those orders with Yes block filled in. Check No (N) block for all orders not applicable. Orders are not valid unless either Yes or No block checked or filled in wherever they appear.)

Select EITHER ☐ Outpatient Observation OR ☒ Trauma Service Inpatient Admission

Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless checked. ☒

1. Admit to trauma service / notify admission office of patient's outpatient or inpatient status

2. Attending physician ✓ Norcross / Luan

3. Diagnosis SLIP MVA

✓ SPINAL CORD ABOVE INJURY & PARAPLEGIA

① MID EX I/P ORIF

② LVE ANEURISM I/P ANEUR

4. Condition STABLE

5. Diet (check one)

☒ NPO

☐ Per PN form

☐ Full Enteral form

☒ Oral diet type ICE CREAMS ONLY

8. Activity (check one)

☒ Bedrest

☐ Out of bed to chair

☐ Out of bed and lb

☒ Other MAY WALK & OT/PT AS THEY SEE FIT

7. VS q1hr x 4, then q2hr x 4, then per routine

☐ Y ☒ N 8. Neuro checks q1hr x 4, then q2hr x 4, then

☐ Y ☒ N 9. Vascular checks (check one): ☐ q1h ☐ q2hrs ☐ Other _____

☐ Y ☒ N 10. ECG monitor

☐ Y ☒ N 11. Pulse oximeter

☐ Y ☒ N 12. Keep head of bed (fill in as appropriate)

☐ greater than _____ degrees

☐ less than _____ degrees

☐ equal to _____ degrees

☒ Y ☒ N 13. Log roll only

☒ Y ☐ N 14. DVT prophylaxis (check all applicable) ☐ Enoxaparin 30 mg SC bid ☒ Heparin 5000 units SC to

☒ Sequential Compression Device

☐ TED hose (length ☐ knee ☐ thigh)

☐ foot pumps

☒ Y ☐ N 15. NG/OG tube to continuous low suction

☐ Y ☒ N 16. Chest tubes to _____ cm continuous pressure via pleurevac or similar device

☐ Y ☒ N 17. Cefazolin 1 gram IV q8h X 24 hours for tube thoracostomy prophylaxis unless other antibiotic ordered under #31

☒ Y ☐ N 18. Urinary catheter to gravity drainage

☒ Y ☒ N 19. Other drains: ① I/P ANEURISM I/P ANEUR

☒ Y ☐ N 19. Supplemental O₂ via (check one): ☒ Nasal cannula at 2 L/min ☐ Face mask at FIO₂ = _____ %

Physician Signature Carly MD

Pager ID 5301

Date 4/29/04

Time 10:45 AM/PM

TRAUMA/FLOOR ADMITS

4/29/04 1700

Check
Coreman

OTE 8000

4-29-04

Client: Randall Green

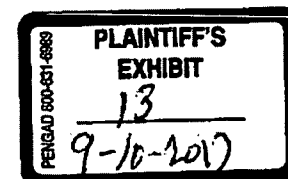
Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel
Date Prepared: January 11, 2011

Routine Medical Care

Recommendation	Indicator/ Nursing Diagnosis	Duration	Frequency Replacement	Unit Cost	Annual Cost	Resource
Visit Primary Care Physician CPT 99213	Reassess/treat general medical conditions and prescription refills	2011- 2030	3 times a year	\$81	\$243	McLeod Family Medicine Dr. Garner
Visit, Urology CPT 99214	Reassess/treat feeling of isolation and depression	2011- 2030	2 times a year	\$133	\$266	Physician Fee Reference 2010 Medical records
Visit, Podiatry CPT 99214	Reassess/treat routine foot care and maintenance of complications	2011- 2030	6 times a year	\$133	\$798	PFR 2010 Medical Records
Routine Medical Subtotal					\$1,307	
Lifetime Subtotal					\$24,833	

Comments: Medical research shows spinal cord injury patients are at risk for potential complications (spine, orthopedic, upper and lower extremity, cardiology, pulmonary, gastroenterology, and urology). For these reasons, specialty physician appointments are recommended on an intermittent basis to assess Mr. Green's medical condition, provide treatment, recommendations, and monitor for the potential complications.



Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Speciality Medical/Evaluation Care

Recommendation	Indication	Duration	Frequency	Cost	Notes	Research
Visit, Gastroenterologist CPT 99214	Assess and monitor gastrointestinal complications	2011- 2030	3 over lifetime	\$133	N/A	PFR 2010 Independent research
Visit, Neurology CPT 99214	Assess and monitor neurological complications	2011- 2030	3 over lifetime	\$133	N/A	PFR 2010 Independent research
Visit, Pulmonary CPT 99214	Assess and monitor respiratory complications	2011- 2030	2 over lifetime	\$133	N/A	PFR 2010 Independent research
Visit, Cardiologist CPT 99214	Assess and monitor cardiovascular complications	2011- 2030	2 over lifetime	\$133	N/A	PFR 2010 Independent research
Visit, Orthopedic CPT 99214	Assess and monitor orthopedic complications	2011- 2030	3 over lifetime	\$133	N/A	PFR 2010 Independent research
Speciality Medical Care Subtotal				N/A		
Lifetime Subtotal				\$1,729		

Comments: Medical research shows spinal cord injury patients are at risk for potential life threatening complications (depression, orthopedic, upper and lower extremity, cardiology, pulmonary, gastroenterology, osteoporosis, and urology). For these reasons, specialty physician appointments are recommended on an intermittent basis to assess Mr. Green's medical condition, provide

Client: Randall Green

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel
Date Prepared: January 11, 2011

Life Expectancy: 19.06 additional years 2011-2030

treatment, recommendations, and monitor for the potential complications. Projected Evaluations

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency Replacement	Unit Cost	Annual Cost	Resource
Physical Therapy CPT 97001	Assess strength and stretching and home exercise program	2011-2030	4 over life expectancy	\$131	N/A	PFR 2010 Dr. Garner and Independent research
Occupational Therapy CPT 97003	Assess ADLs	2011-2030	4 over life expectancy	\$141	N/A	PFR 2010 Independent research
Wheelchair Evaluation CPT 97542	Reassess wheelchair fit, repair, and replacement	2011-2030	Every 5 years	\$120	N/A	PFR 2010 Independent research
Projected Evaluation Subtotal				\$1,544		
Lifetime Subtotal				\$1,544		

Comments: Mr. Green suffered a spinal cord injury resulting in paraplegia. He does not have sensation below his belly button level. He does not have the use of his lower extremities and limited use of his right and left upper extremity. Mr. Green reports cognitive, psychological, and physiological symptoms related to the accident. (Initial medical records indicated Mr. Green suffered a cardiac arrest and post concussive symptoms.) Mr. Green relies on his wife, son, and durable medical equipment/aids for independent function and assist with activities of daily living. Several evaluations are recommended to assess Mr. Green's symptoms, function and deterioration, identify and reduce potential complications, and provide appropriate treatment recommendations. Also, specialty evaluations in the home are recommended to assess the status of durable medical equipment and the need for repair, maintenance, and replacement to reduce safety risk.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Projected Therapeutic Modalities

Modality	Service	Period	Frequency	Cost	Notes	Research
Physical Therapy 97110	Strength and stretching	2011-2030	30 over life expectancy	\$253	N/A	PFR 2010 Independent research
Occupational Therapy CPT 97530	ADL Improvement	2011-2030	30 over life expectancy	\$244	N/A	PFR 2010 Independent research
Psychological Counseling CPT 90806	Address depression and lifestyle changes	2011-2030	20 over life expectancy	\$140	N/A	PFR 2010 Independent research
Family Counseling CPT 90847	Address family role changes	2011-2030	10 sessions	\$159	N/A	PFR 2010 Independent research
PTM Subtotals				\$19,300		
Lifetime Subtotal				\$19,300		

Comments: Mr. Green suffered a spinal cord injury resulting in paraplegia. He does not have sensation below his belly button level. He does not have the use of his lower extremities and limited use of his upper right extremity. Mr. Green reports cognitive, psychological, and physiological symptoms related to the accident. (Initial medical records indicated Mr. Green suffered a cardiac arrest and post concussive symptoms.) Mr. Green relies on his wife, son, and durable medical equipment/aids for independent function and assist with activities of daily living. Several evaluations are recommended assessing Mr. Green's symptoms, function and deterioration, identifying and reducing potential complications, and providing appropriate treatment recommendations. Also, specialty evaluations in the home are recommended to assess the status of durable medical equipment and the need for repair, maintenance, and replacement to reduce safety risk. Mr. Green expressed feelings of depression, role changes, no longer being able to be a provider for his family, and feelings of being a burden to his family.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel
Date Prepared: January 11, 2011

Diagnostics

Procedure	Assessment	Period	Frequency	Cost	Frequency	Frequency
X-Ray Spine CPT 72070, 72100	Assess orthopedic status	2011-2030	5 over lifetime	\$316	N/A	PFR 2010 Dr. Garner
MRI Spine Thoracic/Lumbar CPT 72147, 72149	Assess orthopedic status	2011-2030	5 over lifetime	\$2,604	N/A	PFR 2010 Dr. Garner
X-Ray Upper Extremities CPT 73060 x 2	Assess orthopedic status	2011-2030	3 over lifetime	\$134	N/A	PFR 2010 Dr. Garner
EMG/NCV bilateral upper extremity CPT 95881, 95900, 95904	Assess nerve damage and function	2011-2030	3 over lifetime	\$1,899	N/A	PFR 2010 Dr. Garner
Abdominal Ultrasound CPT 76700	Assess gastrointestinal status	2011-2030	5 over lifetime	510	N/A	PFR 2010 Dr. Garner
MRI Bilateral Hips CPT 73721	Assess affects heterotrophic ossification	2011-2030	2 over lifetime	\$3,244	N/A	PFR 2010
Ultrasound lower bilateral extremity CPT 76880 x 2	Asses for deep vein thrombosis	2011-2030	3 over lifetime	\$760	N/A	PFR 2010 Dr. Garner
Bone Scan CPT 78350	Assess for bone loss and complications	2011-2030	1 over lifetime	\$251	N/A	PFR 2010
Urological Studies CPT 76770, 74430	Assess bladder status	2011-2030	Annual	\$711	\$711	PFR 2010
Diagnostic Subtotal					\$711	
Lifetime Subtotal					\$46,295	

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

**Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel**

Date Prepared: January 11, 2011

Comments: Considering medical records and independent medical research there is a strong possibility of complications such as post-traumatic arthritis, progressive heterotrophic ossification, osteopenia, deep vein thrombosis, fractures, pulmonary compromise, neurological dysfunction, and deterioration in Mr. Green's medical condition. It is reasonable to project periodic diagnostic studies to assess for potential medical complications, instability, degeneration, and diagnosis clarification.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Lab Work

Procedure	Assessment	Period	Frequency	Cost	Subtotal	Notes
General Health Panel PT 80050	Assess side effects of medications and potential complications	2011-2030	Annual	\$123	\$123	PFR 2010
Urinalysis CPT 81000	Assess urinary tract infection	2011-2030	Annual	\$21	\$21	PFR 2010
Specimen Handling fee CPT 99000	Specimen collection	2011-2030	Annual	\$21	\$21	PFR 2010
Lab Subtotal					\$165	
Lifetime Subtotal					\$3,135	

Comments: Mr. Green will be taking prescription and over the counter medications on a long-term basis. Also, Mr. Green has experienced frequent urinary tract infections due to his neurogenic bladder. Given Mr. Green's spinal cord injury and compromised medical condition, periodic lab work is recommended to assess for potential side effects of long term medication, determine appropriate antibiotics, and potential for medical complications. Mr. Green has a chronic urinary tract infection and will be treated only if symptomatic.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel
Date Prepared: January 11, 2011

Medications

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency Replacement	Unit Cost	Annual Cost	Resource
Motrin 800 mg 3 daily #90	Pain	2011-2030	Monthly	\$12	\$144	Red Book 2010
Zantac 150 mg As needed	Gastrointestinal support	2011-2030	6 Annual	\$25	\$150	Drugstore.com
Aspirin 81 mg and 325mg daily #30 each	Cardiac Support	2011-2030	Monthly	\$3	\$36	Drugstore.com
				\$9	\$108	
Metformin 500 2 daily #60	Diabetes	2011-2030	Monthly	\$40	\$480*	Drugstore.com
Lisinopril 20 mg daily #30	Cardiac Support	2011-2030	Monthly	\$14	\$168*	Drugstore.com
Simvastatin 80 mg daily #30	Cholesterol	2011-2030	Monthly	\$36	\$432*	Drugstore.com
Fluticasone Propionate 50 mcg #1	Nasal Congestion	2011-2030	Monthly	\$80	\$720*	Drugstore.com
Tramadol 50 mg 1 to 2 as needed #180	Spasms	2011-2030	Monthly	\$96	\$576	Drugstore.com
Medication Subtotal					\$3,174	
Lifetime Subtotal					\$80,498	

* not included in the total pricing

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Comments: It is anticipated based on the medical records and research that Mr. Green will require long term medications, although these current medications may change as he ages. Medical records indicated periodic urinary tract infections require antibiotic medications. It is reasonable to project future urinary tract infections requiring antibiotic therapy. Generic cost are used unless otherwise indicated in the medical records for name brand medications.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Medical Supplies, Durable Medical equipment, Aids for Independent Living

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency Replacement	Unit Cost	Annual Cost	Resource
Kendall 10 French Catheter 492026	Bladder Program Alteration in elimination	2011-2030	6 per day	\$7	\$15,330	CSNstores.com
Betadine 8 oz	Alteration in Skin Integrity	2011-2030	Monthly	\$9	\$108	Walmart.com
Barrier Cream 4 oz	Alteration in Skin Integrity	2011-2030	2 Monthly	\$3	\$72	Walmart.com
Disposable Pads Box of 50	Self Care Deficit; Hygiene	2011-2030	5/ Day	\$71	\$1,704	Rehabmart.com
Disposable Wipes Box of 72	Self Care Deficit; Hygiene	2011-2030	90/ 3 days	\$5	\$180	Walmart.com
Gloves Medium Box 100	Self Care Deficit; Hygiene	2011-2030	2 Monthly	\$10	\$240	Walmart.com
Disposable Diapers Box of 60	Bowel Program Alteration in Elimination	2011-2030	5/Day	\$20	\$720	SamsClub.com
Aloe Vista Cream 8 oz	Self Care Deficit; Hygiene	2011-2030	3/Month	\$12	\$432	Amazon.com
Protect Powder 5 oz	Self Care Deficit; Hygiene	2011-2030	Monthly	\$8	\$72	Amazon.com

Client: Randall Green

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Life Expectancy: 19.06 additional years 2011-2030

Date Prepared: January 11, 2011

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency/ Replacement	Unit Cost	Annual Cost	Resource
Cotton Balls #300	Self Care Deficit; Hygiene	2011-2030	Monthly	\$2	\$8	Walmart.com
Perennial Cleanser 8 oz	Self Care Deficit; Hygiene	2011-2030	Monthly	\$2	\$24	CVS
Skin/Wound Care Products	Self Care Deficit; Hygiene Alteration in Skin Integrity	2011-2030	Monthly Allowance	\$20	\$240	Allowance
TED Stockings (bilateral)	Alteration in Circulation	2011-2030	2 pair 6 month	\$32	\$1,536	Rehabmart.com
Bilateral Foot Orthoses	Alteration in Mobility Alteration in Skin Integrity	2011-2030	Annual	\$23	\$23	Rehabmart.com
KY Jelly 2 oz	Bladder Program Alteration in elimination	2011-2030	2 Monthly	\$3	\$72	Walmart.com
Rolling Shower Chair	Alteration in Mobility Self Care Deficit; Hygiene	2011-2030	Every 5 years	\$624	N/A	Specialty Medical Supply
Reacher Grabber Kit #3	Alteration in Mobility	2011-2030	Every 3 years	\$18	N/A	Rehabmart.com
Slide board	Alteration in Mobility	2011-2030	Every 3 years	\$25	N/A	Rehabmart.com
Swivel board	Alteration in Mobility	2011-2030	Every 3 years	\$38	N/A	Rehabmart.com
Gait Belt	Risk for Falls	2011-2030	Every 3 years	\$29	N/A	Rehabmart.com

Client: Randall Green

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Life Expectancy: 19.06 additional years 2011-2030

Date Prepared: January 11, 2011

Item	Problem	Duration	Frequency	Cost	Insurance	Source
Hoyer Lift	Alteration In Mobility at risk for falls	2011-2030	Every 10 years	\$598	N/A	Rehabmart.com
Hoyer Sling	Alteration In Mobility at risk for falls	2011-2030	Every 3 years	\$99	N/A	Rehabmart.com
SureHands Track System	Caregiver strain Alteration In Mobility	2011-2030	One time purchase	\$9,000	N/A	Surehands
Maintenance of Track System	Alteration In Mobility	2011-2030	5% of total cost annually	\$90	\$90	Maintenance
Shower grab bars #3	Risk for Falls	2011-2030	One time purchase	\$22	N/A	Rehabmart.com
Electric Hospital Bed & Mattress	Alteration In bed Mobility	2011-2030	Every 10 years	\$2,337	N/A	Invacare
Alternating pressure pad Invacare CG9701	Alteration In Skin Integrity	2011-2030	4 Annual	\$186	\$744	Invacare
Gel mattress overlay	Alteration In Skin Integrity	2011-2030	Annual	\$229	\$229	Rehabmart.com
Trapezes bar over the bed	Alteration In bed Mobility	2011-2030	Every 5 years	\$138	N/A	Rehabmart.com
Back up power generator (bed)	Alteration In Safety	2011-2030	Every 5 years	\$60	N/A	Best Buy
DME Subtotal					\$21,824	
Lifetime Subtotal					\$435,093	

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Comments: The above medical supplies, durable medical equipment, and aids for independent living have been prescribed/recommended for the medical care and assistance with Mr. Green's spinal cord injury and activity of daily living. It is anticipated that Mr. Green will require the listed DME, aids for independent function and medical supplies long term, although these may change as Mr. Green ages.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Wheelchair/Mobility, Accessories & Maintenance/Repairs

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency/ Replacement	Unit Cost	Annual Cost	Resource
Customized Power Wheelchair	Alteration in Mobility	2011-2030	Every 7 years	\$48,387	N/A	Permobil CV500
Power wheelchair maintenance	Alteration in Mobility	2011-2030	5% Annual	\$2,419	\$2,419	
Manual Wheelchair	Alteration in Mobility	2011-2030	Every 7 years	\$1,402	N/A	Invacare
Manual wheelchair maintenance	Alteration in Mobility	2011-2030	5% Annual	\$701	\$701	
Wheelchair Roho seat cushion	Alteration in Mobility Skin Integrity	2011-2030	Every 2 years	\$499	\$499	RoHoInc.com
Wheelchair Subtotal				\$52,892		
Lifetime Subtotal				\$198,451		

Comments: Mr. Green currently uses a Linak UA31 customized wheelchair for mobility. Mr. Green's current wheelchair is in ill repair. The arms are held together with duct tape, the hand controls are loose, it requires frequent battery replacement, and it does not allow for Mr. Green to be in a reclined position with his legs in a raised position. The local wheelchair service supply companies no longer service his current chair. A new custom wheelchair is recommended which will allow Mr. Green greater mobility with the options of balance, standing, stair climbing, and four wheeled terrain. Repetitive standing can help to prevent many problems associated with wheelchair confinement including: skin breakdown, urinary tract infections, bone demineralization, poor circulation, spasticity, muscle contractures and shoulder pain. Mr. Green will require a lifetime of wheelchair mobility, maintenance/replacement, and wheelchair accessories (cushion, cover back pack, cup holder, gloves, tray). A manual back-up chair is also recommended for Mr. Green mobility.

Client: Randall Green

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Life Expectancy: 19.06 additional years 2011-2030

at times of maintenance and power failures. Maintenance cost is estimated to be 5% of the retail price that includes batteries.

Transportation

Item	Category	Period	Frequency	Cost	Cost	Source
Medical Mileage Reimbursement	Medical Mileage Reimbursement	2011-2030	Annual	\$0.19	\$40	IRS.org
Handicap Parking Permit	Alteration in Mobility	2011-2030	Every 2 years	\$20	N/A	SC DMV
Handicap Accessible Van	Alteration in Mobility	2011-2030	1 over life expectancy	\$35,930	N/A	AAvans.com
Vehicle Maintenance	Alteration in Mobility	2011-2030	10% Annual	\$3,593	\$3,593	
Transportation Subtotal					\$3,633	
Lifetime Subtotal					\$105,147	

Comments: Per the Federal Government, mileage incurred for medical appointments in 2010 is reimbursed at \$0.19 per mile. Presently, Mr. Green relies on a 2000 Handicap Accessible Van purchase price \$7,000 and ramp system for \$1,500. Mr. Green has difficulty entering the van in his custom wheelchair due to it being large and bulky and he must use a Breezy 510 chair that was purchased through a newspaper for appointments and errands. This chair does not provide the appropriate trunk support and if not monitored closely leaves Mr. Green at higher risk for falls. Given the severity of Mr. Green's medical condition and safety factors which include: handicap accessible transportation is recommended to maintain Mr. Green's independence, mobility, and safety. Recommendations have been given for the initial purchase of a van, modifications for wheelchair accessibility, maintenance, and repair. Recommendations have also been given for the difference of vehicle insurance on a handicap accessible van. Mr. Green travels approximately 208 miles a year round trip for routine medical appointments.

Client: Randall Green

Life Expectancy: 19.08 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Home Care

Service	Category	Period	Frequency	Rate	Amount	Source
Certified Nursing Assistant	Self Care Deficit	2011-2030	24 hours daily	\$15/hr	\$134,400	Metlife Survey Dr. Garner
Home Health Nursing Visits	Medical Home Care	2011-2030	4/hr Monthly	\$25/hr	\$1,200	Payscale.com
Home Care Subtotal					\$135,600	
Lifetime Subtotal					\$2,584,536	

Comments: Mr. Green is receiving assistance with his activities of daily living, such as showering, shaving, grooming, dressing, bowel and bladder program, meal preparation, house cleaning, laundry, shopping, errands, and reminders for medication and appointments. Given the nature of Mr. Green's spinal cord injury physicians do not anticipate Mr. Green will be completely independent in his ADL's. Given the severity of Mr. Green's spinal cord injury, recommendations are given for continued attendant care with a gradual increase in hours over Mr. Green's lifetime. This Life Care Plan has been completed with Mr. Green continuing to live at home. Should Mr. Green's condition decline, alternate living arrangements should be considered such as an assisted living facility or nursing facility. ***The Metlife Survey 2010, the average cost of nursing home or assisted living facility in the state of SC is \$189 per day. This cost does not include medical providers, specialty service, medications, medical supplies, and durable medical equipment.***

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Housing

Item	Category	Period	Frequency	Cost	Cost	Source
Home Modifications (ramps)	Handicap Accessible Housing	2011-2030	3 over life expectancy	\$4,000	\$4,000	Costhelper.com
Home Modifications (bathroom)	Handicap Accessible Housing	2011-2030	1 over life expectancy	\$7,000 to \$25,000	\$7,000 to \$25,000	Costhelper.com
Home Modifications maintenance and repair	Handicap Accessible Housing	2011-2030	Annual	1% total price of the home	\$1,250	Answer.com
Butler Alarm System	Safety	2011-2030	Onetime Purchase		\$3,749	Simply Home
Butler Monitoring System	Safety	2011-2030	Monthly	\$70	\$840	Simply Home
Housing Subtotal					\$25,839	
Lifetime Subtotal					\$71,584	

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Comments: Presently, Mr. Green lives in a one story home. The home has one entrance ramp for Mr. Green to enter and exit the home there are a total of 4 entrances to the home. Should an emergency occur then there is only one exit. It is recommended that one more ramp be installed in the home for an alternate exit for Mr. Green. The interior of the home is adequate for Mr. Green to maneuver around the home in his wheelchair. The flooring in the home is carpet and solid surfaces. Mr. Green will require a lifetime of handicap accessible housing. Mr. Green lives in a rural area and the land around the home is sandy and uneven. The driveway and parking surface is also sandy and uneven. Mr. Green enjoys doing yard work and raising a garden. It is recommended that there be concrete paths placed around Mr. Green's garden. The median home prices based on Marion City data are \$125,004. (<http://www.city-data.com/city/Marion-South-Carolina.html>)

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Other

Recommendation	Indication/ Nursing Diagnosis	Duration	Frequency Replacement	Unit Cost	Annual Cost	Resource
Case Management	Implementation of plan of care and assess for complications	2011-2030	5 hours Monthly	\$80/hr	\$4,800	VP Medical
Other Subtotal					\$4,800	
Lifetime Subtotal					\$91,200	
Plan total					\$3,668,176	

Comments: Nurse Case Management is recommended to implement Mr. Green's plan of care, communication with health care providers, education of the disease process, and assist with community resources.

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel

Date Prepared: January 11, 2011

Recommendation	Lifetime Subtotal
Medical Care	\$24,833
Specialty Care	\$1,729
Projected Therapeutic Modalities	\$19,300
Diagnostics	\$46,295
Lab Work	\$3,135
Medications	\$60,496
Medical Supplies, Durable Medical equipment, Aids for Independent Living	\$435,093
Wheelchair/Mobility, Accessories & Maintenance/Repairs	\$198,451
Transportation	\$105,147
Home Care	\$2,584,536
Housing	\$71,584
Other	\$91,200
Plan Total	\$3,668,176

Client: Randall Green

Life Expectancy: 19.06 additional years 2011-2030

Diagnosis: T6 paraplegia, neurogenic bladder,
neurogenic bowel
Date Prepared: January 11, 2011

CHART 1
BEFORE-TRIAL LOSS
(04/18/04 - 09/10/13 = 9.39 YEARS)

Earning Capacity		
2004 (04/18 - 12/31)	\$21,000	
2005	30,000	
2006	30,000	
2007	30,000	
2008	30,000	
2009	30,000	
2010	30,000	
2011	30,000	
2012	30,000	
2013 (01/01 - 09/10)	20,700	
Loss in Earning Capacity		\$281,700
Personal Services		
		<u>Hours lost per week:</u>
2004 (04/18 - 12/31)	2,450	10.00
2005	3,500	10.00
2006	3,500	10.00
2007	3,500	10.00
2008	4,000	10.00
2009	4,000	10.00
2010	4,000	10.00
2011	4,000	10.00
2012	4,000	10.00
2013 (01/01 - 09/10)	2,760	10.00
Loss in Personal Services		35,710
Total Before-Trial Loss		\$317,410

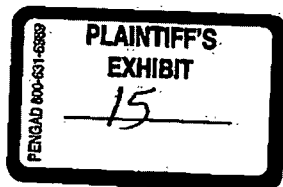


CHART 2
PRESENT VALUE OF AFTER-TRIAL LOSS IN
EARNING CAPACITY
(09/10/13 TO WORK-LIFE EXPECTANCY
AT AGE 70 ON 2020.19 = 6.50 YEARS)

Year Ending	Annual Amount	Discounted to Present Value
2014.69	\$30,000	\$28,571
2015.69	30,747	27,888
2016.69	31,513	27,222
2017.69	32,297	26,571
2018.69	33,101	25,935
2019.69	33,926	25,316
2020.19	17,385	12,660
Totals	\$208,969	\$174,163

**CHART 3
CONSUMER PRICE INDEX
MEDICAL CARE ITEMS IN U.S.
(1960 - 2012)**

(1982 - 1984 = 100)

Year	Index	\$100
1960	22.3	\$100
1965	25.2	113
1970	34.0	152
1975	47.5	213
1980	74.9	336
1981	82.9	372
1982	92.5	415
1983	100.6	451
1984	106.8	479
1985	113.5	509
1986	122.0	547
1987	130.1	583
1988	138.6	621
1989	149.3	669
1990	162.8	730
1991	177.0	794
1992	190.1	852
1993	201.4	903
1994	211.0	946
1995	220.5	989
1996	228.2	1,023
1997	234.6	1,052
1998	242.1	1,086
1999	250.6	1,124
2000	260.8	1,169
2001	272.8	1,223
2002	285.6	1,281
2003	297.1	1,332
2004	310.1	1,391
2005	323.2	1,449
2006	336.2	1,508
2007	351.1	1,574
2008	364.1	1,632
2009	375.6	1,684
2010	388.4	1,742
2011	400.3	1,795
2012	414.9	1,861

Source: Bureau of Labor Statistics.

CHART 4
ANNUAL COMPOUNDED GROWTH RATES FOR THE
GENERAL CPI, TRANSPORTATION, AND
SELECTED MEDICAL CARE ITEMS,
1992 - 2012

1. General CPI	2.49%
2. Transportation	2.74%
3. General Medical CPI Medical care commodities and medical care services.	3.98%
4. Professional Services Physicians, dentists, eye care providers, and other medical professionals.	3.38%
5. Physician Services Includes services by medical physicians in private practice, including osteopaths, that are billed by the physician. Includes house, office, clinic, and hospital visits. (Excludes ophthalmologists.)	3.31%
6. Services by other medical professionals Includes services performed by other professionals such as psychologists, chiropractors, physical therapists, podiatrists, social workers, and nurse practitioners in or out of the office.	2.59%
7. Prescription Medications All drugs and medical supplies dispensed by prescription. Mail order outlets are included. Prices reported represent transaction prices between the pharmacy, patient, and third party payor, if applicable.	3.66%
8. Medical Care Commodities Prescription drugs, nonprescription over-the-counter drugs, and other medical equipment and supplies.	2.91%

Source for data: Bureau of Labor Statistics.

CHART 5
ELEMENTS OF LIFE CARE PLAN

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
A. ROUTINE MEDICAL CARE			
1. Primary Care Physician	annual	\$243	2013 - life
2. Urologist	annual	266	2013 - life
3. Podiatry	annual	798	2013 - life
B. SPECIALTY MEDICAL/EVALUATION CARE			
1. Gastroenterologist	3 over lifetime	133	2013 - life
2. Neurology	3 over lifetime	133	2013 - life
3. Pulmonology	2 over lifetime	133	2013 - life
4. Cardiologist	2 over lifetime	133	2013 - life
5. Orthopedic	3 over lifetime	133	2013 - life
6. Physical Therapy	4 over lifetime	131	2013 - life
7. Occupational Therapy	4 over lifetime	141	2013 - life
8. Wheelchair Evaluation	1 x 5 years	120	2013 - life
C. PROJECTED THERAPEUTIC MODALITIES			
1. Physical Therapy	30 sessions	253 (per session)	2013 - life
2. Occupational Therapy	30 sessions	244 (per session)	2013 - life
3. Psychological Counseling	20 sessions	140 (per session)	2013 - life
4. Family Counseling	10 sessions	159 (per session)	2013 - life
D. DIAGNOSTICS			
1. X-Ray Spine	5 over lifetime	316	2013 - life
2. MRI Spine/Thoracic/Lumbar	5 over lifetime	2,804	2013 - life
3. X-Ray Upper Extremities	3 over lifetime	134	2013 - life
4. EMG/NCV Bilateral Upper Extremity	3 over lifetime	1,899	2013 - life
5. Abdominal Ultrasound	5 over lifetime	510	2013 - life
6. MRI Bilateral Hips	2 over lifetime	3,244	2013 - life
7. Ultrasound Lower Bilateral Extremity	3 over lifetime	760	2013 - life
8. Bone Scan	1 over lifetime	251	2013 - life
9. Urological Studies	annual	711	2013 - life
E. LAB WORK			
1. General Health Panel	annual	123	2013 - life
2. Urinalysis	annual	21	2013 - life
3. Specimen Handling Fee	annual	21	2013 - life

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
F. MEDICATIONS - FOR INFORMATIONAL PURPOSES ONLY			
1. Motrin 800 mg	annual	144	2013 - life
2. Zantac 150 mg	annual	150	2013 - life
3. Aspirin (average of 81 mg and 325 mg)	annual	72	2013 - life
4. Metformin 500 mg	annual	480	2013 - life
5. Lisinopril 20 mg	annual	168	2013 - life
6. Simvastatin 80 mg	annual	432	2013 - life
7. Fluticasone Propionate 50 mcg	annual	720	2013 - life
8. Tramadol 50 mg	annual	576	2013 - life
G. MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AIDS FOR INDEPENDENT LIVING			
1. Kendall 10 French Catheter	annual	15,330	2013 - life
2. Betadine 8 oz.	annual	108	2013 - life
3. Barrier Cream 4 oz.	annual	72	2013 - life
4. Disposable Pads	annual	1,704	2013 - life
5. Disposable Wipes	annual	180	2013 - life
6. Gloves Medium	annual	240	2013 - life
7. Disposable Diapers	annual	720	2013 - life
8. Aloe Vista Cream 8 oz.	annual	432	2013 - life
9. Protect Powder 5 oz.	annual	72	2013 - life
10. Cotton Balls	annual	8	2013 - life
11. Perennial Cleanser 8 oz.	annual	24	2013 - life
12. Skin/Wound Care Products	annual	240	2013 - life
13. TED Stockings (bilateral)	annual	1,536	2013 - life
14. Bilateral Foot Orthoses	annual	23	2013 - life
15. KY Jelly 2 oz.	annual	72	2013 - life
16. Rolling Shower Chair	1 x 5 years	624	2013 - life
17. Reacher Grabber Kit	1 x 3 years	18	2013 - life
18. Slide Board	1 x 3 years	25	2013 - life
19. Swivel Board	1 x 3 years	38	2013 - life
20. Gait Belt	1 x 3 years	29	2013 - life
21. Hoyer Lift	1 x 10 years	598	2013 - life
22. Hoyer Sling	1 x 3 years	99	2013 - life
23. SureHands Track System	1 time	9,000	2013 - life
24. Maintenance of Track System	annual	90	2013 - life
25. Shower Grab Bars	1 time	22	2013 - life
26. Electric Hospital Bed and Mattress	1 x 10 years	2,337	2013 - life
27. Alternating Pressure Pad	annual	744	2013 - life
28. Gel Mattress Overlay	annual	229	2013 - life
29. Trapeze Bar over the Bed	1 x 5 years	136	2013 - life
30. Back-up Power Generator	1 x 5 years	60	2013 - life

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
H. WHEELCHAIR/MOBILITY, ACCESSORIES & MAINTENANCE/REPAIRS			
1. Customized Power Wheelchair	1 x 7 years	48,387	2013 - life
2. Power Wheelchair Maintenance	annual	2,419	2013 - life
3. Manual Wheelchair	1 x 7 years	1,402	2013 - life
4. Manual Wheelchair Maintenance	annual	70	2013 - life
5. Wheelchair Roho Seat Cushion	1 x 2 years	499	2013 - life
I. TRANSPORTATION			
1. Medical Mileage Reimbursement	annual	40	2013 - life
2. Handicapped Parking Permit	1 x 2 years	20	2013 - life
3. Handicapped Accessible Van	1 time	35,930	2013 - life
Less: Estimated Normal Vehicle		(22,000)	
Net Handicapped Accessible Van		13,930	
4. Vehicle Maintenance	annual	3,593	2013 - life
J. HOME CARE			
1. Certified Nursing Assistant	annual	134,400	2013 - life
2. Home Health Nursing Visits	annual	1,200	2013 - life
K. HOUSING			
1. Home Modifications (Ramps)	3 over lifetime	4,000	2013 - life
2. Home Modifications (Bathroom)	1 time	16,000	2013 - life
3. Home Modifications - Maint. & Repair	annual	1,250	2013 - life
4. Butler Alarm System	1 time	3,749	2013 - life
5. Butler Monitoring System	annual	840	2013 - life
L. OTHER			
1. Case Management	annual	4,800	2013 - life

Source: Ms. Peggie M. Nielson, BSN, RN, CNLCP.

CHART 6
PRESENT VALUE OF FUTURE MEDICAL CARE COSTS
(09/10/2013 - LIFE EXPECTANCY AT AGE 79.76 ON 2029.95)

Elements	Present Value	
A. ROUTINE MEDICAL CARE		
1. Primary Care Physician	\$3,352	
2. Urologist	3,668	
3. Podiatry	11,010	
		\$18,030
B. SPECIALTY MEDICAL/EVALUATION CARE		
1. Gastroenterologist	352	
2. Neurology	352	
3. Pulmonology	239	
4. Cardiologist	239	
5. Orthopedic	352	
6. Physical Therapy	437	
7. Occupational Therapy	470	
8. Wheelchair Evaluation	306	
		2,747
C. PROJECTED THERAPEUTIC MODALITIES		
1. Physical Therapy	6,055	
2. Occupational Therapy	5,837	
3. Psychological Counseling	2,230	
4. Family Counseling	1,367	
		15,489
D. DIAGNOSTICS		
1. X-Ray Spine	1,368	
2. MRI Spine/Thoracic/Lumbar	12,143	
3. X-Ray Upper Extremities	355	
4. EMG/NCV Bilateral Upper Extremity	5,015	
5. Abdominal Ultrasound	2,209	
6. MRI Bilateral Hips	5,803	
7. Ultrasound Lower Bilateral Extremity	2,007	
8. Bone Scan	251	
9. Urological Studies	9,763	
		38,914
E. LAB WORK		
1. General Health Panel	1,688	
2. Urinalysis	288	
3. Specimen Handling Fee	288	
		2,264

Elements	Present Value	
F. MEDICATIONS - FOR INFORMATIONAL PURPOSES ONLY		
1. Motrin 800 mg	1,922	
2. Zantac 150 mg	2,003	
3. Aspirin (average of 81 mg and 325 mg)	963	
4. Metformin 500 mg	6,757	
5. Lisinopril 20 mg	2,363	
6. Simvastatin 80 mg	6,079	
7. Fluticasone Propionate 50 mcg	10,134	
8. Tramadol 50 mg	8,105	
		38,326
G. MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AIDS FOR INDEPENDENT LIVING		
1. Kendall 10 French Catheter	204,619	
2. Betadine 8 oz.	1,440	
3. Barrier Cream 4 oz.	963	
4. Disposable Pads	22,745	
5. Disposable Wipes	2,402	
6. Gloves Medium	3,206	
7. Disposable Diapers	9,613	
8. Aloe Vista Cream 8 oz.	5,767	
9. Protect Powder 5 oz.	963	
10. Cotton Balls	105	
11. Perennial Cleanser 8 oz.	322	
12. Skin/Wound Care Products	3,206	
13. TED Stockings (bilateral)	20,500	
14. Bilateral Foot Orthoses	307	
15. KY Jelly 2 oz.	963	
16. Rolling Shower Chair	1,617	
17. Reacher Grabber Kit	75	
18. Slide Board	106	
19. Swivel Board	161	
20. Gait Belt	123	
21. Hoyer Lift	1,036	
22. Hoyer Sling	420	
23. SureHands Track System	9,000	
24. Maintenance of Track System	1,168	
25. Shower Grab Bars	22	
26. Electric Hospital Bed and Mattress	4,046	
27. Alternating Pressure Pad	9,929	
28. Gel Mattress Overlay	3,058	
29. Trapeze Bar over the Bed	353	
30. Back-up Power Generator	155	
		308,390

Elements	Present Value	
H. WHEELCHAIR/MOBILITY, ACCESSORIES & MAINTENANCE/REPAIRS		
1. Customized Power Wheelchair	120,843	
2. Power Wheelchair Maintenance	25,467	
3. Manual Wheelchair	3,503	
4. Manual Wheelchair Maintenance	737	
5. Wheelchair Roho Seat Cushion	3,317	
		153,867
I. TRANSPORTATION		
1. Medical Mileage Reimbursement	523	
2. Handicapped Parking Permit	112	
3. Net Handicapped Accessible Van	13,930	
4. Vehicle Maintenance	46,575	
		61,140
J. HOME CARE		
1. Certified Nursing Assistant	1,742,204	
2. Home Health Nursing Visits	15,665	
		1,757,869
K. HOUSING		
1. Home Modifications (Ramps)	10,371	
2. Home Modifications (Bathroom)	18,000	
3. Home Modifications - Maint. & Repair	16,203	
4. Butler Alarm System	3,749	
5. Butler Monitoring System	9,203	
		55,526
L. OTHER		
1. Case Management		62,656
TOTAL FUTURE MEDICAL CARE COSTS		\$2,515,218

CHART 7
POTENTIAL COMPLICATIONS

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
1. Increased incident of urinary tract infections related to the indwelling catheter or intermittent catheterizations	unknown	unknown	unknown
2. Potential difficulty with blood pressure control	unknown	unknown	unknown
3. Continued bowel, bladder, and sexual dysfunction related to the spinal cord injury	unknown	unknown	unknown
4. Increased muscle and limb spasticity	unknown	unknown	unknown
5. Increased risk of skin breakdown specifically sacral and heel decubitus ulcers	unknown	unknown	unknown
6. Decreased functional status	unknown	unknown	unknown
7. Dietary/nutritional concerns	unknown	unknown	unknown
8. Depression, altered self-image behavioral/psychological maladjustment	unknown	unknown	unknown
9. Heterotopic Ossification	unknown	unknown	unknown
10. Potential for respiratory dysfunction related to the spinal cord injury	unknown	unknown	unknown
11. Continued cardiovascular system dysfunction related to the spinal cord injury	unknown	unknown	unknown
12. Secondary accidents/falls	unknown	unknown	unknown
13. Deep Vein Thrombosis	unknown	unknown	unknown
14. Potential worsening of diabetes mellitus related to the spinal cord injury	unknown	unknown	unknown
15. Hypotension or orthostatic hypotension	unknown	unknown	unknown
16. Autonomic Dysreflexia	unknown	unknown	unknown
17. Increased incident in gastrointestinal system dysfunction and peptic ulcer disease	unknown	unknown	unknown

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
18. Anemia	unknown	unknown	unknown
19. Pain	unknown	unknown	unknown
20. Infections related to open wounds	unknown	unknown	unknown

Source: Peggie M. Neilson, BSN, RN, CNLCP.

CHART 8
PRESENT VALUE OF AFTER-TRIAL LOSS
(09/10/13 - LIFE EXPECTANCY AT AGE 79.76
ON 2029.95 = 16.26 YEARS)

Earning Capacity	\$174,163
Future Medical Care Costs	<u>2,515,218</u>
Total After-Trial Loss	<u>\$2,689,381</u>

CHART 9
TOTAL FINANCIAL LOSS
(04/18/04 - LIFE EXPECTANCY AT AGE 79.76
ON 2029.95 = 25.65 YEARS)

Before-Trial Loss	\$317,410
After-Trial Loss	<u>2,689,381</u>
Total Financial Loss	<u>\$3,006,791</u>

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~~D-68~~

Admission Time 00:00
Source Code 800
Pat Com. # 102759578
Patient Sex M
Birth Date 3/11/1950
Marital Status M
Adm/Reg by
RANDALL M
Advanced Directive? N
AD on File at MUSC?
AD Info Provided? N

Vip Code Desc
Pat. SSN 250-80-3882
Refer. Name
Pat. Emp. Phone

Room-Bed
Attn'd. Doc Name
Admit. Doc Name
Elig. Det. Date
NOK First Name
NOK Home Phone
Family Doctor
PCP Doc Name

Leen
~~NORCROSS, E~~
ANN
(843) 423-3059
UNK., DR
UNK., DR

NOK First Name ANN
NOK Home Phone (843) 423-3059
Family Doctor UNK., DR
PCP Doc Name UNK., DR
PCP Doc Phone
PCP Address 1
PCP Address 2
PCP Address 3
PCP Address 4
E/R Referral

PLAINTIFFS
EXHIBIT
1- Norcross
Se 10-28-09

Primary Diagnosis: CHL
acetabular fr.
wound - forearm
Secondary Diagnosis: ulnar / median nerve injury
esp. insuff. (inter. SCI) - painful circ.

~~no~~ 0630
~~HS~~ 8630
 repair - nerves - JSA
 cation or Special Procedures issue asp. pre-anesthetic
 snch 419 Leon, Wt. Htg Intubation mech vent
 1 q6c Leon 419 ev lcp
 T ORF-acet. Lghts 419 I-IV forearm
 9915 Lghts = 419 femoral traction

Date Dictated _____ Job # _____ Resper # _____
 Date Dictated _____ Job # _____ Resper # _____

24 HOUR CRITICAL CARE PATIENT RECORD Date APR 18 2004

page 11 of 12

(STAMP PLATE)

PROGRESS NOTES

Time: 2230 Record changes in patient's status and patient/family education
Received pt via stretcher from Grand Strand Hospital
intubated. pt alert follows command unable to wiggle
toes. lungs clear upper dim bases BS hyp. #18 @ oral PIV
radial pulses at bilat. 2245 d5g from Grand Strand Schwartz
E blood. Foley draining yellow urine. Bilat pedal pulse Jt.
2315 pt extubated. 3 LNC morphine 2mg IV for pain
lbs sent 010 Mag Sulfate to get total 3 grams IV. Calcium Chloride
x amp 020 FFP x 2 units 030 PRBC x 2 units 035 set placed on
100 NRFM. 0340 NT suction Thick yellow copious sputum/mucous
0350 placed on BiPAP. Set 100% morphine 2mg IV. Versal 1mg IV
0400 1Lx + Liter Bolus. NaBicarb x 4 amps IV. MIVF's did to
5th E 2 amps NaBicarb 125cc/0 0415 morphine 4mg IV.
0415 Report to accompany my reviewed x-rays Mary Collins

Patient: F000426717 GREEN, RANDALL M Physician: COZART, RALPH F Specialty: PS-PLASTIC SURGERY O.R.: OR 4-OR, ROOM 4 x4364		Account No: F01011093196 Room/Bed/T.Loc: F.SIC-3 Oper Date: 04/17/04		DOB: [REDACTED] Age: [REDACTED] Sex: M		Grand Strand RMC Run Date: 04/19/04 Run Time: 0831 Case Closed/Transmitted:		Page: 1				
PROPOSED Procedures: D FINGER TENDON/NERVE REPAIR		Severity MIN	R/L/B GENERAL	ANES TYPE GENERAL	ASA CLASS	ACTUAL Procedures		Severity	R/L/B Wound Surgeon	START	END	
PRE OP DIAGNOSIS		POST OP DIAGNOSIS										
PATIENT ALLERGIES (Last Filled 04/18/04 1425)												
RED: No Known Drug Allergies CONTRAST: No Known Contrast Allergies OTHER: No Known Other Allergies FOOD: No Known Food Allergies												
PRE-OP NOTES 1410-1415: BROUGHT TO PREOP HOLDING ON STRETCHER BRIEFLY. DR. BAURLE COMING IN ROOM. STATING PATIENT NEEDS TO GO BACK TO ER. THEN TO CT IMMEDIATELY FOR ORTHO EVALUATION. PATIENT ORIENTED PERSON. FOLLOWS SOME COMMANDS. MAE. NEEDING CONSTANT REMINDING TO LEAVE IV. DRESSINGS ALONE. SIDERAILS UP. REMAINS ON 10L NOBREATHAER. TRANSPORTED BACK TO FR WITH ORDERLY PER DR. BAURLE AND DR. PETERS.				DATE	TIME	INVASIVE PROCEDURE	SITE	SIZE	DOCTOR	STAFF	QTY	COMMENT
ES by JOYCE A CONNER on 04/17/04 at 1433				** N/A **								
CASE TIMES		CASE TIMES		CASE TIMES		CASE TIMES		CASE TIMES				
SURGEONS SURGEON COZART, RALPH F ASSISTING		IN-OUT	IN-OUT	ANES. STAFF ANES MD PETERS, DAVID C ASSIST/CRNA		IN-OUT	IN-OUT	OTHER CASE STAFF CIRCULATOR SCRUB TECH REP/OTHER OUTSIDE SCRUB				
IN-OUT		IN-OUT		IN-OUT		IN-OUT		IN-OUT				
IMPLANTS												
Inventory Type	Implant	Qty	Manufacturer	Surgeon	Lot Number	Catalog Number	Size	Serial Number	Batch Number	Site	Exp. Date	Qty
ES by JOYCE A CONNER on 04/17/04 at 1525												
EXPLANTS												
Explant Description		Manufacturer	Surgeon	Lot Number	Catalog Number	Size	Serial Number	Batch Number	Site	Exp. Date	Qty	
ES by JOYCE A CONNER on 04/17/04 at 1525												

GRAND STRAND REGIONAL MEDICAL CENTER
MYRTLE BEACH, SC 29572

CONSULTATION REPORT

P: GREEN, RANDALL M
REC #: F000426717

ATTENDING PHYSICIAN: NICHOLSON, GEORGE B
ACCOUNT #: F01011093196

PT: GREEN, RANDALL M
CON: 04/17/2004
DICT PHY: RALPH F. COZART, MD
CONS PHY:

CC: Complex avulsed laceration on right forearm with arterial, muscle and nerve injury.

HPI: The patient is a 54-year-old white male who was in a motor vehicle crash. Apparently he was T-boned at a high rate of speed and sustained multiple injuries. He had a dislocated right hip, an acetabular fracture on the right and a complex avulsion laceration of the right forearm with arterial, muscle and nerve injury.

PME: Unremarkable.

SH: He is a smoker, about 1/2 to 2 packs of cigarettes a day.

MEDS: Aspirin prn.

ALL: None.

FH: Noncontributory.

PH: HEAD/NECK: Unremarkable. He is awake, alert and talkative. He is in a C-collar. LUNGS: Clear. HEART: Regular rate and rhythm without murmur. ABDOMEN: Soft and nontender. EXTREMITIES: Examination of the right upper extremity reveals a laceration of the right forearm approximately 3-4 cm distal to the antecubital fossa all the way down to the bone. There is a very large muscle mass and arterial and nerve injury.

PLAN: The patient will be taken to the operating room for definitive evaluation and care urgently.

INTERVAL NOTE: As we were waiting for the operating room to do repair, he had a CT scan of the acetabulum which showed bone fragments. He was taken back to the emergency room and was awaiting transfer to the operating room and sustained a respiratory and then cardiac arrest, and he was intubated and resuscitated. Initially, he had a hemoglobin of _____ and hematocrit of _____. A second set of labs were drawn. _____ His problem was circulatory and respiratory compromise from _____. I did postpone the surgery _____. _____ local anesthesia to repair the radial artery in the right forearm with interrupted 6-0 Prolene sutures. I also repaired the ulnar artery with interrupted 6-0 Prolene sutures. However, as the ulnar artery was torn, I had to tie that off but had good flow in the radial artery by Doppler. So I then closed the skin with staples. A definitive _____ repair will be done at a later date when he is more stable. The patient had good capillary refill to the fingertips and had brisk bleeding _____ brachial. He also had a good Doppler signal pulses in the radial artery. He tolerated this well. His blood pressure stabilized to above 100 systolic _____. We will have to bring him back to the operating room for definitive care in the next several days when he is stable _____.

CONSULTATION REPORT

GSRMC 26
Page 1 of 2

Plaintiffs' Trial Exhibit #23

GRAND STRAND REGIONAL MEDICAL CENTER

ATT. PHY NICHOLSON, GEORGE B

NAME: GREEN, RANDALL M

MF REC# F000426717

=====

D 04/17/2004 15:54:06

T 04/18/2004 10:58:45/360 Job #: 1974613/Doc #: 1404436-C2

COZART, RALPH F

Electronically Signed by RALPH F COZART on 05/07/04 at 1314

CONSULTATION REPORT

GSRMC 27
Page 2 of 2

Plaintiffs' Trial Exhibit #23

Page 2 of 4		T3119									
Temp	BP	HR	RR	SpO ₂	O ₂ Delivery	Pain Scale 0-10	GCS	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials
1215	96/51	69	20			10	4-5b	NSC	3-4-4	#16 F/dy inserted C clear yellow urine return; UA sent - Pt A+OX3, NS infusing	SB
1225	97/60	66	20			10	4-5b	NSC	3-4-4	Pt to CT Scan via stretcher C.R.N. in attendance	SB
1241	95/51	67								Back from CT - Placed back in monitor bleeding thru dog in place	SB
1251						10	4-5b	NSC	3-4-4	Dr. Dickinson here to seep. Doppler used to obtain Rt radial pulse @ Rt ulnar Pulse noted -	SB
1256	100/51	60	18							Rt hand cool & pale capillary refill 1-2 sec Pt A+OX3 - Dr. Corant here to see pt. Present dog removed by Dr. Corant & reappplied	SB
1310										Td 0.5cc IM Qdeltoid #18 Heptlock placed @ hand. Dr. Corant removed @ AC Heptlock EKG done	SB
1315											
1330	97/62	85	22	99	100%	10	4-5b	NER	11	Ancef 1 gram IM q 8h in 10cc NS. Sutures removed & give to daughter & son-in-law	SB

Initials	Signature / Title
SB	Sandra Barber

PATIENT IDENTIFICATION

Green, Randall

GREEN, RANDALL M
A0601011023126 REG EP
DOB 04/17/01 SEX M FIC 11
SSN 111-11-1111

UFF010-26317
ED

ED Nursing Flow Sheet - Continued

GSRMC 005

12-1-02

Adult Child

Emergency Department

Page 2

Plaintiffs' Trial Exhibit #29

Page 4 of 4												
Time	Temp	BP	HR	RR	SpO ₂	O ₂ Delivery	Pain Scale 0-10	G.C.S.	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials
1335											4th liter NS T w/o.	SB
1345		67/54	115	24	100	100% GPA					Dr. Nicholson @ bedside	
1347											Morphine 4mg IV	
											C-Collar removed by	
											Dr. Nicholson - Pt given	
											Verbal 9mg IV -	SS
1352		67/40	110	24	100	100% GPA		4-5/6	ST		Dr. Lutz reduced RT	
											hip, pt alert @ time	SB
1355											Pt sleeping on/off	
											awakens to verbal	
											stimuli	SS
1400											Pt to O.R. via	
											stretcher	SS

Initials	Signature / Title	PATIENT IDENTIFICATION
SB	Sandra Barakat	Green, Randall

GREEN, RANDALL M	10/10/2017
ED	10/10/2017

ED Nursing Flow Sheet - Continued

GSRMC 006

13119-C

01/10/2017

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Page 2

Plaintiffs' Trial Exhibit #29

Page _____ of _____													
Time	Temp	BP	HR	RR	SpO ₂	O ₂ Delivery	Pain Scale 0-10	G.C.S.	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials	
1415		127/51	135								Pt back from U.R. per Dr. Bannick, who is @ bedside. Pt to have CT hip. Pt to CT Scan for CT hip.	33	
1435											Pt back from CT Scan. Placed back on monitor. BP, Pt getting clammy, resp. and snoring. Dr. Lintz away @ bedside.		
1448											Pt brady ↓ to 37, RR in progress. Pt given Atropine 1 amp, Epi 1 amp IVP. Pt intubated by Dr. Lintz #8 ET tube.		
1452		53/32	135								Masked @ 22 @ lips - see code sheet, Dr. Lintz, Nicholson, Bannick + Corant @ bedside.	35	
1505		174/104									ET placed. Rt side of neck by Dr. Peters from Anesthesia. Bloods & 2 units up on pressure bag.	36	
1501							36 L 85553			36 FF 18183			
1512											HR dropping brady ↓ 37. Atropine 1 amp, Epi 1 amp IVP. Dr. Corant @ bedside to repair & stop bleeding of Rt arm.	37	
1514		64/31	140										
Initials		Signature / Title					PATIENT IDENTIFICATION						
SB		Sandy Bannick					Green, Kendall						

ED Nursing Flow Sheet - Continued

GSRMC 007

Form 100

White - Chart

Laminated - Original - For Quality Review

Page 2

Plaintiffs' Trial Exhibit #29

Page _____ of _____													
Time	Temp	BP	HR	RR	SpO ₂	O ₂ Delivery	Pain Scale 0-10	G.C.S.	Rhythm	RTS	Nurse's Interventions/Evaluations	Initials	
1515											Anterior line Quinot Blood units 3 + 4 ↑ on pressure bags - heparin started @ 1 sec/hr. = 1 mg/min Epi started @ 5 mcg = 1 cc/hr. Epi stopped per Dr. Peters units 3 + 4 infused Platelets 6 units ↑ on pressure bag - Report called to Heather on SICU, Echo completed. Called resp for transport to SICU Pt to SICU & Resp to bag pt, Jim + R. Fre.		
1528													
1538		72/50	143	14									SB
1543		107/52	97	14									SB
1554		113/54	99	14									SB
1610		107/51	99	14	100%	VENT			SR				
1620		107/52	97		100%	VENT							
Initials: <u>SB</u> Signature / Title: <u>Sandra Carson</u> PATIENT IDENTIFICATION: <u>Green, Randal</u>													

ED Nursing Flow Sheet - Continued

GSRMC 008

13119-C

White - Chan

J. 455 314 4411 1011 4111 1111 1111

Page 2

Plaintiffs' Trial Exhibit #29

PAGE A

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	FIFTEENTH JUDICIAL CIRCUIT
	)	
Randall M. Green and Ann Green,	)	Docket No.: 05-CP-26-2805
	)	
Plaintiffs,	)	
vs.	)	VERDICT FORM
	)	
Wayne B. Bauerle, MD and Wayne B.	)	
Bauerle MD, PC	)	
	)	
Defendants.	)	

I. AS TO NEGLIGENCE,

☐ We the jury find in favor of Plaintiff Randall Green and award him

Actual Damages in the amount of \$ _____
(Total Amounts Below)

Medical Expenses	\$ _____
Lost Income	\$ _____
Loss of Earning Capacity	\$ _____
Pain and Suffering	\$ _____
Loss of Enjoyment of Life	\$ _____
Mental Anguish	\$ _____

OR

☐ We the jury find in favor of Defendants Wayne B. Bauerle, MD and Wayne B. Bauerle, MD, PC

II. AS TO EXEMPLARY DAMAGES,

Plaintiffs' Trial Exhibit #31

- ☐ We the jury find that Plaintiff Randall Green is entitled to

Punitive Damages in the amount of \$ _____

OR

- ☐ We the jury find in favor of Defendants Wayne B. Bauerle, MD and Wayne B. Bauerle, MD, PC

III. AS TO LOSS OF CONSORTIUM,

- ☐ We the jury find for Plaintiff Ann Green for Loss of Consortium and award her

Damages in the amount of \$ _____

OR

- ☐ We the jury find in favor of Defendants Wayne B. Bauerle, MD and Wayne B. Bauerle, MD, PC

Foreman

Conway, South Carolina

September _____, 2013

Diagnostic Imaging Report

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
Phone #: 8436921560 Fax #: 8436921555

Name: GREEN, RANDALL M Loc: F.SIC 3 Radiology No:
DOB: 03/11/1950 Age: 54 Sex: M Status: ADM IN Unit No: F000426717
Phys: BROHI - BROOKS, HIRAM B Acct: F01011093196
Reason For Exam: PCXR/ER 12 Exam Date: 04/17/2004

Exams: 000673470 PORTABLE CHEST

Study: Portable chest, film # 1 for this day, 04/17/04.

Indication: Patient on trauma board, patient involved in severe motor vehicle accident with chest trauma.

Findings: Supine portable view of the chest demonstrates metallic densities overlying the base of the film. These are nonspecific considering the trauma board. I do not see direct signs of a displaced rib fracture however lower-most ribs are beyond the field-of-view. No large pneumothorax is seen, accounting for supine position. No definite abnormality of the mediastinum.

Impression:

No acute finding on this single view trauma chest.

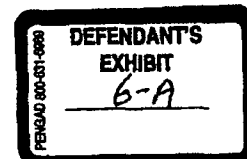
** Electronically Signed by G.SCOTT MENCKEN MD **
** on 04/18/2004 at 0925 **
Reported and Signed by: G.SCOTT MENCKEN, MD

CC: HIRAM B BROOKS

Dictated Date/Time: 04/18/2004 (0724)
Technologist: JENNIFER M FRY RT; JENNIFER PEARCE
Transcribed Date/Time: 04/18/2004 (0843)
Transcriptionist: FRAD.PCS
Electronic Signature Date/Time: 04/18/2004 (0925)
Printed Date/Time: 04/18/2004 (0931)

PAGE 1

CHART COPY



GSRMC 112

1 review those medical records prior to
2 today?

3 A... I have. I do -- I -- I
4 remember Mr. Green. He's one of the
5 cases, because I liked the gentleman,
6 that seemed to stand out. I remember him
7 being a smoker and a drinker and just
8 seemed like one of those hard-working
9 guys like my family, you know.

10 Q. Good old --

11 A. Minus -- minus the drinking
12 part.

13 Q. All right. Let's see. So
14 do you recall the first time you saw
15 Mr. Green on that day?

16 A. Yes.

17 Q. And when was that?

18 A. It's when -- I believe very
19 soon after he arrive -- arrived, if not
20 when he arrived.

21 Q. Okay. Do you recall when
22 that would have been, roughly a time?

23 A. Within five minutes of him
24 getting there. I don't remember exactly

1 if I got the report from the paramedics
2 or if the nurse did, but I -- I believe I
3 recollect that I got it from the medics,
4 but I'm not sure.

5 Q. Okay. So typical procedure
6 would have been for the medics, in this
7 type of case that Mr. Green was involved
8 in -- which was an automobile accident?

9 A. Um-hm.

10 Q. Would the medics have
11 relayed that information to the hospital?

12 A. The medics are supposed to
13 relay it directly to nursing staff.

14 Q. Okay.

15 A. And if a physician is
16 available, not seeing another critical
17 patient or a sick patient, they would be
18 in the room too and get report at the
19 same time or soon after.

20 Q. Do you recall if it was you
21 that got that information?

22 A. I don't remember.

23 Q. Okay. Do you recall when --
24 when Randy first arrived at the hospital,

1 would you go about reducing the hip?

2 A. Typically, the patient is
3 sedated and somebody pushes on their
4 pelvis to keep the pelvis flat, limit the
5 motion of the pelvis. And then I'll flex
6 the hip and knee and apply traction. And
7 in this case it went back in because it
8 was so unstable.

9 Q. Okay. Did you -- would you
10 expect to hear an audible pop when this
11 happens?

12 A. Not always, but you usually
13 feel movement and then you reassess
14 pulses and sensation to make sure that
15 there's no obvious nerve compromise or
16 vessel compromise.

17 Q. Okay. So going through the
18 timeline now, you've -- you're -- you're
19 going through the assessment. You've
20 called several doctors in for consults.
21 One is Cozart, another one is Bauerle.
22 And -- and why do you call him,
23 Dr. Bauerle?

24 A. Dr. Bauerle was on call for

1 orthopedics that day.

2 Q. Do you know if he had been
3 in the hospital at that time?

4 A. I do not know.

5 Q. You don't recall seeing him
6 that day at the hospital?

7 A. I don't recall.

8 Q. Once again, Plaintiffs'
9 Exhibit 2, at the bottom of that first
10 sheet there, it says: I discussed this
11 case with Dr. Bauerle who would
12 eventually like to -- who would
13 eventually like reconstructive CAT scan
14 of patient's acetab- -- acetabulum.

15 When would you expect
16 Dr. Bauerle to have that done?

17 MS. THOMAS: Object to the
18 form.

19 THE WITNESS: I'm sorry.
20 Could you repeat the question?

21 BY MR. FULLER:

22 Q. Yeah. Just referring to
23 your -- your dictated note there that
24 Dr. Bauerle would eventually like to have

1 a reconstructive CAT scan of Mr. Green's
2 acetabulum, when would you expect that to
3 have been done?

4 MS. THOMAS: Same objection.

5 THE WITNESS: Again, every
6 case would be individualized, but
7 I would usually let this decision
8 up to the trauma surgeon,
9 Dr. Cozart, and Dr. Bauerle.

10 BY MR. FULLER:

11 Q. And at -- at that time did
12 you anticipate it would be done in the
13 immediate future?

14 A. Define "immediate."

15 Q. Within the next two to
16 three hours.

17 A. I didn't know how long the
18 patient was going to be in the operating
19 room or what course the patient was going
20 to take.

21 Q. Okay. I'm going to move to
22 Plaintiffs' Exhibit 3.

23 It states here on the -- it
24 looks like about the fourth paragraph

1 down, you see where it states

2 "Dr. Bauerle was contacted regarding the
3 patient's hip injury a second time"?

4 A. Yes.

5 Q. All right. It goes on to
6 state: He had asked for reconstructive
7 views; however, due to the patient's
8 injury to his right forearm requiring
9 surgi- -- surgical intervention, I felt
10 that was better warranted than holding
11 the patient up to get a hip CAT scan.

12 In regards to that
13 statement, did you view Mr. Green's
14 forearm injury as more emergent than the
15 CAT scan?

16 MS. SCALISE: Object to the
17 form.

18 MS. THOMAS: Same objection.

19 THE WITNESS: Can you repeat
20 the question?

21 BY MR. FULLER:

22 Q. Yeah. Let me simplify it
23 just a little bit more.

24 Based on that statement,

1 which injury did you perceive to be the
2 more threatening injury? Was it the
3 lacerated right forearm or was it the hip
4 possible fracture or dislocation?

5 MS. SCALISE: Object to the
6 form.

7 THE WITNESS: According to
8 my dictation, implies that I
9 thought the CAT scan should have
10 been secondary.

11 BY MR. FULLER:

12 Q. Okay.

13 A. At that time.

14 Q. Do you still feel that way?

15 A. I'm not sure. Because I
16 would have to really defer that question
17 to the surgeons. I don't operate, I
18 don't go to the operating room, I don't
19 know what's involved with the specifics
20 of each of these injuries.

21 I know it's better to only
22 take a patient once to -- to the
23 operating room because there's risks of
24 receiving anesthesia, and I usually -- I

1 eventually allow the decision to the
2 trauma surgeon and the treating
3 specialist.

4 In this case, initially,
5 I -- it -- it implies that I wasn't in
6 favor of that, but not everybody agrees.

7 Q. Okay.

8 A. But that's why those --
9 those guys are surgeons.

10 Q. Well, if you had a
11 disagreement with Dr. Bauerle over him
12 taking the patient to -- Mr. Green to get
13 a CAT scan, would you have had a
14 conversation with Dr. Bauerle?

15 A. Well, it looks like we did.

16 Q. All right. Do you recall
17 any specifics from that conversation?

18 A. I do not.

19 Q. It states in your dictation
20 that Dr. Bauer- -- Bauerle was pretty
21 adamant about getting the CAT scan of the
22 hip done first. That almost implies --
23 or were you pressing for Mr. Green to go
24 into the operating room?

1 A. It's my impression that the
2 patient was in the pre-op area.

3 Q. Okay.

4 A. So I was kind of left out of
5 this decision --

6 Q. Okay.

7 A. -- which when the patient's
8 out of the ER and he's in the care of
9 Dr. Cozart and Nicholson, the trauma
10 surgeon, it's rightly so that I'm -- I'm
11 left out of the decision. I would
12 have -- I believe I was trying to -- to
13 do is to make sure that those gentlemen
14 spoke.

15 Q. Right. Okay. I understand
16 that.

17 So you're stating that once
18 he leaves -- once Mr. Green leaves the ER
19 and goes to the OR, he's more or less no
20 longer your responsibility for that
21 particular point in time?

22 A. He's not my responsibility
23 when he's in the operating room.

24 Q. Okay. If he's not in the

1 would you characterize as the most
2 pressing issue?

3 A. Well, at this point, still
4 any chest injury or abdominal or pelvic
5 injury until proven otherwise.

6 Q. Would you -- would -- would
7 you classify the right forearm as a
8 pressing injury as well?

9 A. It's pressing, but not
10 life-threatening, in my opinion.

11 Q. What would cause it to be a
12 life-threatening injury?

13 A. If he had arterial bleeding.

14 Q. Which would lead to -- I
15 mean, I'm assuming you're indicating
16 blood loss would be obviously --

17 A. Yes. And I should add
18 unrecognized arterial bleeding.

19 Q. Unrecognized arterial --

20 A. Which is pretty -- pretty
21 hard to miss.

22 Q. You categorized
23 Mr. Green's -- or characterized
24 Mr. Green's forearm as an oozing of

1 blood. Where would the -- where would
2 the oozing be coming from?

3 A. I believe I answered that
4 before, but all the capillaries and small
5 vessels. Any -- any small vessel. And
6 that was before a pressure dressing was
7 applied.

8 Q. In order to get the hip CAT
9 scan done on Mr. Green, how would that
10 have been done? How is that procedure --

11 A. In this case --

12 Q. -- accomplished?

13 A. -- I don't -- I don't
14 remember.

15 Q. Okay.

16 A. Because he was out of the ER
17 going -- I -- I don't remember how that
18 went about.

19 Q. In -- in your note -- in
20 your dictated note, it indicates that he
21 would be held up or holding the patient
22 up.

23 Could you please elaborate
24 as to -- to what that's referring to?

1 A. Where are you looking?

2 Q. I'm looking at --

3 A. Okay.

4 Q. -- fourth --

5 A. Okay. I see it.

6 Q. Let me -- let me rephrase
7 the question and make it a little more
8 clear.

9 Are you referring to holding
10 the patient up as in physically holding
11 him up or holding him up from getting to
12 the OR?

13 A. Well, he was -- he was in
14 the pre-op area already --

15 Q. Okay.

16 A. -- is my understanding of
17 the timing events. Because I'm not a
18 surgeon, I -- I didn't, at this time,
19 understand the importance of the CAT scan
20 and the fragments in the joint, and I
21 still -- I still don't. You would have
22 to ask Dr. Bauerle the long-term effects
23 of bony fragments in the joint or
24 arthritis and whatnot.

1 Q. And -- and I understand
2 that. I'm -- what I'm trying to get at,
3 at this particular point in time, is
4 the -- I want to know as far as the
5 holding the patient up. Which way are
6 you referring to it that way? Are you
7 talking about a physical holding up or --

8 A. I'm not sure that I
9 understand the question. Lifting the
10 patient up?

11 Q. Precisely. Are you --

12 A. No, no, no. I'm talking
13 about a delay.

14 Q. Okay. That's -- that's what
15 I was getting at.

16 So in that particular note,
17 you're talking about the fact that -- at
18 least your note indicates you -- you
19 disagree with the delay in getting
20 Mr. Green to the OR?

21 MS. SCALISE: Object to the
22 form.

23 THE WITNESS: As long as --
24 as long as the patient is in the

1 ER, I'm directly involved in their
2 care. When they leave the ER,
3 then I'm allowed to go on to other
4 patients.

5 BY MR. FULLER:

6 Q. Okay. I'll move on.

7 The next exhibit is going to
8 be Plaintiffs' Exhibit 4. Are you on the
9 same page with me, Doctor? Okay.

10 A. I believe so.

11 Q. Once again, you note that
12 Dr. Bauerle was adamant to get the x-ray
13 of his right hip.

14 Do you -- do you recall a
15 conversation with Dr. Bauerle at that
16 point in time?

17 A. I do not.

18 Q. At what point do you notice
19 that Mr. Green is -- strike that.

20 A little further down you
21 state that Mr. Green's heart rate went
22 from 60 to 50 to 40. What -- what is
23 that indicating?

24 A. That he's very sick.

1 Q. When you state "sick," what
2 would you --

3 A. That he's about to --

4 Q. That -- that he's about to
5 code?

6 A. That he's potentially about
7 to code, yes.

8 Q. And -- and what exactly is
9 coding? I think we've all been throwing
10 the term around, but could you please
11 describe exactly what a code is?

12 A. Well, there's different
13 definitions, but I believe the general
14 thought is when a patient becomes
15 critically ill, near death.

16 Q. And eventually Mr. Green
17 does code; is that correct?

18 A. Yes.

19 Q. And I believe the record
20 indicates that or his medical records
21 indicate that you were the doctor that
22 performs CPR, resuscitates him, correct?

23 A. I was running that code.

24 Q. And what does running the

1 Q. So hold on. Let me -- let
2 me get this. Dr. Cozart orders a -- a
3 surgery for his forearm and he goes to
4 the ED or --

5 A. He goes to the pre-op area.

6 Q. He goes to the pre-op area.
7 Okay.

8 From pre-op area he goes to
9 x-ray; is that correct?

10 A. I don't -- I don't remember
11 the timing.

12 Q. Okay.

13 A. CAT scan -- it would have
14 been CAT scan. I say x-ray, but it was
15 CAT scan.

16 Q. Okay. So -- so CAT scan.
17 So -- I'm trying to figure out. He comes
18 back from CAT scan and where does he end
19 up at that point in time when he comes
20 back from CAT scan?

21 A. Back in the ER where he
22 codes.

23 Q. Okay.

24 A. He -- he went to CAT scan

1 Q. Do you have any indications
2 how much blood Mr. Green lost?

3 A. I don't know. I don't know
4 what happened when he left the ER.

5 Q. Okay.

6 A. But it -- it was not a
7 significant amount while he was under my
8 care in the ER.

9 Q. At any point in time that
10 you're treating Mr. Green in the ER, are
11 you concerned about blood loss?

12 A. Any trauma patient I'm
13 concerned about blood loss.

14 Q. Okay. For -- for Mr. Green
15 specifically, was -- was that a major
16 concern?

17 A. Not a major concern. He was
18 awake and talking to me the whole time.
19 He was not in any extremis.

20 MR. FULLER: Would anybody
21 have any objections if we take a
22 quick break?

23 MS. SCALISE: No.

24 MR. JOHNSON: Sure.

1 longer functions.

2 Q. In this case there's an issue as to
3 whether or not a spinal infarct is what caused the
4 paraplegia or whether or not it was some trauma
5 event that caused his paraplegia. Okay?

6 A. Uh-huh.

7 Q. So I'm going to be talking about those
8 issues with you over the next -- hopefully we'll be
9 finished with my part within an hour. Okay?

10 A. Okay.

11 Q. Now, do you know what MUSC diagnosed his
12 paraplegia or the cause of his paraplegia while he
13 was at MUSC?

14 A. Spinal cord infarct.

15 Q. Is there anything in your mind or in the
16 records that you've reviewed that indicate anywhere
17 that trauma was the associated cause of his
18 paraplegia?

19 A. Let me be careful to answer that too.
20 Indirectly, what the records from MUSC says is that
21 he had an arrest in Grand Strand during the time he
22 was there, which almost certainly was the cause of
23 the infarction of the spinal cord. My
24 understanding is that that arrest was a result of a
25 traumatic injury he sustained, probably to his arm.

1 And I assume he bled, but I don't know what
2 happened there.

3 So, yes, the trauma led to the spinal cord
4 injury, but it was the injury that caused him to
5 arrest, not an injury to the spinal cord itself, if
6 that makes sense.

7 Q. Yes, sir. The -- and when you say that
8 it was the arrest that was the cause of the
9 infarct, what information have you been provided or
10 were you provided at the time as far as what
11 occurred at Grand Strand Regional Medical Center?

12 A. The only -- I have no recollection. I
13 can only base on what our records say. What our
14 record says that he was admitted to Grand Strand
15 after a motor vehicle collision, had an acetabular
16 fracture, hip dislocation. Hip dislocation was
17 reduced, and at some point during his stay there,
18 he had an arrest and was resuscitated. That's as
19 much as I -- as we got. I'm sure we knew more at
20 the time, but that's all I have available now.

21 Q. The -- I don't -- I've got a blood
22 pressure chart that we've -- we have put together
23 ourselves from the records of Grand Strand, and
24 just -- you know, he comes into Grand Strand around
25 11:30 on April the 17th of 2004. At 14:15, which

1 is 2:15 in the morning --

2 MS. SCOTT: Afternoon.

3 BY MR. DEAN:

4 Q. I mean, sorry. 2:15 in the afternoon, 72
5 over 54. And then at 14:25 there's no blood
6 pressure. And then 14:48 there's no blood
7 pressure. So if between 14:15 and 14:48 there's no
8 blood pressure or oxygen flowing through the
9 system, is that what you're referring to when you
10 say an arrest?

11 MS. CROWE: Object to the form.

12 THE WITNESS: That would be consistent
13 with an arrest. Having not reviewed the
14 records of Grand Strand, I'm not sure if that's
15 what they were referring to, but if the facts
16 as you state them would be correct, that would
17 be consistent with a cause for spinal cord
18 ischemia or an infarction.

19 BY MR. DEAN:

20 Q. How are you so sure that the timing of
21 that arrest or that event is the cause of the
22 spinal infarct?

23 A. Well, it certainly was our impression at
24 the time, and I -- again, in reviewing the charts,
25 I can't find any other explanation for it. He had

1 explain. So if we have a patient with a neurologic
2 injury but no fracture to explain it, we do an MRI
3 to look at the spinal cord itself. It's a better
4 study for that.

5 Q. Is that what you use to identify whether
6 or not an infarct is what caused the --

7 A. It's what we use to try to explain why
8 someone would have neurologic abnormalities that we
9 don't -- cannot explain as bony abnormalities. In
10 this case they've identified an infarct -- or
11 findings consistent with an infarct.

12 Q. And did you do a --

13 MR. DEAN: What's the next number, 7?

14 MS. SCOTT: Yeah, seven.

15 (Exhibit No. 7 was marked for
16 identification.)

17 BY MR. DEAN:

18 Q. Do you recognize the handwriting on
19 Plaintiff's Exhibit Number 7, last one?

20 A. Correct. That's the progress note I
21 wrote.

22 Q. What's the date of your progress note?

23 A. April 23, 2004.

24 Q. With regard to the cause of the
25 paraplegia that you've noted on this, what did you

1 . diagnose as the cause of the paraplegia?

2 A. Spinal cord infarct with paraplegia.

3 Q. And is that what's referred to under
4 number -- item number 4?

5 A. Item number 4 under the diagnosis and
6 problems list.

7 Q. Is there anything on that document that
8 indicates that you attributed the cause of his
9 paraplegia to any traumatic -- or trauma event to
10 his spinal cord --

11 A. No.

12 Q. -- at the accident scene?

13 A. No.

14 (Exhibit No. 8 was marked for
15 identification.)

16 Q. Just for completeness, so maybe we don't
17 have to bother Dr. Leon for a deposition, do you
18 recognize the handwriting on Plaintiff's Exhibit
19 Number 8?

20 A. That's Dr. Leon's distinctive
21 handwriting.

22 Q. Can you take a look at that? I think
23 it's dated two days after yours on 4-25.

24 MR. MCCUTCHEON: I'm missing one
25 somewhere.

1 THE WITNESS: It's dated April 25, 2004,
2 correct?

3 MR. DEAN: Uh-huh.

4 MR. MCCUTCHEON: We're one short.

5 MS. SCOTT: Are we?

6 MR. DEAN: I'll hand you this one, John.
7 Let me find where it's -- yep.

8 BY MR. DEAN:

9 Q. As far as a diagnosis indicated by Dr.
10 Leon in his records, what did he -- what does his
11 exhibit -- his handwriting or his exhibit, Exhibit
12 Number 8, indicate the cause of paraplegia?

13 A. T6 to L2 edema and infarct.

14 Q. And is there anything in his handwriting
15 that you can read that indicates anywhere in it
16 that he attributed the cause of the paraplegia to
17 any traumatic event causing traumatic spinal cord
18 injury at the time of the accident?

19 A. No.

20 Q. Have you discussed this case with Dr.
21 Leon --

22 A. No.

23 Q. -- at any time?

24 A. We certainly discussed it at the time we
25 were providing care. We work as a team, but since

1 then, no.

2 Q. And did you-all discuss at the time when
3 you-all were caring for him what occurred at Grand
4 Strand Regional Hospital?

5 A. We discussed our understanding of what
6 occurred at Grand Strand Regional Hospital.

7 Q. And did you-all have the same conclusion
8 back then that you're testifying to today, that it
9 was your opinion and your belief at that time,
10 that's been unwavered through today, that the cause
11 of the paraplegia was the spinal infarct that
12 occurred at the time of the arrest at Grand Strand
13 Regional Hospital?

14 MS. CROWE: Object to the form.

15 MR. MCCUTCHEON: Object to the form.

16 MS. NUTTER: Object to the form.

17 THE WITNESS: I better be careful how I
18 answer that. My opinion today that I'm holding
19 to is based on the opinion we had -- the
20 documentation of the opinion we had then. So
21 this isn't a separate opinion now. But at the
22 time we believed this was due to an infarct in
23 the spinal cord, and I have no reason, based on
24 my review, to think otherwise five years later.

25 MR. DEAN: Thank you, Doctor, for your

1 Dr. Bauerle regarding deviations from the standard
2 of care?

3 A. Yes, I do.

4 Q. Okay. Can you tell me what those are?

5 A. I think he deviated from the standard of
6 care drastically when Mr. Green was in the
7 preoperative area, Dr. Bauerle at that point asked
8 that he be sent to CT scan, and the patient was
9 totally unstable with a pulse rate of 135; on blood
10 pressure, 76 over 52.

11 And secondarily, instead of having the
12 man brought back to the preoperative area, he went
13 back to the emergency care unit. He went to the CT
14 scan without monitoring, as best I could find. But
15 I think that's really the crux of this man's entire
16 problem.

17 Q. Okay. And do you know if in 2004, there
18 was any type of monitoring available at Grand Strand
19 while someone is going through a CT?

20 A. I do not know if they had portable
21 monitors, but their protocol specify that
22 respiratory therapists be with the patient.

23 Q. And we had started to touch on your
24 opinion that Mr. Green had not been stable since his
25 arrival --

20

1 A. Right.

2 Q. -- at Grand Strand.

3 A. Right.

4 Q. And I think you just told me about the
5 decrease in blood pressure being one sign.

6 A. Right.

7 Q. The increase in respiration.

8 A. And I didn't mention respiration. Pulse
9 rate.

10 Q. Pulse rate. And I also recall -- well,
11 first of all, let's talk about the care he had
12 received prior to going to the CT scan.

13 A. Okay.

14 Q. He had received fluids, had he not?

15 A. He did.

16 Q. And can the receipt of fluids change the
17 pulse rate and the blood pressure?

18 A. It can.

19 Q. And that's sometimes one of the goals of
20 giving fluids; is that correct?

21 A. At times.

22 Q. Also, had he been administered some
23 morphine?

24 A. He had been given morphine, I believe,
25 on two occasions.

1 Q. And can morphine act as a -- can it
2 depress the blood pressure as well as the
3 respiration?

4 A. It can. It produces vasodilatation,
5 which in turn will lower blood pressure.

6 Q. And so those, the administration of the
7 fluids and of the morphine could, in part, explain
8 some of the fluctuations in his vital signs; could
9 it not?

10 A. Certainly not anywhere near completely.
11 And the real problem is that he had received a
12 massive amount of IV fluid. One of the cardinal
13 signs of instability is when you're having to
14 continuously infuse fluids.

15 The general standard is that if you give
16 two liters of normal saline, and at that point you
17 have not reached a stable state, then something else
18 is likely going on. And it's also an indication
19 that you need to switch probably to blood and blood
20 products or at least to hetastarch or to some other
21 substance that will remain within the circulatory
22 system.

23 Q. Okay. And to sidetrack a little bit,
24 you have never practiced as an orthopedic surgeon,
25 have you?

22

1 A. No.

2 Q. Did the choice to have a CT scan prior
3 to the patient going in for surgery, what is your
4 understanding as to why Dr. Bauerle wanted to do
5 that?

6 A. My understanding is that he wanted to
7 see if there were any loose bone fragments in that
8 joint space.

9 Q. Would that be a reasonable thing to do
10 to avoid a second surgery?

11 A. There's no -- well, there's no reason,
12 in the days of modern anesthesia, to try to avoid a
13 second surgery, number one. But number two, with
14 those vital signs, we are basically looking at a man
15 who is on the verge of cardiac arrest, and to send
16 him anywhere other than into the operating room, I
17 think was a dramatic deviation from the standard of
18 care.

19 Q. Okay. And let me ask you what you mean
20 by unstable. Was that based solely on the recorded
21 vital signs in the record?

22 A. Especially on vital signs. It's also
23 based on the fact that the man had a cardiac arrest
24 very shortly thereafterwards. It's based on the
25 blood gas that was obtained right after the arrest,

1 which showed a degree of acidity in the blood that
2 was basically incompatible with life. It's based
3 on -- it's based on the fact that the hemoglobin --
4 although there was some clot in the tube -- had
5 dropped dramatically. It's based on any number of
6 things. It's based on an overall impression of
7 having seen thousands of patients who are unstable.

8 Q. Okay. And let's talk a little bit
9 about -- I think you had alluded to the fact that by
10 ordering the CT scan, there was a delay in him going
11 into the operating room or presumably going to the
12 operating room for the arterial repairs?

13 A. That's correct.

14 Q. How about when he arrived at the
15 hospital, should he have gone to the OR prior to
16 Dr. Bauerle?

17 If we assume that Dr. Bauerle did not
18 give that order for the CT scan, the time period up
19 until that point, should Mr. Green have gone to the
20 OR or undergone that arterial repair before then?

21 MR. QUERY: Object to the form.

22 THE WITNESS: I think he could have been
23 taken to the operating room in a more expeditious
24 fashion.

25 BY MS. THOMAS:

1 Q. Okay. And you mentioned reading the
2 medical records and the depositions that you
3 reviewed. Did any of the other physicians involved
4 in his care fail to timely take him to the operating
5 room for the arterial repair?

6 A. Well, I think Dr. Cozart, who was going
7 to be the primary agent of this procedure, was
8 taking him there within a reasonable amount of time
9 after he initially saw him. There are certainly
10 other problems that I can see.

11 Q. Tell me what you mean by that.

12 A. Well, the man was brought in, he had on
13 a -- he had on a dressing, which is variously
14 described as, in some places, as being bulky, other
15 places as being compressive. And the ER doctor was
16 the only person who ever actually looked at that
17 wound until Dr. Cozart got there.

18 Q. Do you have an opinion as to whether or
19 not the bleeding from that laceration was controlled
20 or uncontrolled?

21 A. The bleeding, well, it was uncontrolled.
22 You know, you can have uncontrolled bleeding without
23 having extremely brisk bleeding. Something that we
24 would see in heart surgery all the time, just a
25 continuous ooze from a raw surface over a period of

1 time, can lead to considerable blood loss.

2 Q. Do you have an opinion as to, I guess
3 the time frame, the window under which repair of
4 that arterial -- of that laceration of the artery
5 should have been affected or should be affected?

6 A. Well, we know that the blood flow to the
7 hand was not totally disrupted, because we have
8 documentation at two points that the regular artery
9 could be -- could be heard by Doppler. So we know
10 that the blood supply was not totally diminished.

11 Ordinarily, with something like that,
12 you'd like to -- you'd like to repair it within, you
13 know, six or seven hours anyway. But I have seen
14 many, many arteries that were occluded at a higher
15 level, and had been that way for days, still with a
16 viable hand.

17 Q. And in fact, in this case, Dr. Cozart
18 did affect the repairs, such as he could --

19 A. Right.

20 Q. -- within that window; did he not?

21 A. I think so.

22 Q. I think we were going through your
23 criticisms of Dr. Bauerle. And the first was, in
24 fact, that he diverted the patient from the preop
25 area to the CT scan.

26

1 A. Uh-hum.

2 Q. Do you believe that that caused any harm
3 to Mr. Green?

4 A. Yes, I do. I think it delayed him
5 reaching Dr. Peters, who would probably have
6 prevented his arrest and resuscitated him
7 appropriately, based on his eventual response to the
8 code.

9 Q. What is your understanding of what
10 subspeciality Dr. Peters is?

11 A. He's an anesthesiologist.

12 Q. And so is it your opinion then, if he
13 had been in the preop area on in the operating room
14 and the anesthesiologist had been present, that he
15 would have been resuscitated sooner?

16 A. I think he would have. I think the rest
17 could -- you know, with greater than 51 percent
18 certainty, I would be willing to say that the arrest
19 could have been prevented.

20 Q. And in fact, Dr. Peters did participate
21 in the resuscitation?

22 A. Yes, he did. He inserted a central
23 venous line. He inserted an arterial line. He
24 ordered blood. He ordered platelets. He did the
25 right things.

1 was done at the call of the code?

2 A. Well, I have a criticism in the way as
3 the code was called, because the patient was taken
4 back to the emergency care unit rather than being
5 returned to the preoperative area. His bradycardia
6 and cardiac arrest were found on a more or less
7 serendipitous fashion when Dr. Lintz happened to
8 walk by the room. In other words, the man was not
9 being watched.

10 Q. Do you believe that loss of blood had
11 anything to do with his arrest?

12 A. I think it had a great deal to do with
13 it. It's very difficult to estimate blood loss
14 because we never know what true volume is without
15 radioisotope studies. But my estimation would be
16 that he lost a minimum and possibly up to his -- up
17 to half of his total blood volume.

18 Q. And do you have an opinion as to where
19 that loss occurred?

20 A. I think it occurred into the bandages.
21 The one thing, and I do not know is how much
22 occurred at the scene.

23 Q. Okay. That was my question.

24 So you were talking cumulative, not
25 since -- just since his arrival at the hospital?

1 opinion?

2 A. That is my opinion. His body was
3 underperfused.

4 Q. And that would have been two hours prior
5 to the code?

6 A. Yes. Well, that would have been
7 actually at his -- by the time he was returned to
8 the CT scan.

9 Q. Do you think he was in hemorrhagic shock
10 when he left for the CT?

11 A. I think he was -- yeah. Yes, I do. I
12 think by that time, so many things had gone awry,
13 it's hard to point to one and say, this is the thing
14 that's producing the greatest instability at this
15 point. You know, the fact that -- the fact that his
16 hemoglobin is so low, I mean that by itself
17 decreases the ability to deliver oxygen to the
18 tissues so dramatically, that that's also a major
19 factor. The acidosis is a major factor. I mean,
20 there are so many factors involved here.

21 Q. Could the administration of all the
22 fluid that we talked about earlier have had a
23 dilutional effect on the hemoglobin?

24 A. Well, the only way a hematocrit ever
25 drops is through a dilution. As I pointed out to

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1 a markedly diminished blood flow or total
2 interruption of blood flow through the great spinal
3 artery or the Artery of Adamkiewicz. There's
4 virtually no other way to create an infarct through
5 a spinal cord from T6 all the way down to L2. That
6 is -- that is infarct that is characteristic of
7 compromised blood supply. I've created several
8 paraplegics myself, having warned them ahead of time
9 it was possible, in repairing aneurysms. You see it
10 with aortic dissections. You see it with --
11 occasionally, with embolic processes. But certainly
12 after -- after a prolonged period of shock, I mean,
13 particularly with a hemoglobin that low and acidosis
14 that bad. The spinal cord's blood supply is very
15 tenuous. It could not get along with less than it
16 has, generally speaking.

17 Q. Can a spinal cord contusion also cause a
18 spinal infarct?

19 A. Well, what you would be talking about,
20 there's an acronym -- there's an acronym for it in
21 the literature, but the entire phrase is spinal cord
22 injury without radiologic abnormality.

23 As best I can determine, that's never
24 been described in a thoracic cord in an adult. It
25 almost always occurs in children. It's almost

1 always in the part of the spinal cord in the neck.

2 To see it the thorax, I'm not even sure
3 that that's possible without a penetrating injury or
4 one of two things: Either a fracture or
5 subluxation. And subluxation means that
6 transposition of two vertebral bodies so that the
7 cord is crimped.

8 Q. And you would certainly see that on
9 radiological studies?

10 A. You would see that on everything. And
11 in addition, you would probably have seen soft
12 tissue injury, at least the hematoma. There would
13 have to be something.

14 Q. The document that I've been given list
15 several of the caregivers, and also various
16 statements as to the alleged violations of standard
17 of care. And on this document, it says that
18 Dr. Lintz deviated from the standard of care in,
19 number one, failing to adequately evaluate the
20 forearm wound and recognize its limb threatening
21 nature. Is that your opinion?

22 A. I may have written this, but if I did,
23 then I really am not sure that I can agree with what
24 I wrote in this circumstance, because it's true, he
25 did have responsibility to evaluate the wound, but

38

1 the forearm wound. Is that your opinion?

2 A. It is.

3 Q. Number two is, failure to control the
4 bleeding by application of direct pressure.

5 A. I agree with that, yes.

6 Q. Okay. And the next one, I think you've
7 kind of alluded to. It says, his role as trauma
8 leader by overseeing the patient's course prior to
9 his being taken to the operating room, and thereby
10 allowing deterioration of his condition, and the
11 development of severe metabolic derangement from
12 overuse of crystalloids in resuscitation. Is that
13 your opinion?

14 A. It is.

15 Q. And by crystalloids, are you talking
16 about the initial fluids that he was given?

17 A. The saline.

18 Q. Okay. And number four, failure in role
19 of trauma leader to prevent him from being taken to
20 the CT scan.

21 A. Yes. And you know, the whole -- the
22 whole concept of trauma team is that there has to be
23 somebody in charge. Otherwise, it's just a
24 totally -- it's just totally random movement. And I
25 can't find in the record anyplace where -- outside

1 of Dr. Lintz -- that any of these people who were on
2 the so-called trauma team actually communicated with
3 each other.

4 Q. Okay. And I think number five is in
5 administering the morphine that we talked about
6 earlier.

7 A. Right. I don't think you should ever
8 give an unstable patient a narcotic.

9 Q. Is that for the reasons that we
10 discussed; that it may cause the depression?

11 A. And increasing instability.

12 Q. And failure to institute blood products,
13 and I think we talked about that, that it's your
14 opinion after the initial administration of the
15 saline --

16 A. Right.

17 Q. -- blood products should have been
18 considered at that point?

19 A. Yes, or at least something that would --
20 the problem with crystalloids is that they don't
21 remain in the vascular system. They become
22 disseminated out through the tissue. And at some
23 point, you have to switch to something that's going
24 to remain in the system.

25 Q. Okay. The next section, I think on the

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1 last page of this document, addresses Dr. Bauerle.

2 And I think we have talked about some of these
3 things, but I'll go down the list and see if you
4 agree with these statements. Failing to evaluate
5 the patient in a timely fashion.

6 A. I agree with that.

7 Q. Okay. Tell me what you mean by that.

8 A. Well, I mean that when Dr. Lintz first
9 called Dr. Bauerle, that would have been the time
10 for Dr. Bauerle to come in.

11 Q. Now, do you have an understanding as to
12 whether or not Dr. Bauerle knew that there was a
13 dislocated hip fracture when he was initially
14 called?

15 A. My initial thought was that he did know.
16 That he did know. I read in his deposition, he said
17 that he did not know. So, you know, I can't be
18 totally sure. But I do know Dr. Lintz had to call
19 him twice, and that Dr. Bauerle had already -- as
20 Dr. Lintz put it -- was adamant that he was going to
21 have a reconstructive CT scan done; and there was a
22 decision being made without even seeing the patient.

23 Q. Okay. And number two says, failing to
24 carry out sufficient evaluation to recognize the
25 patient was in shock or to evaluate his most recent

1 vital signs.

2 A. I agree with that.

3 Q. Okay. And I guess, what is your basis
4 for that statement?

5 A. Well, there were two possibilities.
6 Either Dr. Bauerle looked at those vital signs and
7 sent the patient to CT, which would be negligence;
8 or either he didn't look at the vital signs, and
9 sent the patient to CT. That would be negligence.
10 It would be. So to me, it's a -- you know, it's
11 just simply a dilemma.

12 Q. And I think we talked about number three
13 a little bit. You told me why you felt Mr. Green
14 was unstable. And here it says, sending a severely
15 unstable patient to CT scan despite the objections
16 by Dr. Lintz. Tell me what you mean by that.

17 A. Well, when Dr. Lintz was talking to
18 Dr. Bauerle on the telephone, he expressed an
19 opinion to him that he thought the time, the
20 patient's time, would be better spent in being taken
21 directly to the operating room and cared for, rather
22 than spending time in getting an additional CT scan
23 on him. And that is the point where he used the
24 word adamant to describe Dr. Bauerle's response.

25 Ordinarily -- well, that's -- I was

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1 going to say something that would just be
2 conjecture.

3 Q. Did you get that understanding from
4 Dr. Lintz's deposition?

5 A. I did. Although not quite as strongly
6 as I did in the original notes.

7 Q. Okay. When you say without adequate
8 monitoring and nursing attendance as dictated by
9 GSRMC, which I'm assuming that means Grand Strand
10 Regional Medical Center?

11 A. Right.

12 Q. Tell me what that means.

13 A. Well, their own protocol states that
14 their respiratory therapist is supposed to accompany
15 the patient. Whereas what happened here, as best I
16 can tell, is an orderly accompanied the patient.
17 And when a patient is put in the CT scanner, he's --
18 he's there. I mean, there's nobody in the room with
19 him. What you would ordinarily do, if you felt
20 absolutely pressed to take a patient like this to CT
21 scan, would be to go with him yourself.

22 Q. Meaning the physician?

23 A. Yeah.

24 Q. Okay. Without specifying that he be
25 returned to the preoperative holding area, rather

1 than the emergency care unit.

2 A. Right.

3 Q. And do you know if Dr. Bauerle knew that
4 he was in the preoperative area?

5 A. Well, he saw him in the preoperative
6 area, so he knew where he was. And it's totally
7 mysterious to me as to why he was sent back to the
8 emergency care unit.

9 Q. And was that, to your knowledge, did
10 Dr. Bauerle order him be brought back to the
11 emergency room or is that just something that
12 happened?

13 A. Well, it's mentioned in several places
14 that he was taken back to wait for the
15 interpretation of the X-rays by the radiologist.
16 And again, I can't understand that, because no
17 matter what the radiologist said, the form was still
18 going to have to be managed.

19 Q. Okay. And then next it says, without
20 discussing with or gaining approval from the trauma
21 team leader. Who is the person that you contend
22 Dr. Bauerle should have discussed the CT scan with
23 or have gained approval from?

24 A. Well, Dr. Nicholson, primarily. But he
25 certainly should have informed Dr. Cozart of what he

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1 was doing.

2 Q. Okay. And by depriving the patient of
3 a chance to avoid cardiac arrest.

4 A. Yes.

5 Q. Is it your contention that but for going
6 to the CT scan, the cardiac arrest would not have
7 happened?

8 A. It's my contention.

9 Q. Is it possible that he could have had
10 the cardiac arrest in the operating room?

11 A. Well, we never say anything's
12 impossible.

13 Q. Was it inevitable that he would have a
14 cardiac arrest?

15 A. No, it was not.

16 Q. And you probably already -- we probably
17 already talked about this, the things that in your
18 opinion should have been done to avoid the cardiac
19 arrest, and I think that would have included the
20 administration of blood products --

21 A. Right.

22 Q. -- earlier in his course of treatment?

23 A. Right.

24 Q. Anything else?

25 A. Well, I think, you know, not only the

1 administration of blood products, but a thorough
2 evaluation of his coagulation profile should have
3 been done. A blood gas would have been extremely
4 helpful to get some idea of the pH or the degree of
5 acidity in the blood. But simply controlling the
6 bleeding would have been the best option.

7 Q. The last part of this document speaks as
8 to Grand Strand Regional Medical Center. And we may
9 have kind of touched on these things in discussing
10 your other opinions, but the first one is failing to
11 disseminate trauma protocols among employees and
12 medical staff. And I guess, does that mean that
13 they did not follow their own protocol, in your
14 opinion?

15 A. Well, it's simply that I can't see any
16 evidence that a protocol existed, I mean, from the
17 behavior of the people involved.

18 Q. Okay. And number three, where it talks
19 about the poor monitoring of the patient.
20 Specifically there, are you talking about the
21 nursing care?

22 A. I am. Generally speaking, a nurse who
23 is experienced in the emergency room or in the
24 intensive care unit, when she's having to
25 continuously give more and more fluid to maintain

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1 the blood pressure, she informs a physician, and
2 they make other appropriate plans.

3 Q. Okay. And number five is, failing to
4 properly train and supervise the doctors under its
5 employer or with whom it contracted. Tell me
6 what -- well, first of all, do you agree with that
7 statement?

8 A. I don't think it's the responsibility of
9 the hospital to train the doctors to be physicians
10 or to be surgeons or to treat shock. You know, I
11 think you should -- you shouldn't have people on
12 your hospital staff who don't know how to do those
13 things. But I think it is incumbent on the hospital
14 to be sure that the trauma rules are more than a
15 protocol in a notebook that is made to satisfy a
16 joint commission, which is what happens with missed
17 protocol.

18 Q. Have we touched on all the opinions that
19 you intend to offer as to causation, in other words,
20 what caused any harm to Mr. Green?

21 A. I can't think of any others right now.

22 Q. Okay. You are listed -- it's listed
23 that you're also going to talk about damages. Are
24 you prepared --

25 A. Damages in terms of monetary damage?

1 Q. Well, that's my question. What is your
2 understanding of what you are prepared to testify
3 about as to damages to Mr. Green?

4 A. Well, I can't -- I can't testify in
5 terms of monetary damages, but that information
6 should be readily available. I'm not sure what it
7 costs to care for a paraplegic for a year. And I'm
8 not sure to -- you know, I know that his extent to
9 earn a living was impaired, but I don't know what
10 his sources of income were before, so I can't. And
11 I certainly can't speak to economic damages.

12 Q. Okay. How about his prognosis, will you
13 be offering any testimony as to -- well, first of
14 all, are you going to be offering any testimony as
15 to his condition today?

16 A. No.

17 Q. And any future medical needs?

18 A. No.

19 Q. Any decrease of projected lifespan?

20 A. No. I mean, those things are simply
21 outside...

22 Q. Certainly.

23 MS. THOMAS: Could we do one thing?

24 Could we take a little break and let me just read
25 this?

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1 (A recess transpired.)

2 BY MS. THOMAS:

3 Q. Doctor, have you given me all of the
4 opinions that hold as to deviations from the
5 standard of care by Dr. Bauerle?

6 A. I have.

7 Q. This case is set to be tried September
8 9. I would ask that if you generate any additional
9 opinions or that you change your opinions as to
10 Dr. Bauerle, that you would let Mr. Query know.

11 A. Certainly.

12 Q. Then I will reserve the right to come
13 back and talk to you about those things.

14 A. Certainly.

15 Q. If that occurs.

16 MS. THOMAS: That's all the questions I
17 have for you.

18 THE WITNESS: Okay. Thank you.

19 EXAMINATION

20 BY MR. QUERY:

21 Q. Very briefly, Dr. Chariker. If the term
22 damages were defined as physical harm to the person
23 of Mr. Green, would you have opinions as to the
24 physical harm that occurred to him as a result of
25 the deviations from the standard of care by

1 Dr. Bauerle?

2 A. I have an opinion with regard to the
3 anatomic damage that resulted.

4 MR. QUERY: Thank you.

5 EXAMINATION

6 BY MS. THOMAS:

7 Q. Let me ask you if that opinion is
8 anything differently than you've already expressed?

9 A. No. He's paraplegic and that's...

10 Q. And it is your contention that the
11 paraplegia is a direct result of the previously
12 mentioned deviations from the standard of care by
13 Dr. Bauerle?

14 A. It is.

15 Q. Is it solely due to the deviations by
16 Dr. Bauerle, or is that in conjunction with the
17 deviations that you've enumerated from the other
18 medical providers?

19 A. I think there were other factors
20 involved, certainly, but I think that that one
21 decision was the thing that probably tipped the
22 scale.

23 MS. THOMAS: Okay. That's all the
24 questions I have.

25 (The deposition was concluded at 9:25 AM.)

1 would instruct --

2 MR. MCCUTCHEON: Cranberg. And I have
3 no objections.

4 MR. SAUTTER: All right, sir. Okay.
5 Thank you, Jack.

6 BY MR. SAUTTER:

7 Q. Now, let's talk a little bit about the
8 field of neurology. What does the field of
9 neurology include?

10 A. The field of neurology that -- is that
11 branch of medicine dealing with diseases or damage
12 to the -- to the nervous system, to the brain, the
13 spinal cord, and the nerves.

14 Q. And is there a term for inadequate blood
15 supply to the spinal cord; and what is that term,
16 Doctor?

17 A. Well, that would be ischemia to the spinal
18 cord. Ischemia of the spinal cord.

19 Q. And are there different degrees or grades
20 in the severity of ischemia of the spinal cord?

21 A. Yeah; there can be. There can be a, you
22 know, a reduced blood supply to the spinal cord that
23 renders the spinal cord, you know, not working
24 properly but not so severe as to kill it.

1 But if there is sufficient ischemia for a
2 sufficient amount of time, then the neurons, the
3 cells, in the spinal cord will die.

4 Q. And when the cells and the tissues in the
5 spinal cord die, what is that called?

6 A. When they die due to insufficient blood
7 supply, that's called an infarct.

8 Q. A spinal cord infarct, Doctor?

9 A. Yes. An infarct of the spinal cord; that's
10 correct.

11 Q. Yes, sir. And how long does it take for
12 inadequate supply of blood to the spine to cause
13 cell death in the spinal cord?

14 A. Well, it can be as little as a few minutes.

15 Q. And is it fair to say that the longer the
16 cord has an inadequate supply of blood, that the
17 greater the damages are?

18 A. Well, if there's one area -- one portion of
19 the spinal cord that's not getting enough blood
20 supply and -- if there's a very tenuous blood supply
21 to the spinal cord and -- yes, then perhaps the
22 tissue would survive more than a few minutes and
23 would die after, you know, say, several minutes or
24 ten minutes or whatever.

1 But if the ischemia -- if the lack of blood
2 supply is severe enough, then even just a few
3 minutes of no blood supply can kill that spinal cord
4 tissue; and then it's sort of irrelevant -- once the
5 tissue is dead, it's sort of irrelevant how much
6 ischemia is going to that tissue afterwards or how
7 -- or what -- the duration of no further blood
8 supply going to that area of spinal cord is sort of
9 irrelevant because the tissue is already dead after
10 a few minutes.

11 Q. The spinal cord tissue that you're talking
12 about that suffers from ischemia and goes to infarct
13 or death, does that tissue regenerate itself?

14 A. No, it does not regenerate.

15 Q. So what does -- what does that mean?

16 A. That means that the -- those nerve cells
17 that die, those nerve cells are not coming back; and
18 that means that the function that those nerve cells
19 were responsible for, that function is lost. And
20 that creates disability or, you know, deficits for
21 the patient that they didn't have before.

22 Q. And are you familiar with the term
23 paraplegia?

24 A. Yes.

1 Q. What is that, Doctor?

2 A. Paraplegia means paralysis of both legs.

3 Q. And is that a common injury from spinal
4 cord infarct?

5 A. Yes, it is.

6 Q. Is that the only likely injury from spinal
7 cord infarct -- the paraplegia?

8 A. Well, first of all, it depends what part of
9 the -- what level the spinal cord has been --

10 Q. Well, when answering my question in this
11 case, I would like for you to maybe confine --
12 confine your response to the lower thoracic cord
13 area.

14 A. Okay. The lower thoracic cord is where Mr.
15 Green had his spinal cord infarct, and the
16 consequences of an infarct in that region are
17 actually the consequences that Mr. Green has
18 suffered.

19 That's paralysis of both legs; loss of
20 feeling, in his case, from the belly button down to
21 his toes. So no -- no loss of feeling from -- I
22 mean, no feeling from the belly button down; no
23 control of his bladder, or at least insufficient
24 control of his bladder; and insufficient control of

1 his bowels, and loss of sexual functioning.

2 Q. Doctor, by reason of your experience,
3 training, and knowledge, are you able to give an
4 opinion to a reasonable degree of medical certainty
5 as to the most probable cause of Mr. Green's damages
6 and injuries that you just described?

7 A. Well, Mr. Green -- yes, I am.

8 Q. And what would that opinion be?

9 A. Mr. Green had no problems with his spinal
10 cord after the motor vehicle collision, and his only
11 problem with his spinal cord occurred after the
12 cardiopulmonary arrest in the Grand Strand Hospital
13 emergency room.

14 And so the cause of his infarct and
15 attendant disabilities are -- the cause of his
16 spinal cord infarct and the various disabilities
17 that I listed were suffered during that arrest.

18 Q. And, Doctor, just let me go back for a
19 second, and I will be asking you about opinions
20 about the cause of Mr. Green's injuries and his
21 prognosis. And if I ask you a question that
22 involves providing your opinion, will you provide
23 that opinion to a reasonable degree of medical
24 certainty?

1 A. Yes. In fact, my answer to the preceding
2 question was provided -- was given to a reasonable
3 degree of medical certainty, and I can adhere to
4 that --

5 Q. Okay.

6 A. -- standard in any subsequent answers I
7 make.

8 Q. Okay. And if I ask you a question as to
9 the cause of Mr. Green's spinal cord infarct and the
10 damages that you laid out, will you provide the most
11 probable cause?

12 A. Yes.

13 Q. Okay. Now, based upon your review of the
14 records, when Mr. Green was brought into the
15 emergency room of the Grand Strand Regional Medical
16 Center by ambulance, what was he suffering from?

17 A. Well, his main -- he had two main problems.
18 One was a severe laceration of his right arm, and
19 the other was a fracture of his right acetabulum or
20 -- that's part of his hip. So he had the right arm
21 laceration, and he had the right hip fracture.

22 Q. Now, the -- and, Doctor, the acetabular on
23 the right hip, is that actually the socket where the
24 femur head sits in?

1 A. Yes; that's right.

2 Q. Okay. Based upon your review of the
3 records when he presented -- when Mr. Green
4 presented at the emergency room of the Grand Strand
5 Regional Medical Center, was he suffering from
6 problems with his spinal cord?

7 A. No, he was not. There were many -- there
8 were multiple physicians and other --

9 Q. Do you see any evidence in the --

10 A. Hold on.

11 Q. Go ahead, Doctor.

12 A. When he was brought to Grand Strand
13 Hospital, there were -- he was not having any
14 evidence of spinal cord problems. He was moving his
15 legs fine, and that was noted by multiple
16 clinicians, including Dr. Bauerle, who wrote in his
17 note, quote: I first assessed him in the
18 preoperative holding area. He was actually moving
19 all four extremities well, and was awake, alert, and
20 oriented, and he complained of no other
21 musculoskeletal injuries or discomfort other than
22 the right hip, unquote.

23 So there was zero evidence of any kind of
24 spinal cord problem before the arrest.

1 Q. And was that Dr. Bauerle's note?

2 A. Yes.

3 Q. And if you look, there's some numbers and
4 letters on the bottom of it. Is that contained in
5 what you have as GSRMC documents 19 and 20?

6 A. Yes; that was what I was quoting from.

7 Q. All right. Based upon your review,
8 training, knowledge, and experience, what was your
9 impression of Mr. Green's medical condition when he
10 left Grand Strand Regional Medical Center?

11 MR. MCCUTCHEON: I'm going to object to
12 both form and substance. That calls for
13 pure speculation. You may answer.

14 THE WITNESS: Well, he still had the
15 fracture of the socket of his right hip. He
16 still had the laceration of his right arm,
17 but now he had a new additional problem,
18 which was an infarct of his spinal cord.

19 BY MR. SAUTTER:

20 Q. And do you have an opinion to a reasonable
21 degree of medical certainty as to when that spinal
22 cord infarct -- when Mr. Green sustained -- most
23 probably sustained that spinal cord infarct?

24 A. Yes, I do.

1 Q. And what is that, Doctor?

2 A. He was -- he was having no spinal cord
3 problems before his cardiopulmonary arrest, and he
4 was having the spinal cord problems after the
5 arrest. So the infarct occurred during the arrest.

6 Q. Now, you're talking about arrest. What is
7 -- can you explain what arrest means to the jury,
8 please.

9 A. Well, after Dr. Bauerle had Mr. Green leave
10 the preoperative area and go to CAT scan and then
11 the CAT scan was done and then Mr. Green was
12 returned to the emergency room, back in the
13 emergency room, his heart stopped and he stopped
14 breathing. That's the arrest I'm talking about.

15 Q. All right.

16 A. And, of course, that's -- that's a --
17 that's an emergency. You can't go without a pulse
18 or breathing, and your tissue is at risk of not --
19 of dying anywhere -- you know, any organ in the body
20 is at risk of dying because they're not getting
21 supply when your heart stops and when you're not
22 breathing.

23 And Mr. Green was -- there was a code
24 called where he was -- his -- there were

1 compressions being made to his chest to create a
2 rudimentary sort of heart beat which simulated a
3 heart beat and then -- and they were also
4 mechanically breathing for him. This arrest lasted
5 26 minutes, according to the resuscitation record.

6 And, as I say, during that time, the --
7 there's -- his organs are at risk; and, indeed,
8 unfortunately, during that time, he suffered -- his
9 spinal cord suffered lethal damage.

10 Q. Okay. You talked about code. What does it
11 mean for a patient to code and, specifically, in the
12 emergency room where -- such as Mr. Green did?

13 A. Well, a code is usually -- like in my
14 hospital, a code blue is called when someone has an
15 arrest of their heart or their breathing. And it's
16 announced over the loud speaker. It's sent by pager
17 to doctors who respond to a code, and everyone drops
18 everything and rushes to the patient who's not
19 breathing or not having a heart beat.

20 And these resuscitative measures that I
21 explained, you know, compressions of his chest
22 externally and breathing for the patient, are the
23 measures instituted during a code in order to try to
24 save the patient.

1 Q. At what point in his treatment did Mr.
2 Green have the cardiac arrest?

3 A. Well, it was -- it occurred after he
4 returned from the CAT scan that Dr. Bauerle had
5 ordered back in the emergency room. According to
6 the resuscitation records, the code started at
7 2:48 p.m. This was -- he had arrived in the
8 emergency room at 1:00 p.m.

9 Q. Okay. And was Mr. -- from your review of
10 the records, can you tell where Mr. Green was when
11 Dr. Bauerle ordered that he have the CT scan?

12 A. Yes.

13 Q. And where -- where was he?

14 A. He had been in the preoperative area. What
15 had happened -- the sequence of events was that Mr.
16 Green was picked up by ambulance at the scene of the
17 motor vehicle collision. He was brought to the
18 emergency room at Grand Strand Hospital.

19 The emergency doctor at Grand Strand,
20 Dr. Lintz, made arrangements for -- he understood
21 that Mr. Green had a severe laceration of his right
22 arm and that he had this fracture in the socket of
23 his right hip. He made arrangements for -- he
24 called both Dr. Cozart, a surgeon to deal with the

1 arm, and Dr. Bauerle, the orthopedist, to deal with
2 the hip, and Dr. Cozart was -- was -- had -- made
3 arrangements for -- arrangements were made for Mr.
4 Green to be taken to the operating room to have the
5 arm repaired, and he was in the -- he was already
6 moved out of the emergency room to the preoperative
7 holding area.

8 He was poised to go into the operating room
9 when Dr. Bauerle came on the scene and interrupted
10 that sequence and sent Mr. Green to CAT scan, and
11 then, from CAT scan, back to the emergency room, not
12 back to the preoperative area, but instead back to
13 the emergency room.

14 Q. So -- so was the --

15 A. So the surgery that was poised to happen
16 was interrupted and did not occur in the -- as
17 intended.

18 Q. Did -- did the ordering to the CT scan
19 ultimately delay the repair of the radial artery and
20 the ulnar artery?

21 A. The arteries that were severed and the
22 laceration, yes. It did delay the repair of those
23 arteries.

24 Q. And from your review of the medical

1 records, do you have an opinion as to whether Mr.
2 Green was losing blood during this time?

3 A. Yes; he certainly was.

4 Q. And did -- to a reasonable degree of
5 medical certainty --

6 A. I mean, the records states that dressings
7 applied to the forearm were soaked in blood, and
8 this was an ongoing process. So he was losing
9 blood.

10 That was the whole point of getting him
11 into the operating room: To tie up the arteries
12 that were causing blood loss -- that were cut that
13 were -- that were open and that were bleeding. The
14 reason to have the surgery was to repair those
15 arteries to stop the bleeding and also to repair the
16 damage -- the other damage to the forearm.

17 Q. So what -- what role did the bleeding from
18 the right arteries of his forearm have in the
19 arrest, if you could give an opinion on that?

20 A. Well, the -- as I explained, at 2:48 p.m.,
21 Mr. Green's heart stopped -- or at least there was
22 no pulse, and he was not breathing. And the most --
23 the cause for that arrest that was -- there's really
24 no dispute about it; that the only plausible

6

1 A According to the patient, at the time of
2 the wreck is when that occurred.

3 Q All right, sir. And in the same time
4 frame as the automobile accident the paralysis
5 occurred?

6 A Yes. According to the patient.

7 Q Yes.

8 A I wasn't around.

9 Q All right, sir. And you have not made
10 any -- or have you made any independent examination
11 with regard to the cause of his paralysis?

12 A No. You mean could I investigate and go
13 back and determine truly was the wreck the cause of
14 the paralysis?

15 Q Yes, sir.

16 A No.

17 Q So what has been the nature of your
18 treatment of Mr. Green?

19 A Well, he's had multiple problems since the
20 wreck. And just trying to get everything under
21 control from his urinary problems to his bowel
22 problems to several pressure ulcers to an abscess in
23 his thigh or hip, to repeated infections. It's just
24 routine things you take care of somebody for when
25 they have a spinal cord injury.

10

1 THE WITNESS: You ended with a question.

2 So I need to give an answer. I don't recall
3 any -- I don't have any notes about the ulcers
4 on his feet.

5 BY MR. QUERY:

6 Q All right, sir. You do recall that there
7 was an episode involving ulcerated feet sometime
8 within the last couple of years?

9 A Yes, sir, just from memory.

10 Q And he was treated by whom?

11 A Dr. Myers, I believe, is his podiatrist,
12 but I don't have any of his notes.

13 Q Yes, sir. Dr. Garner, if you could then
14 just tell us in some detail exactly what the
15 neurogenic bladder, neurogenic bowel, what those
16 terms mean, and whether they're a part of Randy's
17 life, and how that affects his day-to-day life.

18 A He does have both neurogenic bowel and
19 bladder, which means he can't empty his bladder. He
20 has to do self-catheterizations periodically, which
21 means he or his wife has to stick a tube through his
22 penis into his bladder and drain his bladder
23 periodically.

24 His bowels have been both ways. There was awhile
25 that after a course of antibiotics for one of his frequent

1 infections, he had uncontrollable diarrhea. They were just
2 running all the time. And in other times they will have to
3 manually evacuate his bowels. His wife has to stick a
4 finger in and literally dig them out. And exactly which has
5 become his predominant problem lately, I don't recall cause
6 he's been both ways. And -- but that is part of his daily
7 life. It's a very big part of his daily life is getting his
8 bowels and bladder to function. Excuse me, not to get them
9 to function but to deal with their lack of function as a
10 daily occurrence. Of course, it severely affects your daily
11 life.

12 Q And I'm sorry, I think I asked this
13 before, but please pardon me for repeating myself if
14 I did.

15 The lack of sensation, how does that or does that
16 affect the ulcers that might occur?

17 A It makes you much more likely to get an
18 ulcer because you don't have any of the sensation of
19 pain, a warning that you left pressure on your foot
20 too long. So the skin will actually and the tissues
21 underneath will actually begin to die for lack of
22 circulation just from pressure. And you and I would
23 experience discomfort and would move long before
24 that happened. But his lack of sensation means that
25 he has to consciously think every position he gets

12

1 in, he can't stay there very long. He's got to
2 constantly move or have somebody move his feet and
3 ankles, and the type of shoes he wears, the foot
4 support he has on his wheelchair, all have to keep
5 that in mind that you have to evenly distribute the
6 pressure so he doesn't get pressure ulcers because
7 he won't know that it's beginning to occur. And
8 these things can occur in just a matter of hours.
9 If you cut off the blood supply to tissue for very
10 long, it begins to die, and he won't know. You and
11 I wouldn't get these ulcers because we wouldn't
12 leave ourselves in a position long enough to get
13 one. So it's a direct contributor to that.

14 Q Are those pressure ulcers or the potential
15 for pressure ulcers limited to his feet?

16 A No. Anywhere. But most common place we
17 see them are on people's buttocks from sitting in a
18 wheelchair, or from sitting anywhere he sits. He
19 has to have special pads in his wheelchair so he
20 doesn't get them. Where you and I will shift from
21 time to time, he's unaware of the discomfort.

22 The other is laying in a bed over any bony
23 pressure point like your iliac crest, the greater tuberosity
24 in your hip, the part that sticks out of your hip. Ankles.
25 When you lay on your side, those things all have pressure.

1 And when he lays on his side, he or somebody has to
2 continually move him. And he has to constantly move. He
3 can't just stay in one position. Most of the parts of his
4 lower body are subject to this. And he does a pretty good
5 job, he and his wife, of consciously making sure he doesn't
6 get them.

7 Q Is sexual function affected by his
8 paralysis?

9 A Well, I'm sure it has. I can't remember
10 ever having that conversation with him. But I'm
11 sure that he has none.

12 Q And Doctor, are these -- is this a
13 condition that is likely to change?

14 A No. Barring some new discovery in
15 medicine, no. This is permanent.

16 Q Give us just a minute.

17 VIDEOGRAPHER: Off the record at 11:28.

18 (Off-the-record conference.)

19 VIDEOGRAPHER: Back on the record 11:28.

20 BY MR. QUERY:

21 Q I guess finally, Doctor, is Mr. Green's
22 general health affected by his paraplegic condition?

23 A Oh yes. He's a lot more likely to have
24 infections of all kinds, not just from pressure
25 ulcers. Just the fact of sticking a catheter in

14.

1 your bladder four, five, six times a day is more
2 likely to induce infection. He has had urinary
3 tract infections. His bowel function is a problem.
4 Paraplegics are more likely to have renal failure in
5 the future. They get pneumonias more often just
6 cause they don't move. But infections in general
7 are a real potential problem for him. Those are
8 probably his two greatest, pressure ulcers and
9 infection.

10 But his general health, you know, if you don't
11 move and exercise, then cardiac function deteriorates. He
12 can't do enough aerobic activity to keep his heart healthy
13 either. It affects his general health in a lot of ways.

14 Q Thank you, Doctor. Please answer any
15 questions that counsel may have.

16 A Through all this, I forgot to say whether
17 degree of medical certainty. Should I have said
18 that at the end of every sentence?

19 Q No. That's why I kind of asked you the
20 general in the beginning.

21 A Okay. Good.

22 Q So I will ask you then, any opinions that
23 you have expressed, have those been to a reasonable
24 degree of medical certainty?

25 A Yes, sir, they have.

1 Q Thank you.

2 EXAMINATION

3 BY MS. THOMAS:

4 Q And if they have not been to a reasonable
5 degree of medical certainty, have you told us that?

6 A If they would not have been, I would have,
7 yes.

8 Q Okay. Thank you.

9 Dr. Garner, my name is Lisa Thomas, and I
10 represent Dr. Bauerle, and I just have a few questions for
11 you this morning.

12 As Mr. Green's primary care physician, you not
13 only take care of the complications that result from his
14 paralysis, but you take care of any medical complaint that
15 he comes in with, is that true?

16 A Yes.

17 Q And I believe in looking through your
18 medical records, you also treat him for diabetes.

19 A Yes.

20 Q For high blood pressure.

21 A Yes.

22 Q For high cholesterol.

23 A Yes.

24 Q And I think there's even a note or a
25 mention of some hearing issues.

16

1 A There was one recently, yes.

2 Q And none of those conditions are related
3 to his paralysis, are they?

4 A I don't think so, but I didn't know him
5 before the accident. So I don't know if he was a
6 diabetic beforehand. I don't know if he had -- that
7 would be the one that would be most likely. In his
8 injuries, did he have a pancreatic injury that
9 rendered him diabetic. But the cholesterol and high
10 blood pressure, no.

11 Q Okay. And so it would be fair to say that
12 you treat him for whatever injury or medical
13 complaint that he has when he comes in.

14 A Yes. Or at least send him where he needs
15 to go if we can't handle it.

16 Q Or refer him to someone if it's not a
17 specialty that you would handle.

18 A Right.

19 Q And that would include his treatment for
20 the paralysis or the complications from the
21 paralysis as well as his general health.

22 A Yes.

23 Q That's all the questions I have for you,
24 Doctor. Thank you.

25 EXAMINATION

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Randall M. Green and Ann Green

Plaintiffs,

vs.

Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC, Grand Strand Regional
Medical Center, LLC and Carolinas Medical
Response, Inc.

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

**AMENDED
ANSWER TO
DEFENDANT GRAND STRAND
REGIONAL MEDICAL CENTER
REQUEST TO ADMIT**

**TO: THE DEFENDANT, GRAND STRAND REGIONAL MEDICAL CENTER, LLC AND
ITS ATTORNEY, WELDON R. JOHNSON, ESQUIRE**

The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC, answering Defendant, Grand Strand Regional Medical Center's Request to Admit,
would state as follows:

I. RESERVATION OF RIGHTS

1. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any rights to pursue and be
heard on any and all defenses set forth in its Answer to the Complaint.

2. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any objections which may
be appropriate to Request to Admit.

3. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand
Orthopaedic Consultants, LLC, specifically reserves and does not waive any objections which may

DISCN 06/13/1

be otherwise available to it and further states that no response should be deemed as an admission of relevancy, materiality or admissibility of any response or document produced. It further reserves the right to amend or supplement its response, if appropriate.

II. GENERAL OBJECTION

1. The Defendant, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic Consultants, LLC object to responding to any Interrogatory or Request for Production that seeks information which constitutes confidential attorney-client communication or which falls within the scope of Rule 26(b) or which exceeds the scope of discovery otherwise provided by the South Carolina Rules of Civil Procedure or by statute or common law.

III. RESPONSES

1. The employees of Grand Strand Regional Medical Center did not proximately cause or contribute to the injuries and damages alleged to have been sustained by Plaintiffs in the Third Amended Complaint.

ANSWER: Admit.

JOHN B. McCUTCHEON, JR.
LISA A. THOMAS
Attorneys for Wayne B. Bauerle, MD, Wayne B.
Bauerle, MD, PC and Strand Orthopaedic
Consultants, LLC



McCUTCHEON, McCUTCHEON & BAXTER, PA
208 Elm Street P. O. Box 1003
Conway, SC 29526 (843)248-7225

March 4, 2008

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

Randall M. Green and Ann Green)

Plaintiffs,)

vs.)

Wayne B. Bauerle, MD, Wayne B.)
Bauerle, MD, PC and Strand Orthopaedic)
Consultants, LLC, Grand Strand Regional)
Medical Center, LLC and Carolinas Medical)
Response, Inc.)

Defendants.)

**AFFIDAVIT
OF
SERVICE**

TO: THE PLAINTIFFS, AND THEIR ATTORNEY,

PERSONALLY APPEARED before me, Janet A. Ramsden, who upon oath, says that she mailed a copy of the Defendants, Wayne B. Bauerle, MD, Wayne B. Bauerle, MD, PC and Strand Orthopaedic Consultants, LLC Amended Answer to Defendant Grand Strand Regional Medical Center's Request to Admit to all counsel, together with Affidavit of Service by Mail, in connection with the above-captioned matter by depositing same in the United States Mail, in Conway, South Carolina, on this 4th day of March, 2008, bearing proper postage and addressed as follows:

Weldon R. Johnson, Esquire
1613 Main Street
Post Office Box 8448
Columbia, SC 29202

Vernon Glenn, Esquire
211 Scott Street
Mt. Pleasant, SC 29464

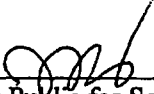
Joseph P. McLean, Esquire
Clarke, Johnson, Peterson & McLean
P. O. Box 1865
Florence, SC 29503

Paul N. Uricchio, III, Esquire
147 Wappoo Creek Drive, Suite 205
Charleston, SC 29412

DISCN 06/13/1

Janet A. Ramsden
Janet A. Ramsden

SWORN TO before me this
4th day of March, 2008

 (L.S.)
Notary Public for South Carolina
My Commission Expires: 9/14/2001

**Covenant Not to Sue and Covenant
Not to Prosecute or Execute
Judgment, dated May 31, 2013**

**(To Be Filed Under Seal
by Counsel for
Respondents/Appellants)**

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No. 2011-CP-26-7403

Randall M. Green and Ann Green,.....Respondents-Appellants,

v.

Wayne B. Bauerle, M.D. and

Wayne B. Bauerle, M.D., P.C.,.....Appellants-Respondents.

NOTICE OF APPEAL

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MAR 17 2014

SC Court of Appeals

Randall M. Green and Ann Green appeal the post-trial order of the Honorable Steven H. John, dated October 16, 2013, Granting in Part and Denying in Part Appellants-Respondents', Wayne B. Bauerle, MD, and Wayne B. Bauerle, MD, PC, Motion for Set-off. This appeal is taken from the order dated February 13, 2014 denying Respondents-Appellants', Randall M. Green and Ann Green, Motion to Alter or Amend the Order Granting in Part and Denying in Part Appellants-Respondents' Motion for Set-off, said order having constituted the final judgment of the trial court. Respondents-Appellants received a notice of appeal from Appellants-Respondents on March 11, 2013.

(Signature follows on the next page.)

March 14, 2014

E. Brooks Hurt for OGG

O. Grady Query, Esquire
Elizabeth Brooks Hurt
Query Sautter Forsythe, LLC
The Wappoo Centre
147 Wappoo Creek Drive, Suite 202
Charleston, South Carolina 29413
(843) 795-9500

L. Morgan Martin, Esquire
L. Morgan Martin, PA
1121 Third Avenue
Conway, South Carolina 29526
(843) 248-3177

Cristin Uricchio, Esquire
Uricchio Law Firm
The Wappoo Centre
147 Wappoo Creek Drive, Suite 205
Charleston, South Carolina 29412
(843) 795-9300

Counsel for Respondents-Appellants

Other Counsel of Record:

John B. McCutcheon, Jr., Esquire
Lisa A. Thomas, Esquire
Thompson & Henry, PA
1300 Second Avenue, Third Floor
Post Office Box 1740
Conway, South Carolina 29528
(843) 248-5741

Andrew F. Lindemann, Esquire
Davidson & Lindemann, P.A.
1611 Devonshire Drive
Post Office Box 8568
Columbia, South Carolina 29202
(803) 806-8222

Counsel for Appellants-Respondents

FILED
STATE OF SOUTH CAROLINA COUNTY) IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY 2013 OCT 17 AM 10:35) FIFTEENTH JUDICIAL CIRCUIT
CASE NO: 2005-CP-26-2805

CELAMIE HUGGINS-WARD
Clerk of Court
Randall M. Green and Ann Green

Plaintiffs,

vs.

Wayne B. Bauerle, M.D., and Wayne B.
Bauerle, M.D., P.C.,

Defendants.

ORDER GRANTING IN PART AND
DENYING IN PART DEFENDANTS
WAYNE B. BAUERLE, MD, AND
WAYNE B. BAUERLE, MD, PC'S
MOTION FOR SET OFF

FACTS

This medical malpractice case was tried before a jury during the week of September 9, 2013, with the Honorable Steven H. John presiding. The jury found for Randall M. Green, under a medical malpractice theory, in the amount of \$2.3 million and Ann Green, under a loss of consortium theory, in the amount of \$550,000.

Prior to trial, Defendant Grand Strand Regional Medical Center, LLC ("Grand Strand") settled with the Plaintiffs for \$2 million. The ambulance company, Carolinas Medical Response, Inc., settled with the Plaintiffs for \$25,000.00. In addition, Mr. Green settled with the at-fault driver for \$100,000.00, and he received \$150,000.00 in settlement of his underinsured motorist claim. Likewise, Mrs. Green received \$100,000.00 in settlement with the at-fault driver and an additional \$75,000.00 in settlement of her underinsured motorist claim. Finally, the Medical University of South Carolina (MUSC) settled with the Plaintiffs for \$160,000 for medical negligence stemming from allegations that a sponge was left in Mr. Green's leg by staff at MUSC.

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MAR 17 2014

SC Court of Appeals

Following the trial, the Defendants moved to off set the verdict with the amounts paid in settlement on behalf of Grand Strand, Carolinas Medical Response, the at-fault driver (including the underinsured motorist payments), and MUSC.

For the below reasons, the Defendants' Motion for Set Off is granted in part and denied in part. The Court grants a set-off for the amounts paid in settlement on behalf of Grand Strand and Carolina Medical Response, and denies a set-off for the amounts paid in settlement on behalf of the Medical University of South Carolina and the at-fault driver including the underinsured motorist payments.

LAW AND ANALYSIS

I. SET-OFF

"When a release or a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death: (1) it does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide, but it reduces the claim against the others to the extent of any amount stipulated by the release or the covenant, or in the amount of the consideration paid for it, whichever is the greater." S.C. Code Ann. § 15-38-50.

"A nonsettling defendant is entitled to credit for the amount paid by another defendant who settles." Hawkins v. Pathology Associates of Greenville, P.A., 330 S.C. 92, 113, 498 S.E.2d 395, 406 (Ct. App. 1998) (citing Powers v. Temple, 250 S.C. 149, 156 S.E.2d 759 (1967); Vaughn v. City of Anderson, 300 S.C. 55, 386 S.E.2d 297 (Ct. App. 1989)). "Therefore, before entering judgment on a jury verdict, the court must reduce the amount of the verdict to account for any funds previously paid by a settling defendant, so long as the settlement funds were paid to compensate the same plaintiff on a claim for the same injury." Smith v. Widener, 397 S.C. 468,

2/18
A.A.

471-72, 724 S.E.2d 188, 190 (Cl. App. 2012) (citing Hawkins v. Pathology Associates of Greenville, PA, 330 S.C. 92, 113, 498 S.E.2d 395, 406 (Cl. App. 1998)). "When the settlement is for the same injury, the nonsettling defendant's right to a setoff arises by operation of law." Smith, 397 S.C. at 472, 724 S.E.2d at 190 (citing Ellis v. Oliver, 335 S.C. 106, 113, 515 S.E.2d 268, 271-72 (Cl. App. 1999)). "Therefore, a plaintiff's claim for actual and punitive damages arising from the same injury is the same claim for purposes of setoff under section 15-38-50(1)." Smith v. Widener, 397 S.C. 468, 473, 724 S.E.2d 188, 191 (Cl. App. 2012).

In Ellis v. Oliver, 335 S.C. 106, 515 S.E.2d 268 (Cl. App. 1999), the Court of Appeals explained that "[a]pplication of the settlement credit was statutorily mandated in this case. Section 15-38-50 grants the court no discretion in determining the equities involved in applying a set-off once a release has been executed in good faith between a plaintiff and one of several joint tortfeasors." Ellis, 335 S.C. at 113, 515 S.E.2d at 272.

In the case at bar, this Court finds that the Plaintiffs' settlements with Grand Strand and Carolinas Medical Response were for the same injury, that being Mr. Green's paralysis and the loss of consortium by Mrs. Green, as was litigated against Dr. Bauerle and for which the jury returned its verdict against Dr. Bauerle.¹ The Court disagrees with the Plaintiffs' claim that they suffered different injuries. Likewise, the Court rejects the Plaintiffs' argument that their settlements were for different causes of action.² In accordance with Ellis v. Oliver and Smith v.

¹ For ease of discussion, the Defendants Wayne B. Bauerle, M.D., and Wayne B. Bauerle, M.D., P.C. shall be referred to collectively as "Dr. Bauerle."

² In opposing the Defendants' Motion for Set Off, the Plaintiffs argue that their settlement with Grand Strand and the verdict against Dr. Bauerle resulted from different causes of action. This Court disagrees. In making this argument, the Plaintiffs cite to the Order filed May 1, 2013, where Judge Larry Hyman granted partial summary judgment to Grand Strand on the causes of action for vicarious liability and negligent hiring, supervision and training. Nonetheless, Judge Hyman did not dismiss the Plaintiffs' negligence cause of action which was the

Widener, supra, the settlements from Grand Strand and Carolinas Medical Response shall be set-off because they concerned the same injury as the jury verdict against Dr. Bauerle.

However, the Court further concludes that the settlements on behalf of the at-fault driver (including the underinsured motorist payments) and MUSC concerned different injuries than the injury for which the jury found Dr. Bauerle liable. Specifically, the settlement with MUSC concerned an injury to Mr. Green's leg, which the Court finds to be a separate injury from Mr. Green's paralysis. In addition, the Court finds that the settlement with the at-fault driver concerning events occurring prior to Mr. Green's paralysis do not concern the same injury. Because those settlements involved different injuries, this Court rules those settlements are not subject to a set-off.

II. APPORTIONMENT OF THE SET-OFF

At trial, the jury found for Randall M. Green in the amount of \$2.3 million and Ann Green in the amount of \$550,000. Grand Strand settled with the Plaintiffs for \$2 million and Carolinas Medical Response settled for \$25,000 prior to trial. Those settlements did not provide for a specific allocation of the settlement amounts between Mr. Green and Mrs. Green. In making an equitable allocation of those settlement amounts between Mr. Green and Mrs. Green, the Court finds that it is reasonable, fair, and just to utilize the jury's verdict as to the Plaintiffs' claims. As a result, this Court will apply the percentage of the total verdict given to each Plaintiff by the jury to apportion the settlements between Mr. Green's claim for medical malpractice and Mrs. Green's claim for loss of consortium.

first cause of action in the Fourth Amended Complaint where the very same allegations of negligence were alleged against all Defendants including Grand Strand and Dr. Bauerle. Moreover, the settlement with Grand Strand occurred before any appeal rights were extinguished. The Plaintiffs still had the right until thirty days after final judgment was entered to appeal the grant of partial summary judgment by Judge Hyman, and the Plaintiffs' settlement with Grand Strand was intended to and did extinguish all claims against Grand Strand.

The South Carolina Supreme Court has specifically authorized the equitable *reallocation*

See e.g., Rutland v. South Carolina Department of Transportation, 400 S.C. 209, 734 S.E.2d 142.

In the case at bar, the jury found for Mr. and Mrs. Green for a combined verdict of \$2.85 million against the Defendants. The jury awarded Mr. Green \$2.3 million of the total \$2.85 million verdict, or 80.70% of the total verdict. The jury awarded Mrs. Green \$550,000 or 19.30% of the total verdict. Using that allocation, this Court rules that the \$2 million settlement with Grand Strand shall off set the verdict for Mr. Green in the amount of \$1,614,035.09 and the verdict for Mrs. Green in the amount of \$385,694.91. Likewise, the settlement between Plaintiffs and Carolinas Medical Response shall off set the verdict for Mr. Green in the amount of \$20,175.44 and the verdict for Mrs. Green in the amount of \$4,824.56.

ORDERED that the Defendants' Motion for Set Off is granted in part and denied in part as set forth above. The Clerk of Court is directed to enter judgment in the amount of \$665,789.47 in favor of the Plaintiff Randall M. Green against the Defendants and to enter judgment in the amount of \$159,480.53 in favor of the Plaintiff Ann Green against the Defendants.

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SC Court of Appeals

STATE OF SOUTH CAROLINA
COUNTY OF HORRY
RANDALL M. GREEN AND ANN GREEN,

Plaintiff,

v.

WAYNE B. BAUERLE, MD, and WAYNE B.
BAUERLE, MD, PC,

Defendants.

) IN THE COURT OF COMMON PLEAS
)
) FIFTEENTH JUDICIAL CIRCUIT

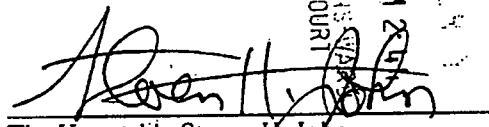
) C/A # 2011-CP-26-7403

) ORDER DENYING DEFENDANT'S
) MOTION TO ALTER OR AMEND
) ORDER GRANTING PARTIAL
) SET-OFF

This matter came before the Court on Defendant's Motion dated November 7, 2013, to Alter or Amend the Court's Order Granting Partial Set-Off. The Court has considered Defendant's Motion and all other matters in the Clerk of Court's file. The Court believes it addressed the matters in its previous Order. The Court finds that oral arguments would not assist it in this matter and that any additional arguments would be redundant and unnecessary. It is therefore

ORDERED that Defendant's Motion to Alter or Amend the Court's Order Granting Partial Set-Off is denied and the previous Order is reaffirmed in toto.

14 FEB 13 PM 2:14
CLERK OF COURT



The Honorable Steven H. John
Resident Judge
Fifteenth Judicial Circuit

February 13, 2014
Conway, South Carolina

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No. 2011-CP-26-7403

Randall M. Green and Ann Green,.....Respondents-Appellants,

v.

Wayne B. Bauerle, M.D. and

Wayne B. Bauerle, M.D., P.C.,.....Appellants-Respondents.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Wayne B. Bauerle, M.D. and Wayne B. Bauerle, M.D., P.C. by depositing a copy of it in the United States Mail, postage prepaid, on March 14, 2014, addressed to his attorneys of record at their offices as follows:

John B. McCutcheon, Jr., Esquire
Lisa A. Thomas, Esquire
Post Office Box 1740
Conway, South Carolina 29528

Andrew F. Lindemann, Esquire
Davidson & Lindemann, P.A.
Post Office Box 8568
Columbia, South Carolina 29202

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MAR 17 2014

SC Court of Appeals

March 14, 2014

E. Brooks Hunt for
OGQ

O. Grady Query, Esquire
Elizabeth Brooks Hurt
Query Sautter Forsythe, LLC
The Wappoo Centre
147 Wappoo Creek Drive, Suite 202
Charleston, South Carolina 29413
(843) 795-9500

L. Morgan Martin, Esquire
L. Morgan Martin, PA
1121 Third Avenue
Conway, South Carolina 29526
(843) 248-3177

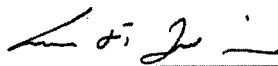
Cristin Uricchio, Esquire
Uricchio Law Firm
The Wappoo Centre
147 Wappoo Creek Drive, Suite 205
Charleston, South Carolina 29412
(843) 795-9300

Counsel for Respondents-Appellants

CERTIFICATE OF COUNSEL

The undersigned counsel certifies that the Record on Appeal contains all material proposed to be included by all parties and not any other material.

DAVIDSON & LINDEMANN, P.A.

BY: 

ANDREW F. LINDEMANN
1611 Devonshire Drive
Post Office Box 8568
Columbia, South Carolina 29202
(803) 806-8222

*Counsel for Appellants-Respondents
Wayne B. Bauerle, M.D. and Wayne B.
Bauerle, M.D., P.C.*

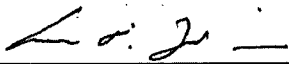
Columbia, South Carolina

September 30, 2014

CERTIFICATE OF COMPLIANCE

The undersigned counsel for the Appellants-Respondents Wayne B. Bauerle, M.D. and Wayne B. Bauerle, M.D., P.C. certifies that the Record on Appeal complies with the Supreme Court's Revised Order of April 15, 2014, regarding personal identifiers and sensitive information.

DAVIDSON & LINDEMANN, P.A.

BY: 

ANDREW F. LINDEMANN
1611 Devonshire Drive
Post Office Box 8568
Columbia, South Carolina 29202
(803) 806-8222

*Counsel for Appellants-Respondents
Wayne B. Bauerle, M.D. and Wayne B.
Bauerle, M.D., P.C.*

Columbia, South Carolina

September 30, 2014